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*Revisiting the Canada Health Act (1984):
What Are the Impediments to Change?*
by

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I am honoured to be associated with the celebration of the 30th anniversary of the Institute for Research on Public Policy. I am also flattered to be the first speaker of this series commemorating the excellent work of the Institute through workshops, the monthly *Policy Options/Options politiques*, research papers, conferences, all facilitating the discussion of Canadian public policies over three decades. When Hugh Segal invited me to revisit the *Canada Health Act (1984)*, however, I wondered for a minute if I would not sound like an old record – a very unpleasant feeling. It is a fact that I am boringly consistent, I admit. Hugh's gentle irony, not to say powerful irony – not really sarcasm – was in a low mode that day, and I simply accepted.

The mandate I was given reads very simply: *The Canada Health Act (1984)*, Why did you do it? What would you be doing today? (which I translated in my head as: Would you do it again?...) So, first: back to history. Then I will share with you how I view the situation today.

But before starting, let me make it very clear: I do not believe health care in Canada is in a state of crisis. It is imperfect and it has problems, but it is not in crisis and, on the whole, it has served and is still serving Canadians rather well.

"Medicare" twenty years ago:

On April 9, 1984, after four and a half years of very public discussions, negotiations, disagreements between Ottawa and the provinces; active hostility from organized medicine; as well as heated debates and opposition in the House of Commons, the *Canada Health Act (CHA)*¹ was unanimously adopted on third reading by all parties. The Act became law on April 17, and was first applied in July of the same year.

It very much repeated the history of the unanimous passage, on April 10, 1957 – 27 years before almost to the day - of the *Hospital Insurance and Diagnostic Services Act* in the House, under Paul Martin Sr.'s leadership. *HIDS*, as it is still referred to, was the very foundation of our public and universal national health care system. The other half of the foundation was to come 10 years after, when the *Medical Care Act* introduced by Allan MacEachen passed third reading on December 8, 1966. It did not make unanimity however, and two MP's voted against the legislation, but it still received a 99% parliamentary support.

Why did the government table the *CHA*? To correct a situation of erosion of medicare caused by the fact that the 1977 change to the mode of federal financing of that program from a 50-50 cost-sharing to an annual block-funding to the provinces had no enforcement mechanism, should a breach of the federal legislation occur. This is the short, technical answer. The reality was of course far from that clear. I have documented² how the dossier took life in February, 1979, when Ed Broadbent repeatedly challenged me quite aggressively at Question Period about Ontario

¹ A legislation deemed necessary to clarify the five program criteria mandated by the federal government as the basis for its transfer payments to the provinces towards hospitals and physicians services costs, and to ban institutional user fees and physicians' extra-billing which might have lead to a two-tiered health care system.

² Monique Bégin, *Medicare: Canada's Right to Health*, Optimum Publishing International Inc., Montreal, 1988, 215 p.

physicians' extra-billing. Soon after came the issue of user fees by hospitals or other institutions: long-term care, etc. I had never heard of that and, in truth, I did not know what Broadbent was talking about. But he was credible, so I knew I had a problem.

As the 1977 *Established Programs Financing Act*, or *EPF*, – the legislation that did away with the old 50-50 cost-sharing concept – had passed just before I became the Minister of National Health and Welfare, health care was considered by my Department a dossier “under control” and I had not been briefed much about it. The *EPF* legislation had not repealed the two pillars of medicare: *HIDS* and the *Medical Care Act*. So their conditions and regulations about universality, comprehensiveness, portability and public administration still applied, with one major drawback: the feds could no longer refuse to reimburse their half of the costs when it was felt there was a problem, for we had chosen a major tax points transfer associated to an “automatic” monthly lump sum global payment for health (and post-secondary education) sent to each provincial Treasurer, with no enforcement mechanism.

Why was the health care system suddenly faced with extra-billing by physicians and user-fees by provincial institutions? Certainly for ideological reasons and political philosophy which questioned the role of government in society all over the Western world. The so-called neo-conservative economics had swept the country and elites on all sides had fast bought into the return to the private sector and economic *laissez-faire*. In Ottawa, the first attacks to dismantle the Canadian Welfare State – or safety net - had started in the Fall 1977, with fierce behind-the-scene battles to do away with the universality of family allowances. Partisan politics did not help; in 1979-1980, eight of the ten provinces had conservative governments while the Trudeau's Liberals were obviously at the end of a political regime. Other causes could be traced to the climate of economic crisis of the early 80's – “stagflation” with unemployment at the two digits level, inflation at 12% and interest rates above 20%. The 1975-1978 Anti-Inflation Board (wage and price control), from which physicians' incomes had not been exempted, also probably played a role.

My first challenge was to learn the facts and the magnitude of the alleged crisis. My Department had no statistics and was no longer capable of monitoring the situation, the “cost-sharing” staff having dropped from 200 to 12 experts. Bit by bit, we were slowly able to establish what was going on. For example, we were able to determine that, in 1979, 17.9% of the 14,000 Ontario doctors had opted-out of medicare and were extra-billing – never heard of – and provinces had started cutting health budgets. I concluded that extra-billing and user-fees were a case of erosion of the system and that something had to be done. But what and how? The constitutional challenge – controlling provincial institutions and health professionals' behaviour - was not insignificant and was the most important task to address. It took almost three years to find a way and we succeeded thanks to top constitutional experts outside of government. Convincing Cabinet was also a challenge, but on that I will not say more.

Bill C-3 (the *Canada Health Act*) was developed by Justice and National Health and Welfare, and I tabled it on December 12, 1983, at the same time that a copy was hand delivered to each of my provincial counterparts. Its purpose was to (indirectly) ban extra-billing by physicians and user-fees by provincial institutions through a novel “non-punitive” enforcement mechanism: a one dollar penalty on the province's block-fund for one dollar of extra-charges to patients, whatever the source of these extra-charges. Penalties would apply as soon as the legislation was the law of the

land, but provinces would have three years to put their house in order. If they had done so within the three years, they would receive back the entire penalty imposed on them.

Otherwise, Bill C-3 repeated the conditions of *HIDS* and the *Medical Care Act*, to which we added the fifth criterion of “accessibility” in order to complement that of “universality”. A Preamble was written to specify the intent of the federal transfers. Finally, a general enforcement mechanism for eventual future breaches, yet unspecified, was devised. It was based on discretionary financial penalties.

Assessing the *Canada Health Act*

At the end of the first three years, penalties had been levied against seven of the ten provinces. The total penalties amounted to \$245 M. Extra-billing accounted to \$134 M compared to user fees which amounted to \$111 M. Through mechanisms of their choice, and after a 23 day long doctors’ strike in Ontario, all provinces had banned these extra-charges practices, and all penalties had been reimbursed to them. So the *Canada Health Act* had done what it was meant to do: do away with extra-billing and user fees.

In practice, however, the *CHA* has not been applied since. In the words of the Auditor General in his 1999 report:

“We found that the federal government has never imposed discretionary financial penalties on provinces and territories for non-compliance with the five criteria of the *Canada Health Act*. (...) In the last five years, six cases of non-compliance have been resolved through (a non-intrusive approach).”³

The report notes that other cases have not been resolved, including breaches of the criterion of “portability” in five provinces. Considerable discussions between the parties took place, but the cases remained unresolved. In my opinion, if there is one *CHA* criterion that can still be enforced despite the flaws of the Act, it is “portability”.

Outside of its strict legal role and of its existence as a piece of legislation, good or bad, the *Canada Health Act* also certainly played an important role in rooting our public, universal health insurance system in the Canadian psyche. Medicare became deeply entrenched in our national identity. There is no doubt in my mind that this love of medicare or of the *CHA* protected the program from further erosion.

Which takes me to today's situation.

Today's situation

The first question I would ask myself is: What is modern health care and what we are trying to achieve in terms of public policies? Assessing what we have learned about what makes us healthy; observing the geometric progression of medical knowledge; noting the new forces driving

³ *Report of the Auditor General of Canada to the House of Commons*– November 1999, Chapter 29, p. 15

changes in both diagnostics and treatments, as well as the impact of information technologies on everything; taking into account socio-economic and demographic changed realities, I would conclude that a legislation based solely on hospitals and doctors, as is the *CHA*, is not appropriate at all, and is even detrimental to good health policy.

My second question would have to be about money: Are we spending enough or not of public funds for our universal health care systems? I would conclude that some additional, targeted, public funding is desirable towards the transition to an integrated delivery model. I would also conclude that our system is definitely sustainable, and that, generally speaking, Canada's expenditures have not been out of control. If, at one point, they had become higher than those of European countries, they were slashed in the most brutal way of all industrialized countries, when a sum of \$30 B was taken away from the system during the 90's in the (successful) efforts to put our fiscal house in order. Today, with Germany, we are still in the top spenders, but way below the USA, with other countries following us quite closely in terms of GDP percentage going to health care.

In the course of examining the second question, I would note that we have not been able to address the reforms that we know should be brought upon the ten provincial systems to ensure their sustainability, and I would worry seriously about that. I am referring here to the famous Queen's/U. of Ottawa's research on sustainability lead by Doug Angus and the most recent C.D. Howe Institute research by Cam Donaldson.⁴

My third and final question is not so much a question as an observation: if health care itself is not – yet - in deep trouble, its governance certainly is. The mechanism of government partnership and collaboration – that of federal-provincial conferences - has become totally dysfunctional over the years and nothing points towards any form of improvement.

Reconnecting these three answers together, I come to the conclusion that, if we somehow know where we want to go with health care policies, we have no governance capacity to get there. We do not have a perfect blueprint for action although we developed a number of disjointed attempts to create a common vision for health policies, the latest being the document agreed upon by the First Ministers in September 2000. What is missing is an implementation plan, which brings us back to funding and governance.

What would I do now?

First, I believe that the *Canada Health Act (1984)* can now be re-opened. For those who wonder if I became a turncoat, let me explain that this has always been for me an issue of strategy, not of principle. And yes, I do support a public, universal medicare. And yes, I also support the five conditions actually in the legislation. I used to be a good politician and my scanning of today's environment suggests that, with the Romanow Commission on the Future of Health Care in Canada (and with the Kirby Senate Committee) we do have a window of opportunity to undertake a

⁴ Douglas E. Angus, Ludwig Auer, J. Eden Cloutier, Terry Albert, *Sustainable Health Care for Canada*, Queen's/University of Ottawa, 1995, 146 p.
Cam Donaldson et al, *Managing Medicare: The Prerequisite to Spending or Reform*, C.D. Howe Institute Commentary, No. 157, January 2002, Toronto, 21 p.

serious revision of the *CHA*. We have enough champions of medicare to take that risk and we must act now. The public has lost the sense of their entitlements while stakeholders badly need clear rules of the game. How do we achieve that renewal? The gap between the *CHA* potential and what needs to take place includes not just changes to the legislation but to the funding of health care and to its mode of governance.

Positive federal-provincial relations in our country have been a key ingredient in building Canada-wide health care systems. Such successful relations were based, for a good 30 years following WWII, on “federal-provincial diplomacy and negotiation”, a Canadian success of federalism.⁵ They were also based on significant federal fiscal contributions.⁶

As was emphatically stated last week at the McGill conference on health care in Canada, when health care budgets represent 40% going on 50% of provincial resources, we must ask ourselves questions about balance.⁷ (A note in passing: this observation is absolutely not an endorsement of the last years’ provincial tax cuts, usually done for pure partisan politics.) The feds are seen as not sharing fairly in the risks of a constantly evolving and growing health care system, the burden falling squarely on provincial governments. So, the first change concerns the 1995 *Canada Health and Social Transfer (CHST)*. This legislative federal transfer mechanism should be rescinded and a new Act written that would cover only health financing. The whole contentious issue of the value, and of the very fact, of tax points’ transfer to the provinces should be put to rest once and for all. In that sense, the 1977 *EPF* was a mistake, maybe an unavoidable one in that decade of provincial autonomy. Tax points transfers are a taxation capacity lost forever and they carry no enforcement power whatsoever. So let us stop talking about them. For both accountability purposes and for good governance, we should revert back to the spirit of a 50-50 cost-shared arrangement, block-funded by cash transfers established in multi-year blocks. Although the federal government will not be able to participate immediately at 50% of the total public health care costs, its cash share could reach immediately, say, 25% for example, and increase based on capacity, keeping in mind that provincial health budgets need stability and predictability.

A new approach to governance should be designed. It seems to me that a Council of provincial Health Ministers, with a permanent secretariat, similar to the Council of Ministers of Education, is as good a start as any to maximize the cooperation between provinces. As health care is above all made of human resources, individual provinces are vulnerable if health reform initiatives mean losing professionals to other regions of the country or to the US. As to the cooperation between the two levels of government, all we know is that innovative administrative approaches are needed here, re-balancing the conventional mechanism of F/P/T conferences and new ways of doing business. Will it be done under the 1999 Social Union Framework Agreement (SUFA)? Like most Canadians, I don’t know what is happening on that front.

I do recall however that, for years, the provinces wanted to enforce the federal legislation among themselves, a politically flawed proposal and an extraordinary challenge to Parliament. We should be reminded here of a key feature of medicare as a subsidy and transfer program from the better-

⁵ Richard B. Simeon, *Federal-Provincial Diplomacy – The making of recent policy in Canada*, University of Toronto Press, Toronto, 1972.

⁶ Cf. for example, the work of Duane Adams for the Saskatchewan Institute of Public Policy and/or Queen’s University.

⁷ Michel Decter in his keynote address.

off people (and provinces) to the less well-off people (and provinces).⁸ The provinces are simply not equal among themselves, never have been and never will be. So, simply moving the confrontation between two levels of government to the one level of the provincial governments is not the solution.

The same applies to the second mechanism of enforcement of the *CHA* – that of discretionary financial penalties through orders-in-council, which is not operational and never will be. Good politics (and good public policies) require what good human relations require, namely that people talk, exchange, share, discuss, easily and freely between each other, in good faith and in a safe space. The approach described in the legislation is, and will be seen to be, fundamentally adversarial and arbitrary, not just in the provinces and in the country, but even around the Cabinet table. Politics is always somehow adversarial, we know that. It does not follow that situations of conflicts and tensions are of necessity dysfunctional. Broad issues of governance and of the enforcement of the *CHA* somehow go hand in hand.

One idea some colleagues are working on in order to somehow de-politicize the governance of health care is that of arms-lengths Councils of multi stakeholders reporting to their respective Parliament and Legislatures. They could be elected or appointed or a mix of both. They might replace existing bureaucracies and have total health budgets control or they might have very specific powers over the interface of federal and provincial action. For example, if we think of the notion of “quality” as an overarching dimension of health care, but not a *CHA* condition, we could have Quality Health Care Councils to measure performance outcomes, offer incentives for best practices, and enforce legislation when needed, with a capacity for remediation through a non-punitive approach. Building new, effective, governance should be debated in a truly public way.

As I said, I would reopen the *CHA*. The increased federal funding would correspond to an enlarged definition of coverage. To the existing hospitals’ and doctors’ coverage, I would add most elements of the First Ministers’ agreement and of an integrated services model: health promotion/disease prevention, primary care, mental health, rehabilitation, chronic care, as well as home care services and drugs when they are direct substitutes of hospital care. A universal home care program and a universal pharmacare would be left for future action.

I would keep the same five conditions/criteria for federal funding. Two of them however should be reviewed at this point in time: “public administration” and “comprehensiveness”.

“Public administration” does not mean what the public believes it means. It is most misleading and our students, reflecting the population in general, are shocked when taught that, in Canada, the funding/financing is public but that the delivery of services is private, in that physicians are not civil servants and hospitals have boards, not deputy ministers. The program criterion of the legislation reads as follows: “(...) the health care insurance plan (hospitals and doctors) of a province must be administered and operated on a non-profit basis by a public authority (...) responsible to the provincial government (...)” which amounts to a non-definition.

⁸ Terrence Sullivan and Patricia M. Baranek, *First Do No Harm: Making Sense of Canadian Health Reform*, Malcolm Lester, Toronto, 2002.

In the early 80's, laundry and food were contracted out to the private sector by hospitals. Later, laboratory work followed in a proportion of at least 50%. Without discussing the quality control issues, or the eventual savings, we intuitively know that these initiatives have not eroded our universal health insurance. The same applies to the 1983 management contract given by the Hawkesbury Hospital Board of Trustees to the American Medical International⁹ for seven consecutive years. The question that should be answered is this one: when is it that medicare is in danger of erosion? We could keep the flexibility of the condition but base it on a guiding principle: the onus is on the province to demonstrate, not just to the federal government but to our national and provincial Councils, that private initiatives will neither be a direct nor an indirect distortion or erosion of the public, universal health care system in that province or in the country.

"Comprehensiveness", another condition of the *CHA*, raises a different challenge. Its definition has to change if the range of services covered extends to much more than hospitals and doctors. Do we then keep the concept of "medically necessary" services? Its philosophy is that it is up to the treating physician's judgment to decide what is best for his/her patient. I still defend this approach, but we should find a way to connect that concept to the need to adopt evidence-based practices and to make sure medical research outcomes are systematically integrated in medical decision-making.

In any event, this condition of "comprehensiveness" is already under pressures from all quarters and for all sorts of reasons. For example, the Mazankowski report reopens it. Its Recommendation 3 about creating an on-going expert panel to determine the coverage of every new treatment, service or drug, could however serve as the basis for an in-depth public discussion in the country. One thing is sure: it is a question of choices and choices are being made every day without citizens knowing. Right now, choices are made on moralizing grounds by insurance plans de-listing services or by unwritten but no more real quotas for procedures imposed on physicians in hospitals, and these decisions are widely inconsistent. For example, the de-listing of services, a completely secretive process, must be made explicit as a matter of accountability. Choices should be made based on what works and what does not work, and what does do justice to population health needs. As research tells us, "the overarching goal of priority-setting is legitimacy and fairness".¹⁰

As a foot note, the September 2000 agreement and federal funding targeted for "medical equipment" and "health information technology" of \$1.5 B should be constituted as a 10 year national fund, playing by analogy the role of the defunct national Health Resources Fund, with an increased budget and with a transparent very public accountability mechanism. None exists right now and a press release from the Minister's office is certainly not proper accountability.

When do we start?...

⁹ Owner of 105 hospitals in the USA and other countries.

¹⁰ Peter A. Singer, "Needed: An honest way to set priorities", *National Post*, April 30, 2001.