EXECUTIVE SUMMARY

Is the Canada Health Act a Barrier to Reform?

by Nadeem Esmail and Bacchus Barua

Despite spending more on health care than the majority of developed countries with universal-access health-care systems, Canada performs poorly in international comparisons of the performance of health systems. Canada's health policies also differ from those of other nations with universal-access health care—in particular, those that have the developed world's best performing universal systems—in a number of ways. These include policies affecting private involvement in the insurance and delivery of core medical services, patient cost-sharing, dual practice by physicians, and activity-based funding for hospitals. Evidence of how Canada's health-care system underperforms coupled with concerns about its fiscal sustainability in the future suggest the need for policy reform.

Canadian health-care policy, including decisions about what services will be provided under a universal scheme, how those services will be funded and remunerated, who will be permitted to deliver services, and whether those services can be partially or fully funded privately is determined exclusively by provincial governments in Canada. However, the federal government influences provincial decisions to a significant degree by exercising its federal spending power through the Canada Health Act (CHA), a financial act that defines the terms and conditions under which provincial governments will retain access to their full portion of the Canada Health Transfer, valued at $37.2 billion in 2017/18.

The analysis presented in this publication suggests the CHA raises a significant financial barrier to a number of health-policy choices that would align Canada's approach to universal health-insurance policy more closely with those of the developed world's best performing universal systems. Some of these policies—for example, cost sharing by patients—are explicitly disallowed by the CHA and enforced by the threat of non-discretionary financial penalties. Some policies are only explicitly disallowed under certain conditions: for example, private parallel insurance sharing the cost of medically necessary services with the public insurance plan, but not necessarily otherwise.

Most of the policies pursued by the more successful universal health-care systems are, however, not explicitly disallowed but may be interpreted by the government of the day to contravene certain aspects of the CHA. For example, a parallel and fully independent private insurance system, for-profit hospitals, and dual practice by physicians are not explicitly prohibited by the CHA, so long as care provided in the public scheme remains accessible to all under uniform terms and conditions without cost sharing. Nevertheless, each of these could potentially, although not necessarily, be interpreted by the government of the day as contravening certain criteria of the CHA.

A key concern with the CHA, therefore, is its vagueness about a number of policy options that might be pursued by

provincial governments. Only about user charges and extra billing is the CHA reasonably clear on what is, and what is not, permissible if provinces wish to retain access to their full portion of the Canada Health Transfer. Outside these areas, and even to some extent within them, the CHA's vagueness leaves determinations of permissibility for a range of policies up to the federal government of the day, creating not only a present lack of clarity for provincial policy makers but also questions about what might be disallowed in future by governments with a different view of a particular policy. It is not surprising, then, that provinces appear to have taken a risk-averse approach, with a number of common provincial policy choices going well beyond what is explicitly required by the CHA for full access to federal cash transfers.

To the extent that the federal government is interested in seizing the opportunity to replicate in health care the success of the welfare reform of the 1990s, it would need to reform the CHA, remove ambiguity to minimize uncertainty and the potential for politically motivated interpretations of the act, decentralize decision making by encouraging provinces to be less reliant on federal transfer payments, and allow greater policy flexibility for provincial governments, which are directly accountable to patients and payers. Doing so would bring greater accountability to the health-care system and free the provinces to innovate and experiment with policies commonly found in other countries with more successful universal health-care systems. The likely result would be improved timely access to quality care regardless of a patients' ability to pay.

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