

A photograph of a woman in a white lab coat standing on a balcony, looking out a large window. The window has a large, colorful logo of the Canada Health Act, which includes the Royal Coat of Arms and the text "CANADA HEALTH ACT" in red. The scene is brightly lit, suggesting daytime.

# Is the Canada Health Act a Barrier to Reform?

Nadeem Esmail and Bacchus Barua



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# Contents

Executive Summary / i

Introduction / 1

1 The Failures of Canadian Health Policy and the Case for Reform / 2

2 How Canadian Health Policy Differs from Other Systems / 5

3 What Is the Canada Health Act? / 16

4 To What Extent Is the Canada Health Act a Barrier to Reform? / 19

5 Options for Reform / 26

Conclusion / 30

References / 33

About the Authors / 39

Acknowledgments / 40

Publishing Information / 41

Purpose, Funding, and Independence / 42

Supporting the Fraser Institute / 42

About the Fraser Institute / 43

Editorial Advisory Board / 44

# Executive Summary

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.

# Introduction

Despite spending more on health care than the majority of developed countries that seek to provide universal access regardless of a patient's ability to pay, Canada performs poorly on a number of key health-care indicators of the availability of medical resources and timely access (Barua et al., 2017a). While there is no simple or single reason why Canada's health-care system underperforms in comparison to other comparable countries providing universal health care, it is worth noting that there are a number of ways in which the policy informing Canada's health-care system differs. For example, in contrast to more successful universal health-care systems, private involvement in the financing and delivery of core medical services, patient cost-sharing, dual-practice of physicians, and activity-based funding for hospitals are either entirely absent or relatively uncommon in the Canadian context (Esmail and Walker, 2008; Barua and Esmail, 2015; Globerman, 2016).

## Why is this the case?

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 partly or fully funded privately is determined exclusively by provincial governments in Canada. However, the federal government significantly influences provincial decision making 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 (Department of Finance Canada, 2017).

The objective of this paper is to determine the extent to which the CHA may create significant financial barriers to a number of health-policy choices that would more closely align Canada's approach to universal health-insurance policy with those of the developed world's best performing universal systems. The first section of this paper highlights some of the well-known failings of Canada's health-care system and presents the case for reform. The second summarizes notable ways in which the policies that characterize Canada's health-care system differ from those found in eight comparable countries with universal health care. The third section introduces and describes the Canada Health Act, while the fourth section answers the question at the heart of this publication: to what extent is the Canada Health Act a barrier to reform. The fifth and final section briefly presents a set of options for reform and a conclusion follows.



# 1 The Failures of Canadian Health Policy and the Case for Reform

Before delving into whether the Canada Health Act (CHA) represents a significant obstacle to employing the sorts of policies commonly found in other successful countries with universal health care—and, if so, to what extent—it is important to ask why the question needs to be asked in the first place. If the present situation is both financially sustainable and able to deliver timely access to quality care regardless of a patient's ability to pay, then the need for reform is less clear. However, this is not the case. Empirical evidence suggests that there are a number of ways in which the Canadian health-care system is failing and that there is cause for concern for its overall sustainability.

A recent study examined the age-adjusted cost and performance of 29 universal health-care systems in high-income countries and concluded that: “Canada ranks among the most expensive universal health-care systems in the OECD. However, its performance for availability and access to resources is generally below that of the average OECD country, while its performance for use of resources and quality and clinical performance is mixed” (Barua, Hasan, and Timmermans, 2017: 41). Of particular concern is the fact that Canada had significantly fewer physicians (ranking 25<sup>th</sup> out of 29) and acute care beds (27<sup>th</sup> out of 27) compared to the average OECD country in the cohort in 2015. It is therefore unsurprising that, in 2014, roughly 4.5 million of Canadians (14.9%) aged 12 and older, reported that they did not have a regular medical doctor (Statistics Canada, 2014). Of these,<sup>1</sup> an estimated 2.4 million indicated that this was the case because doctors were not taking new patients, doctors were retiring and leaving the area, or simply that no doctors were available where they lived<sup>2</sup> (Statistics Canada, 2014; calculations by authors). Canada also ranked poorly for the availability of important medical technologies like MRI's (20<sup>th</sup> out of 27) and CT scanners (22<sup>th</sup> out of 28). Unfortunately, research also suggests that the few diagnostic technologies that are available are ageing and outdated (Esmail, 2011).

Perhaps the most spectacular failure of Canada's health-care system can be seen in the data for wait times, which have become a defining feature of the Canadian health-care experience. A recent study by the Commonwealth Fund (in association with the Canadian Institute for Health Information [CIHI]) of adults in Australia, Canada, France, Germany, the Netherlands, New Zealand,

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1. 45.9% of respondents reported that they had not looked for a regular doctor

2. Respondents could choose more than one reason for not having found a regular medical doctor. 13.1% did not give a specific reason for not having a doctor.



Norway, Sweden, Switzerland, the United Kingdom and the United States found that Canada is not just lagging, but scraping the bottom when it comes to indicators of timely access to health care (CIHI, 2017; Osborn, Squires, Doty, Sarnak, and Schneider, 2016). A sample of Canada's poor performance is presented below:

- ability to get an appointment on the same or next day when sick—worst
- ability to get after-hours care (without visiting an emergency department)—second worst
- wait for treatment in the emergency department—worst
- wait to see a specialist—worst
- wait for elective surgery—worst

Although Canada clearly performs poorly in these various aspects, there are a number of ironies worth noting. For example, although an estimated 2.4 million Canadians reported that they could not find a regular medical doctor, and Canada clearly has one of the lowest physician-to-population ratios amongst high-income countries with universal health care, a report by The Royal College of Physicians estimated that “[s]ixteen percent of new specialist and subspecialist physicians said they could not find work” (Fréchette, Hollenberg, Shrichand, Jacob, and Datta, 2013). It also seems that the few resources we do have are not being used efficiently. A 2011 study found that “[a]pproximately 14 percent of Canadian hospital beds are filled with patients who are ready to be discharged but for whom there is no appropriate place to go” (Sutherland and Crump, 2011). This is particularly galling given that Canada ranked last in terms of the availability of acute-care beds per capita among the countries analysed in *Comparing Performance of Universal Health Care Countries, 2016* (Barua, Timmermans, Nason, and Esmail, 2016).

On a related note, the Montreal Economic Institute [MEI] examined the use of 49% of the operating rooms in Quebec's public hospitals between April 2005 and March 2006 and found that, in addition to an average of nearly one (out of an average of 11.5) closed O/R per hospital, the rate of use of “open” operating rooms was only 46% for day shifts on weekdays. Further, while 62% of operating rooms were open weekday evenings, they were used at only 9% of their capacity. On weekends, the opening rate fell to 45%, while the rate of use fluctuated between 6% and 8% (Frappier and Laberge, 2007). This underuse of available resources is again particularly troubling given that Canada ranked last among the 10 countries with universal health care included in the Commonwealth Fund's measurement of wait times for elective surgery. Unfortunately, regulations ensure Canadians are effectively “stuck” in the public system with few options other than crossing the border into a different country.

It is important to highlight here that these failures have little to do with the notion of universal health care or spending. Several examples of universal

health-care systems that outperform Canada on a number of metrics can be found in Barua, Hasan, and Timmermans (2017). Further, not only does Canada rank among the top spenders, but provincial governments have been increasing spending at unsustainable rates for years, with the result that health care now consumes 40.1% of provincial program spending, 7.3% of their GDP, a trend that is projected to continue growing in the future, albeit at a slower pace (Barua, Palacios, and Emes, 2017).

Of course, there is no simple or single reason that Canada's health-care system underperforms in comparison to other countries with universal health care that spend similar amounts. But, there are a number of ways in which Canada's health-care system differs with regards to policy. Some of the most notable differences are discussed in the next section.

## 2 How Canadian Health Policy Differs from Other Systems

Health-care systems differ dramatically in the way they are financed, regulated, and deliver services. It has, however, been pointed out in numerous studies that Canada's system differs from other successful universal health-care systems in some very specific ways. For example, private involvement in the insurance and delivery of core medical services, cost-sharing requirements, dual practice, and activity-based funding for hospitals are either entirely absent or relatively uncommon in Canada (Barua and Esmail, 2015; Globberman, 2016; Esmail and Walker, 2008). Whether or not this is due to the restrictions imposed by the Canada Health Act, provincial regulations, or simply inertia on the part of policy makers will be examined in later sections. However, it is useful to first examine how other relatively successful universal health-care systems approach these important policy considerations. In this section, we compare Canada with Australia, France, Germany, the Netherlands, New Zealand, Sweden, Switzerland, and the United Kingdom. The countries all share the goal of ensuring universal access to health care regardless of the patient's ability to pay; and generally perform on par or better on most indicators of performance (Barua, Hasan, and Timmermans, 2017); and perform notably better than Canada on available indicators of timely access to care.

### Insurance of core medical services

The government of every country in the Organisation for Economic Co-operation and Development (OECD) provides some manner of health insurance for its populace. In some cases, comprehensive health-care coverage is provided by a government-run insurance scheme on a universal basis; in others, it is provided by government only for specifically identified population groups while the bulk of the population obtains coverage through a purely voluntary private-insurance system. Between these two extremes, fall various types of mixed insurance systems, including those where comprehensive private insurance is mandatory and those where private insurance is designed to cover only the care not funded by the public system. Some systems even allow consumers to choose between comprehensive private and public health insurance.

The nine countries in our cohort (Canada plus eight comparative countries) can generally be categorized into one of two groups: those where the government is the primary insurer providing benefits through a tax-funded national health-care system, and those that rely on a social health-insurance system where multiple insurers compete in a regulated environment (table 1).

Table 1: Health care insurance in Canada and eight other OECD countries

|                | Primary Insurance System                  | Primary Private Insurance | Secondary Private Insurance |                                 |                             |                          |                          |
|----------------|---|---------------------------|-----------------------------|---------------------------------|-----------------------------|--------------------------|--------------------------|
|                |   |                           | Can cover core services     | Expanded coverage (non-medical) | Expanded choice of provider | Quicker access           | Choice of doctor         |
| Australia      | Tax-Funded National Health System         | x                         | ✓                           | ✓                               | ✓                           | ✓                        | ✓                        |
| <b>Canada</b>  | <b>Tax-Funded National Health System</b>  | <b>x</b>                  | <b>x</b>                    | —                               | —                           | —                        | —                        |
| France         | Tax-Funded National Health System         | x                         | ✓                           | ✓                               | x                           | x                        | ✓                        |
| Germany        | Multiple insurers, with choice of insurer | ✓                         | —                           | ✓                               | ✓                           | ✓                        | ✓                        |
| Netherlands    | Multiple insurers, with choice of insurer | ✓                         | —                           | —                               | —                           | —                        | —                        |
| New Zealand    | Tax-Funded National Health System         | x                         | ✓                           | ✓                               | ✓                           | ✓                        | ✓                        |
| Sweden         | Tax-Funded National Health System         | x                         | ✓                           | —                               | ✓                           | ✓                        | —                        |
| Switzerland    | Multiple insurers, with choice of insurer | ✓                         | —                           | ✓                               | ✓                           | ✓                        | ✓                        |
| United Kingdom | Tax-Funded National Health System         | x                         | ✓                           | ✓                               | —                           | ✓                        | —                        |
| Sources:       | OECD, 2016a, Q2; Q2, Subitem 1            | Barua and Esmail, 2015    | OECD, 2016a, Q22b, Item 3b  | OECD, 2016a, Q23, Item 1        | OECD, 2016a, Q23, Item 2    | OECD, 2016a, Q23, Item 3 | OECD, 2016a, Q23, Item 4 |

Note: Data presented have been simplified for the purposes of presentation based on the authors' interpretation. Data for New Zealand are from the OECD's 2012 survey. For precise definitions and details, see OECD, 2012; 2016a.

Canada belongs to the first group of tax-funded health-care systems along with Australia, France,<sup>4</sup> New Zealand, Sweden, and the United Kingdom. However, this is where the similarities in the availability of insurance end, particularly in the role of private insurance for core medical services. Unlike Canada, each of these countries allow private insurers to cover health-care goods and services included in the basic<sup>5</sup> benefit package, including when these are delivered by providers whose services are eligible for funding by basic primary health coverage (to varying extents). For example, in Australia, private insurers can offer coverage for enhanced non-medical accommodation services (for example, private rooms in hospitals), expanded choice of providers, choice of doctor, and quicker access to health care.

At the other end of the spectrum, multiple insurers compete in a regulated environment to provide basic benefits in Germany, the Netherlands, and Switzerland. Germany's universal health-care system consists of two insurance systems: Statutory Health Insurance (GKV) and Private Health Insurance (PKV). Both are funded by premiums. The GKV system covers about 86% of the population (Busse and Blumel, 2014: 8) and is provided by about 145 competing independent, not-for-profit sickness funds. Germans earning over a certain amount (€57,600) can opt out of the GKV system and purchase private insurance for basic benefits from 24 for-profit and 19 not-for-profit insurance companies (Barua and Esmail, 2015).

In the Netherlands, residents must purchase a standard insurance package from one of a number of private insurers, who may choose to operate on a for-profit basis in a regulated but competitive market. In 2011, there were 27 health-insurance companies competing in the market. The market leader (Achmea), with a 32% market share, was a for-profit company while the three other largest conglomerates were private not-for-profit companies (OECD, 2012).

Switzerland has a similar system in which the federal government is primarily concerned with ensuring universality (through legislation and supplementary funding) to its citizens in an environment of managed competition among insurance companies and providers of health care. However, insurers are not allowed to make

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4. In the OECD 2012 survey on health system characteristics, basic health care coverage in France was described as being provided by “multiple insurers with automatic affiliation” for individuals. The 2016 update, describes it as having “a single health insurance fund (single-payer model)”. The Commonwealth Fund notes that “[o]ver the past two decades ... the state has been increasingly involved in controlling health expenditures funded by statutory health insurance” (Mossialos, 2017). The system is primarily funded by taxes, insurers are non-competitive, and citizens can only opt out in rare cases. For the sake of simplicity, the authors therefore classify it as a tax-funded, national health system.

5. Auraaen, Fujisawa, de Lagasnerie, and Paris (2016) note that while “[t]he boundaries of health coverage are not uniformly defined across OECD countries ... [a] wide range of interventions considered as “core medical care” are probably covered in all OECD countries”. This study uses the terms core/basic to refer broadly to medically necessary in-patient, out-patient, and specialist care. It is notable that, even within Canada, provincial governments may hold differing definitions of which hospital and physician services may be considered medically necessary.

profits on the basic, compulsory insurance package but may offer supplementary insurance packages on a for-profit basis. Of the 67 insurers approved to offer social health insurance,<sup>6</sup> 33 were registered as a *Société Anonyme/Aktiengesellschaft* (SA/AG)—that is, as a corporation with shareholders (OFSP, 2014).

### Delivery of core medical services

The question of who pays for the services—an individual, a public insurer, or a private insurer—is independent of the question of the profit motive of the institution where the service is delivered. Regardless of the source of payment, core medical services may be delivered in public, private, not-for-profit, or private, for-profit hospitals.<sup>7</sup> A recent study by Barua and Esmail (2015) explained how private hospitals are not only compatible with the notion of universal health care but are, in fact, a common feature in well-performing systems and there is a great degree of variation in the ownership of hospitals across the nine countries (table 2). For example, while private for-profit hospitals only constitute 4% of all hospitals in Sweden, they represent 43% of hospitals in Germany.

It should be noted that the presence of private hospitals does not imply that access to them is restricted to those who have private insurance or who can pay out of pocket. For example, in Australia, governments often contract with private hospitals for the provision of universally accessible services. In Germany, although about a third of the total number of hospital beds are in private, for-profit hospitals, 99% of all beds in the country are accessible to individuals with GKV (statutory) coverage (Busse, 2014). In Switzerland, public and private hospitals compete with one another for patients under the universal scheme, which is likely why the OECD suggests that “[d]ifferentiation according to ownership and profit is not relevant in the Swiss health system” (OECD, 2017b).

The Netherlands presents an interesting case where universal health care is ensured, but no hospital is classified as a “public” organization. While a for-profit motive is prohibited by the 1971 Hospital Facilities Act, hospitals are in fact generally allowed to earn profits,<sup>8</sup> but they cannot be distributed to shareholders (a regulation that was still being debated in parliament as of June 13, 2017). The OECD reports there were 324 locations where for-profit medical organizations provided care in 2014. This includes for-profit hospitals that “do not have a license for health insurance coverage” as well as “the number of independent treatment

6. Six of the insurers (not SA/AG) are included in the list of approved insurers though they only practise the daily allowance insurance.

7. A recent survey of the literature on hospitals and surgical clinics finds that competition, and a blend of public and private (both for- and not-for-profit) delivery, will likely have a positive impact on some measures of health care and little impact on others (Ruseski, 2009).

8. Any profit will add to the equity (equity assets) of the hospital (L. Ligtenberg, Nederlandse Zorgautoriteit, personal communication via e-mail, June 7, 2017).

Table 2: Hospitals, by ownership, 2015 (or most recent year)

|                      | Total      | Public     | Private<br>not for profit | Private<br>for profit | Proportion of private,<br>for-profit hospitals |
|----------------------|------------|------------|---------------------------|-----------------------|--|
| Australia (2014)     | 1,322      | 698        | 107                       | 517                   | 39%  |
| <b>Canada (2015)</b> | <b>719</b> | <b>712</b> | <b>0</b>                  | <b>7</b>              | <b>1%</b>                                      |
| France (2015)        | 3,089      | 1,389      | 691                       | 1009                  | 33%  |
| Germany (2015)       | 3,108      | 806        | 979                       | 1323                  | 43%  |
| Netherlands (2014)   | 505        | 0          | 181                       | 324                   | 64%  |
| New Zealand (2015)   | 165        | 85         | 28                        | 52                    | 32%  |
| Sweden*              | 83         | 77         | 3                         | 3                     | 4%   |
| Switzerland** (2013) | 293        | 61         | 82                        | 150                   | 51%  |
| United Kingdom       | —          | —          | —                         | —                     | —  |

Sources: OECD, 2017a; \*\*Barua and Esmail, 2015; \*Anell, Glenngård, and Merkur, 2012

centres, which offer treatment (medical specialist care) that is covered by the compulsory health insurance” (OECD, 2017b). The extent to which they provided core medical services under a definition comparable to other countries is unclear.

Another interesting case is Canada, where most hospitals are technically private, not-for-profit institutions. However, as Esmail and Walker have pointed out, they “are governed largely by a political process, given wage schedules for staff, are told when investment can be undertaken, denied the ability to borrow privately for investment, told which investments will be funded for operation, and forcibly merged or closed by provincial governments” (Esmail and Walker, 2008). Similarly, the OECD’s health-care research categorizes no private, not-for-profit hospitals in Canada, and classifies them as being publically owned “as they are controlled by government units” (OECD, 2017b). In addition to the seven private, for-profit hospitals delivering core medical services in Canada, other medically necessary surgical care and diagnostic imaging is also provided by private, for-profit clinics that specialize in specific procedures. Research indicates that in 2007/2008 there were approximately “72 private for-profit surgical hospital [and/or] clinics operating in 7 provinces, excluding those that sell purely unnecessary [sic] services such as cosmetic surgery and the abortion clinics” (Mehra, 2008: 42). Again, the question of whether or not such activity is expressly prohibited (or discouraged) by the Canada Health Act, will be explored in section 4.



Clearly, private hospitals are found in several other countries with universal health care (and even in Canada, albeit to a very limited extent). It is also of note that physicians are generally allowed to practise both in publicly funded, universal settings and in private settings (a policy known as “dual practice”) rather than having their activities restricted to one setting only. As can be seen in table 3, however, the ability of outpatient and inpatient specialists to engage in such dual practice in Canada is severely restricted in contrast to the other countries in our cohort. Again, the question of whether the CHA is responsible for this policy will be examined in section 4.

Table 3: Dual-practice of physicians

|                    | Outpatient Specialist           | Inpatient                       |
|--------------------|---------------------------------|---------------------------------|
| Australia          | ✓ — always                      | ✓ — always                      |
| <b>Canada</b>      | <b>x</b>                        | <b>x</b>                        |
| France             | ✓ — always                      | ✓ — sometimes                   |
| Germany            | ✓ — always                      | —                               |
| The Netherlands    | ✓ — always                      | ✓ — always                      |
| New Zealand*       | ✓                               | ✓                               |
| Sweden             | ✓ — sometimes                   | ✓ — sometimes                   |
| Switzerland        | ✓ — always                      | ✓ — always                      |
| The United Kingdom | ✓ — always                      | ✓ — always                      |
| Sources:           | OECD, 2016a, Q30d; *Gauld, 2013 | OECD, 2016a, Q31d; *Gauld, 2013 |

### Methods of remuneration for core medical services

Doctors are generally paid by one of three methods: salary, capitation payment,<sup>9</sup> or fee for service. Each of these methods has advantages and disadvantages that result from the degree to which the payment method is related to the actual output of the physician and the incentives inherent in each. Doctors can also be paid through a mixed system that incorporates two or all three of these methods of

9. Physicians are paid a “[p]rospective lump-sum payment per enrolled patient covering a range of services” (OECD, 2016c).

payment to capture the positive effects of each, while mitigating the negative. Table 4 provides the predominant employment status and method of remuneration for primary physicians and outpatient and inpatient specialists.

Table 4: Physician Employment and Payment

|                    | Primary<br>physicians                  | Outpatient<br>specialists                 | Inpatient<br>specialists                  |
|--------------------|--|---|---|
| Australia          | Privately employed,<br>fee for service | —   | Self-employed,<br>mixed                   |
| <b>Canada</b>      | <b>Self-employed,<br/>mixed</b>        | <b>Self-employed,<br/>fee for service</b> | <b>Self-employed,<br/>fee for service</b> |
| France             | Self-employed,<br>mixed                | Self-employed,<br>fee for service         | Publicly employed,<br>salary              |
| Germany            | Self-employed,<br>fee for service      | Self-employed,<br>fee for service         | —   |
| The Netherlands    | Self-employed,<br>mixed                | Self-employed,<br>fee for service         | Self-employed,<br>mixed                   |
| New Zealand        | Self-employed,<br>mixed                | —   | —   |
| Sweden             | Publicly employed,<br>salary           | Publicly employed,<br>salary              | Publicly employed,<br>salary              |
| Switzerland        | Self-employed,<br>fee for service      | Self-employed,<br>fee for service         | Private,<br>mixed                         |
| The United Kingdom | Self-employed,<br>mixed                | Publicly employed,<br>salary              | Publicly employed,<br>salary              |
| Sources:           | OECD, 20161, Q29a Q29b                 | OECD, 2016a, Q30a and Q30c                | OECD, 2016a, Q31a and Q31c                |

Note: FFS = Fee-for-service. Mix implies a mixture of fee-for-service, salary, and capitation for primary physicians, but only fee-for service and salary for in-patient physicians. Data for New Zealand is from the OECD's 2012 survey.

The payment of physicians supplying primary and outpatient specialist services in Canada is similar to the methods employed in the other countries in our cohort. Primary-care physicians are generally self-employed and remunerated using a mix of salary, fee for service, and capitation payments, except in Australia, Germany, and Switzerland where fee for service is the predominant method of payment. Physicians supplying outpatient specialist services are predominantly self-employed and paid on a fee-for-service basis, except in Sweden and the United Kingdom where such specialists are predominantly publically employed and salaried.

In general, no clear trend can be concluded from the data regarding physicians supplying inpatient specialist services in our cohort. In France, Sweden, and the United Kingdom inpatient specialists are predominantly publically employed and paid a salary. Canada is the only country in the cohort where inpatient physicians are paid predominantly on a fee-for-service basis. Such physicians are remunerated using a mix of fee-for-service and salary in Australia, the Netherlands, and Switzerland.

The method of remuneration for hospitals generally falls into two categories (table 5). The first involves the use of prospective global budgets under which the “funding total and its allocation across hospitals is set at the beginning of the fiscal year. The funding levels and allocations may be adjusted over time—using socio-demographic, political and economic factors to determine future payments—but mainly follow historic patterns” (CIHI, 2010: 3). In other words, global budgeting provides a specific grant to a hospital irrespective of activity in that particular year and the hospital’s resources are, therefore, not directly and specifically linked to the services provided. Canada is the only country in the cohort that relies almost<sup>10</sup> exclusively on prospective global budgets to fund its hospitals, although Sweden also uses this method for public and private not-for-profit hospitals (representing the majority of institutions in the country). The rationale for using such a system of block grants provides governments with a direct means of controlling hospital expenditure or costs that is simple to administer (Leonard, Rauner, Schaffhauser-Linzatti, and Yap, 2003; Park, Braun, Carrin, and Evans, 2007). Such a payment structure, however, disconnects funding from the provision of services to patients. For this reason, there are few incentives to provide a higher or superior quality of care, or to function efficiently. Conversely, the incentive structure encourages the delivery of few services, quicker discharges, the avoidance of costly patients, and shifting patients to outside institutions as a means of controlling expenditures.

An increasingly common way to fund hospitals is to base payment on some measure of activity. Activity-based-funding (ABF), according to the strictest definition, provided by the Canadian Institute for Health Information (CIHI),

can be defined by two features: first, a case mix system<sup>11</sup> is used to describe hospital activity and to define its products or outputs; second, a payment price is set for each case mix group in advance of the funding period and payments to the hospital are made on a per case basis ... Other funding models that share principles of activity-based funding include case mix funding, diagnosis-related group (DRG)–based funding, patient-focused funding, pay for performance (P4P), payment by results (PbR), prospective payment system (PPS) and service-based funding. (CIHI, 2010: 3)

10. Some provinces have begun moving towards more activity-based funding. For example, Ontario made some movement in this direction with the introduction of the Health System Funding Reform (HSFR), which introduced Health Based Allocation Model [HBAM] funding to pay hospitals based on demographics and complexity, and Quality-Based Procedures [QBP] funding to pay hospitals based on a price-times-volume approach with incentives to reimburse providers for delivering high-quality care (Ontario Ministry of Health and Long-Term Care, 2017). British Columbia also implemented a limited pilot program involving patient-focused funding in 2010 whereby “hospitals receive financial incentives for delivering acute-care services for a competitive, set price” (British Columbia Ministry of Health Services, 2010).

11. For a detailed description of case-mix system and activity-based funding, see CIHI, 2010.

The OECD categorizes most of these payment forms as DRG-like,<sup>12</sup> “which refers to a payment linked to the type and severity of hospital cases. Each patient is classified in a specific ‘diagnostic’ group according to his/her principal diagnosis and a fixed reimbursement is given to the hospital for treating the patient” (OECD, 2016b: 3).

As can be seen in table 5, DRG-like (or per procedure/service) payments are the predominant method used to remunerate hospitals in most countries examined in our cohort. In some countries, this method of payment is combined with a form of global budgeting. Notably, Australia, France, the Netherlands, and the United Kingdom use DRG-like payments for public hospitals but “locate this within an overall global budget”. Such budgeting is more pronounced at a hospital level in Australia and the United Kingdom, which “could be argued

Table 5: Detailed Acute-Care Hospital Payment

|                | Public   | Private<br>not for profit                            | Private<br>for profit                |
|----------------|--|--|--------------------------------------|
| Australia      | Per case,<br>DRG-like                                | By procedure,<br>service                             | By procedure,<br>service             |
| <b>Canada</b>  | <b>Prospective<br/>global budget</b>                 | <b>Prospective<br/>global budget</b>                 | <b>Prospective<br/>global budget</b> |
| France         | Per case,<br>DRG-like                                | Per case,<br>DRG-like                                | Per case,<br>DRG-like                |
| Germany        | Per case,<br>DRG-like                                | Per case,<br>DRG-like                                | Per case,<br>DRG-like                |
| Netherlands    | Per case,<br>DRG-like                                | Per case,<br>DRG-like                                | —                                    |
| New Zealand    | Prospective<br>global budget                         | —  | —                                    |
| Sweden         | Prospective<br>global budget,<br>per case, DRG-like* | Prospective<br>global budget,<br>per case, DRG-like* | Per case,<br>DRG-like                |
| Switzerland    | Per case,<br>DRG-like                                | Per case,<br>DRG-like                                | Per case,<br>DRG-like                |
| United Kingdom | Per case,<br>DRG-like                                | By procedure,<br>service                             | Retrospective                        |

Sources: OECD, 2016a, Q28a, Item 1; \*Anell, Glenngård, and Merkur, 2012    OECD, 2016a, Q28b, Item 1; \*Anell, Glenngård, and Merkur, 2012    OECD, 2016a, Q28c, Item 1

Note: Data for hospitals in New Zealand and private, not-for-profit, hospitals in Sweden are based on the OECD's 2012 survey.

12. “Diagnosis Related Groups [DRGs] refers to groups of hospital cases based on diagnoses, procedures performed and patient characteristics (age, gender and co-morbidities)” (OECD, 2016b: 3). “Developed in the United States, DRGs were introduced in the hospital management of many European countries over the last twenty years” (HOPE, 2009: 92).

to have DRG-based budgeting rather than DRG-based reimbursement”. In the Netherlands, the budget is “set across the entire hospitals sector” while “France deploys a mix of both setting budgets at the hospital level and at the national level, and links this to a broader macroeconomic spending target across the health sector” (OECD, 2013: 13). Such budgeting constraints are not found in countries like Germany and Switzerland. In fact,

the German approach to the implementation of DRGs is that they are a pricing tool and not an expenditure management tool, [reflecting] its commitment to rigorous costing [and] the idea that financial controls should not stand in the way of patients accessing services. This has meant that, while hospitals receive price signals from DRGs, they have a high degree of control over their total budget through their decisions on whom to treat, how many people they wish to treat in any one year, and which DRG group to record them in. (OECD, 2013: 14)

### Regulation of direct payments by individuals for core medical services

As mentioned previously, the health-care insurance systems in the nine countries in our cohort can generally be categorized into one of two groups: those where the government is the primary insurer providing benefits through a tax-funded national health-care system, and those that rely on a social health-insurance system where multiple insurers compete in a regulated environment (table 1). Regardless of the system examined, individuals are ultimately responsible for paying for health-care services.<sup>13</sup> Indirect payments, which are generally unrelated to the quantity of services rendered to the individual, are made through the tax system in countries like Australia, France, New Zealand, Sweden, and the United Kingdom. Meanwhile, in countries like Germany, the Netherlands, and Switzerland, such payments are made through insurance premiums (again, supplemented by the tax system).

There are, however, also various forms of direct payments related to the level of services provided that individuals may be required to make. These forms of what is commonly referred to as cost-sharing may be in the form of deductibles (fixed lump-sum payments required before insurance kicks in), co-insurance payments (representing a share of the cost of each service), and copayments (fixed payments per service) (table 6). Although the levels and types of direct payments

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13. Individuals ultimately pay for health-care services, whether they are funded directly, through voluntary or mandatory insurance premiums, or through various forms of taxation. Of course, the amount each individual will pay will vary depending on the method of funding. For example, in a general tax-funded system like Canada's, those with very low income will pay little to nothing while those with higher incomes will pay much more in comparison.

Table 6: Cost Sharing

|                | Deductible | Outpatient<br>Primary | Outpatient<br>Specialist | Inpatient<br>Acute |
|----------------|------------|-----------------------|--------------------------|--------------------|
| Australia      | x          | Sometimes             | Sometimes                | Sometimes          |
| <b>Canada</b>  | x          | x                     | x                        | x                  |
| France         | x          | ✓                     | ✓                        | ✓                  |
| Germany        | x          | x                     | x                        | ✓                  |
| Netherlands    | ✓          | x                     | x                        | x                  |
| New Zealand*   | x          | ✓                     | x                        | x                  |
| Sweden         | ✓          | ✓*                    | ✓*                       | ✓*                 |
| Switzerland    | ✓          | ✓                     | ✓                        | ✓                  |
| United Kingdom | x          | x                     | x                        | x                  |

Sources:            OECD, 2016a, Q11            OECD, 2016a, Q12, Item 2            OECD, 2016a, Q12, Item 2            OECD, 2016a, Q12, Item 1

Note: \* Data based on the OECD's 2012 survey.

expected of patients vary greatly from country to country, almost every country in our cohort requires residents to pay either a deductible (the Netherlands), co-insurance (France), co-payments (Germany), or some combination of all three (Switzerland). In fact, the only countries where such direct payments for core-medical services are entirely absent are the United Kingdom and Canada.

Of course, the most straightforward form of direct payment is the purchase of health-care services by individuals using their own funds to pay the cost of the service. While there is no direct data source to corroborate the notion that individuals are allowed to do so in the countries included in our cohort, to the authors' knowledge, the only instances<sup>14</sup> where individuals have been prevented from doing so have been recorded in Canada. Whether the absence of direct payments by individuals for core medical services in the form of cost-sharing or private purchase is the result of the CHA will be examined in section 4.

14. More generally, it has been suggested that there are only three countries in the world where individuals are legally prevented from paying for health care services: Canada, Cuba, and North Korea (Goodman, 2012: 48).

### 3 What Is the Canada Health Act?

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 partly or fully funded privately is determined exclusively by provincial governments in Canada. This is in accordance with the Constitution Act of 1867, which defined the distribution of legislative powers between the two levels of government. The federal government does, however, influence provincial decision-making by exercising its federal spending power, which was defined by former Prime Minister P.E. Trudeau as “the power of Parliament to make payments to people or institutions or governments for purposes on which it [Parliament] does not necessarily have the power to legislate” (Richer, 2007: 4). The federal spending power may also be defined as excess taxation by the federal government, acquiring funds beyond those required to fulfill the federal government’s responsibilities, to influence policy-making outside its Constitutional jurisdiction.

The Canada Health Act (CHA) (Government of Canada, 2018) is an exercise of the federal spending power. It 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 (Dep’t of Finance Canada, 2017).<sup>15</sup> The Canada Health Act is a financial act that governs provincial access to federal spending; it does not directly govern the activities of any individual or health-care provider in Canada. The substantial financial cash transfers connected to compliance with the CHA do, however, strongly influence provincial policy decisions.

The CHA is the third major iteration of acts related to an exercise of the federal spending power in health care, following from the Hospital Insurance and Diagnostic Services Act of 1957, and the Medicare Act of 1966. Many components of the CHA find their origin in these previous Acts, though they were updated and amalgamated in the CHA. All three Acts have played an important role in shaping health-care policy across Canada. The CHA comprises 23 sections, 10 of which are most relevant in understanding the federal impact on provincial policy making. Five Program Criteria that must be adhered to by provincial governments in order to maintain full access to their portion of the Canada Health Transfer are outlined in sections 8 through 12. Sections 18 through 21 provide the non-discretionary reductions in transfers that occur if provinces allow either user charges or extra

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15. For comparison, spending of provincial and territorial governments was estimated to be \$148.3 billion in 2016 (CIHI, 2016).



billing. In addition, section 2 of the CHA gives important definitions, some of which are notable by their absence. The remaining sections include discussions of the federal government's purpose and intent, a requirement to report to the federal government and recognize federal support, discussions of how violations of the Act will be handled by the federal government, and a definition of the cash transfer that is governed by the CHA.

The five criteria outlined in sections 8 through 12 are often referred to in discussions of Canadian health policy as the “principles” of the CHA. These are: public administration, comprehensiveness, universality, portability, and accessibility. *Public administration* is a requirement that the provincial health-insurance plan must be administered and operated on a non-profit basis by a public authority. *Comprehensiveness* requires provincial governments to cover all insured health services (hospital and physician services as well as surgical-dental services). *Universality* requires provincial governments to cover 100% of insured persons in the province under uniform terms and conditions. *Portability* requires provincial governments to ensure coverage when residents are travelling or moving to or from another province. *Accessibility* requires provincial governments to ensure access to the system is not impeded or precluded by user charges and extra billing or otherwise and to ensure reasonable compensation is provided to providers of health care.

These may all seem reasonable and minimally intrusive requirements by the federal government into provincial jurisdiction and policy making. As shown in the next section, however, the particulars of each show the importance of the CHA in discouraging certain provincial policy options. Certain definitions that are notable by their absence also play an important role.

The CHA states (in sections 14 through 17) that provincial violations of these five criteria can result in a reduction or complete withholding of the federal cash transfer for health care. Importantly, determination of provincial non-compliance for a criterion is entirely at the discretion of the federal government. Though the CHA requires that the federal minister of health consult with provincial governments prior to finding a violation of the five program criteria, it is ultimately the federal government that will determine violations unilaterally.<sup>16</sup>

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16. For a more detailed explanation of the process that is followed by the federal Minister of Health to enforce the Canada Health Act, see Madore (2005) and Boychuk (2008a). Despite the requirement that a process is to be followed, including consultation with the provincial government found to be in violation of the CHA, final authority for interpretation and enforcement lies solely with the federal Minister of Health. Further, as noted by Bridge (2007: 9): “[c]ourts have consistently held that they cannot rule on whether a province has complied with the CHA ... this is a political rather than a legal matter.” Boychuk adds that the CHA “is not justiciable—it is neither agreed to by both parties, legally binding on either party, nor does it create a set of citizen entitlements which may be claimed through the courts” (2008a: 5).

The penalties associated with violations of the program criteria (and the requirement for reporting and recognition of federal contributions in section 13) are discretionary and entirely up to the federal government. Allowing extra billing and user charges results in non-discretionary penalties for provincial governments under sections 18 through 21 of the CHA. Under these sections, federal transfers shall be reduced by the amount determined to have been charged to patients either through user charges (charges authorized or permitted by provincial health insurance plans) or extra billing (charges to insured persons in addition to the amount paid by provincial health insurance plans).

## 4 To What Extent Is the Canada Health Act a Barrier to Reform?

As we saw in the previous section, the Canada Health Act (CHA) governs one part of the financial relationship between Canada's federal and provincial governments (Gov't of Canada, 2018). The CHA does not apply to any individual, health-care provider, or other business in Canada, and does not directly set health policy for Canadians. This is not to say the CHA is unimportant as it can create significant financial barriers to a number of health-policy choices that would align Canada's approach to universal health insurance more closely with those of the developed world's best performing universal systems.

A key concern about the CHA is its vagueness in relation to a number of policy options that might be pursued by provincial governments. Only on the topics of user charges and extra billing is the CHA reasonably clear on what is and 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 to be decided by the federal government of the day, creating not only a lack of clarity for provincial policy-makers but also questions about what policies might be disallowed in future by governments with a different view of a particular policy.<sup>17</sup>

It is not surprising then that provinces appear to be risk-averse in setting health policy, with a number of common provincial policy choices for the financing and provision of physician and hospital services going well beyond what is required by the CHA for full access to federal cash transfers.<sup>18</sup> This section of the publication analyses key aspects of the CHA as they pertain to the characteristics

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17. A federal government could clarify what policies are and are not acceptable under the CHA to remove this lack of clarity for provincial governments. No government has so far done so in the more than 30 years since the CHA's enactment. Federal governments have made two key interpretive statements, however. The Epp letter (1985) provided a broad overview of the federal position on the CHA's implementation and interpretation; the Marleau letter (1995) gave the federal government's position on facility fees in private clinics (Health Canada, 2010).

18. Provincial risk aversion in setting health policy may be related both to a desire to maintain access to federal transfers in their entirety, and to a desire to avoid confronting a public that has come (incorrectly) to consider the Canada Health Act the safeguard and guarantor of Canada's universal medical system, and reflective of (or a foundation of) Canadian values. In either case, and as noted above, provincial adherence to the Canada Health Act (and potential federal interpretations of it) is a political matter.

of other, successful universal health-care countries discussed in section 2. The aim is to clarify what reforms of the financing and provision of physician and hospital services the CHA prevents and allows.<sup>19</sup>

*Does the CHA restrict private insurance or direct private payment for core medical services?*

The CHA does not explicitly disallow parallel or separate private insurance for medically necessary physician and hospital services, or direct full payment for those services. The CHA explicitly requires only that provincial governments provide a public insurance scheme covering “medically necessary” hospital services, medically required physician services, and medically required surgical-dental procedures that require a hospital for patients; the scheme is to be publicly administered, universal, comprehensive, portable, and accessible without cost sharing or extra-billing.<sup>20</sup> None of the five conditions explicitly mentions such a policy approach or discourages provinces from allowing privately funded voluntary insurance for, or direct private purchase of, medically necessary physician and hospital services; and neither is this touched on in the sections surrounding extra billing and user charges (see, for example, Boychuk, 2008a).<sup>21</sup>

While the CHA does not explicitly disallow private insurance or direct private payment, various interpretations of the CHA’s five criteria, and in particular interpretations of the criterion of *Accessibility* (section 12), suggest that it could be read to do so. Central to these interpretations is the vagueness of the CHA, and in particular the undefined term “reasonable access” found under the criterion of accessibility.<sup>22</sup> A legal opinion provided to the Canadian Union of Public Employees (CUPE) by the law firm Arvay Finlay, for example, argues that reasonable access under the criterion of accessibility could be violated by a policy that allowed the quality or speed of insured health services to vary with

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19. This is only one lens through which the impact of the CHA might be examined. Emery and Kneebone (2013) examine the problems created by the CHA’s lack of clear definition for the term “medically necessary”. Blomqvist (2010) considers whether the CHA has outlived its usefulness in the conclusion to a broader analysis of Canadian health-care policy and the problems with the health-care system in Canada.

20. Emery and Kneebone (2013) discuss the problems associated with a lack of definition for the term “medically necessary”, finding that resulting politically and fiscally driven restrictive provincial decisions may have left many Canadians inadequately prepared for catastrophic outcomes, and may undermine Medicare’s goal of equity.

21. On the other hand, provincial decisions around the term “medically necessary” could create room for a larger role for the private sector in both the financing and delivery of physician and hospital services (see, for example, Emery and Kneebone, 2013).

22. Blomqvist (2010) also takes issue with the criterion of *Accessibility* and how it limits efficiency-enhancing health-policy options.

ability to pay (Arvay and Rankin, 2000).<sup>23</sup> Similarly, a federal government could determine that privately financed health-care services are threatening reasonable access to universally accessible services, perhaps by drawing providers from the universal system or by increasing queues for access to publicly insured services (Madore, 2005).<sup>24</sup>

The CHA does disallow private insurance for medically necessary services that shares the cost of medically necessary services (as opposed to add-on uninsured or non-medically necessary services like private accommodation or superior implants) with the public insurance scheme.<sup>25</sup> Such partial private funding would violate the requirement not to allow extra billing, or billing in addition to the amount paid by the government health-care insurance plan, resulting in non-discretionary penalties under sections 18 through 21.

Interpretations of the CHA's five criteria might find such a policy approach also violates sections of the CHA that could be subject to discretionary penalties. For example, partial private funding might be considered to violate the criterion of *Accessibility* as a province might be considered to be impeding reasonable access to services due to some of the claimed negative consequences of allowing private funding, including reduced support for the public system or longer waiting lists for those in the public system. While shared partial public payment for services would result in a reduction in federal transfers for health care, there does not appear to be a similar explicit penalty or violation of the CHA if a province chose to subsidize purchases of parallel private health insurance as is done in Australia.

Allowing a private insurance company to operate the universal scheme as an agency of the public authority is however explicitly permitted by the CHA under the criteria of *Public Administration*, including when it is offered on a premium-funded (as opposed to tax-funded) basis. The CHA requires that a public authority administers and operates the insurance plan of a province on a non-profit

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23. This reading could also be extended to preclude physicians and health-care providers charging fees for enhanced services such as superior implants or more advanced cancer treatments, even if they did not affect timeliness.

24. While the Supreme Court of Canada largely rejected this perspective in the landmark *Chaoulli* decision, that decision was limited to the Province of Quebec and governments across Canada seem to have largely ignored both the decision and its implications for monopoly coverage of medically necessary/required physician and hospital services. This may change in the near future, with a court case presently underway in BC seeking similar freedoms for patients subjected to long and harmful waits in the government monopoly health care system.

25. For example, the CHA permits private payments for services, such as private accommodation, that are not medically necessary or required alongside the medically necessary or required hospital or physician intervention. The CHA disallows private payment for medically required physician service alongside public funding of medically necessary hospital service for a medically necessary intervention.

basis, that the private insurance provider's accounts are subject to assessment and approval by the public authority, that amounts to be paid are determined by the public authority, that the private insurance provider operates as a monopoly, that premium payment is not a precondition of receiving services, and that there be no variability in the insurance product offered. Competing multiple-insurer systems like those found in Germany, Switzerland, or the Netherlands, or even a non-competing multiple-insurer system like Japan's are explicitly disallowed by the CHA as a model for the insurance plan of the province, which allows only a singular public authority (a public authority) and a singular agency (any agency) to be designated (Madore, 2005). Personalization of policies under the insurance plan of the province, and variability in insurance premiums as seen in Switzerland and the Netherlands are also expressly disallowed by the requirement that the public insurance program be offered on uniform terms and conditions under the criteria of *Universality* and *Accessibility*.

*Does the CHA restrict private delivery of core medical services?*

The CHA does not explicitly address the ownership of health-care providers, and there is no express CHA violation for provinces that allow or contract with private providers to deliver medically necessary services. It is worth noting that a large portion of medically necessary care in Canada is delivered by private physicians operating independently, while private surgical clinics play an important role in the delivery of diagnostic services and treatments to patients. And, while the overwhelming majority of Canadian hospitals are public institutions,<sup>26</sup> there is nothing explicit in the CHA that would generate reductions in federal transfers if a provincial government funded care provided by private, not-for-profit or private, for-profit hospitals, as long as that care was available under CHA-compliant terms of the universal scheme.

This does not mean that a federal government could not interpret the CHA to discourage further private provision of health-care services, or to discourage the activities of private clinics. For example, a federal government could judge these facilities to be harmfully cherry-picking less-sick or more-profitable patients over more-sick patients, generating poorer outcomes than public hospitals, or harming public hospitals by attracting health-care providers to privately owned and operated facilities. While research and international experience clearly disagree with these perspectives (Ruseski, 2009; Esmail and Walker, 2008; and Barua and Esmail, 2015), a federal government could nevertheless determine that a provincial policy allowing private provision of services compromises reasonable access to health care under the criterion of *Accessibility*. Though that may seem farfetched, former Health Minister Diane Marleau stated in 1995 that private clinics were a concern to the federal government in a letter to the provinces, noting the federal government's concerns around "weakened support for the tax

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26. See Barua and Esmail, 2015: 28–30 for a more detailed explanation. Also, see p. 9, above.

funded and publicly administered system”, reductions on cost control, concentration on easy procedures compared to the more complicated cases left to the public system, attracting providers from the public system, and devoting resources to “features which attract consumers, without in any way contributing to the quality of care”. Minister Marleau went on to state that regulations should be put in place to “ensure reasonable access” (Health Canada, 2010: 166).<sup>27</sup> Clearly, the undefined term “reasonable access” could play, and perhaps has already played, an important role in provincial policy making.

*Does the CHA restrict dual practice by physicians?*

The Canada Health Act does not explicitly require provinces to disallow dual practice, a policy that permits physicians to work in both public and private settings. As noted above, the CHA’s primary focus is on the financing of health care, and ensuring that services are fully funded (100% coverage, first-dollar coverage) by the publicly administered scheme. Provinces are free, according to the explicit requirements under the CHA, to allow physicians to practice in both public and private settings as long as the services they provide in public settings are accessible, comprehensive, universal, portable, and publicly administered, and without cost sharing or extra billing.

Once more, this does not mean the CHA could not be interpreted to disallow this policy option, especially if a federal government determined dual practice for physicians compromised reasonable access to health-care services under the public scheme. This judgement may depend on the often-heard argument that allowing dual practice will lead to lengthening queues in the public scheme to make the private alternative more attractive for patients, and reduce access to publicly funded care by reducing the availability of physicians to the public system. While the evidence surrounding dual practice for physicians is not certain about these possible negative consequences, especially in the absence of salaries for physicians in the public system, and while many other nations have seen fit to allow dual practice (including the world’s top-performing universal-access health-care systems),<sup>28</sup> the federal government is free to interpret reasonable access unilaterally. Once more, there is some precedent for a federal government doing so, as Ujjal Dosanjh, a former Federal Minister of Health, stated that dual practice is not permitted under the CHA’s criterion of *Accessibility* (Madore, 2006).

27. Boychuk (2008: 9) notes that Federal Health Minister Dian Marleau’s action was primarily the result of British Columbia’s Minister determining that “specific practices were non-compliant with CHA requirements” and that “the province went beyond encouraging the federal minister to apply transfer reductions and actually made the reductions mandatory under federal legislation” and that this instance of penalties levied by the federal government should be interpreted with caution.

28. Measured in terms of the timeliness of services, availability of services, and health and medical outcomes (Barua, Timmermans, Nason, and Esmail, 2016).



*Does the CHA restrict methods of remuneration for physicians and hospitals?*

The CHA does not restrict provincial decisions about how medically necessary physician and hospital services will be remunerated, as long as full payment (first-dollar coverage) is provided for those services. There are some additional requirements surrounding compensation and payment beyond not allowing extra-billing that must be met by provinces under the criterion of *Accessibility*, including a requirement that payment be made in accordance with a tariff or system of payment authorized by the law of the province; that there must be provision for payments of amounts to hospitals for the cost of insured health services; and that the province must provide reasonable compensation for all insured services provided by medical practitioners. Provinces are considered to have complied with the requirement for reasonable compensation if they negotiate compensation agreements with provincial organizations of medical practitioners, settle any disputes about compensation through conciliation or binding arbitration, and accept the outcome of that arbitration other than through an Act of the legislature.

This is not to say that a particular funding approach could not be interpreted to violate the CHA by a federal government, perhaps by its determining that a policy will have a negative impact upon the universal scheme and thus compromise reasonable access. History suggests, however, that this is unlikely. Canadian provinces have been experimenting and moving towards alternative funding approaches for physician care for many years (capitated funding models in primary care, for example); and activity-based funding for hospitals has been the subject of much conversation and some experimentation (by Ontario and British Columbia, for example). While there remains a possibility that a federal government might see a change in methods of remuneration as a violation of the CHA that affects access to federal transfers, that possibility is at this time remote.

*Does the CHA restrict cost sharing for core medical services?*

Of the various policies that are employed by other, more successful, universal-access health-care systems, this is one that is clearly and explicitly disallowed by the CHA and the only policy that results in a defined and non-discretionary penalty under the CHA. Sections 18 through 21 of the CHA require reductions in federal cash transfers for health care if provinces allow or require user fees (cost sharing) or extra billing for medically necessary services under the public insurance scheme. In either case, the CHA requires federal transfers be reduced on a dollar-for-dollar basis for the amount determined to have been charged to patients in a given province.

Provinces that wish to have access to their full cash transfer for health care must ensure medically necessary or required services provided through the public scheme are fully funded (100% or first-dollar coverage), without any allowance for providers or facilities to request privately funded payments (such as a facility fee) above what will be paid under the public scheme for medically necessary

treatment. Charges are explicitly permitted only for accommodation or meals for those who require chronic care and are more or less permanent residents of a hospital or other institution. Charges (user fees or extra billing) may also be permitted under the explicit terms and conditions of the CHA for services that are not considered by the province to be medically necessary (a term that is not clearly defined in the CHA), which ostensibly would include private accommodation, superior implants to the one provided under the public scheme, and new medical therapies not covered by the public scheme.

While sections 18 through 21 set out clear, non-discretionary, dollar-for-dollar penalties for user-fees or extra-billing, they do not preclude a federal government's ability to withdraw all cash transfers for health care by determining such a policy has violated one of the five criteria of the CHA. This might include considering user fees or extra billing to have compromised reasonable access under the criteria of *Accessibility*, which states in full that a province must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons. Even in the policy area most clearly defined in the CHA, there is no certainty of the financial consequences of non-compliance for a reform-minded provincial government.

## 5 Options for Reform

As described in section 2, Canada differs from other, more successful, universal health-care systems in its policies concerning private insurance or direct private payment for core medical services, private delivery of core medical services, dual practice by physicians, methods of remuneration for hospitals, and cost sharing for core medical services (as well as several other policies beyond the scope of this paper; see Esmail and Walker, 2008).

The analysis in section 4 reveals that the degree to which the CHA is responsible for obstructing the pursuit of these policies varies. Some policies commonly found in other, more successful, universal health-care systems are explicitly prohibited, with the threat of non-discretionary financial penalties, by the CHA: for example, cost sharing by patients for publicly funded core medical services. Some policies are only explicitly prohibited under certain conditions: for example, private parallel insurance for core medical services that shares the cost of medically necessary services with the public insurance plan, but not necessarily otherwise.

Most of the policies pursued by other, more successful, universal health-care systems are not, however, explicitly prohibited, 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, and activity-based funding 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 and without cost sharing. However, each of these could potentially, although not necessarily, be interpreted by the government of the day as contravening certain aspects of the CHA, perhaps most commonly the requirement for reasonable access under the criterion of *Accessibility*. As Boychuk notes: “enforcement of the CHA is primarily a political rather than legal issue ... the interpretation and enforcement of the CHA remains a prerogative of the federal minister ... with important areas remaining open to federal interpretation” (2008: 5).

The resulting ambiguity has contributed to policy inertia and an absence of innovating and experimenting with policies commonly found in other, more successful, universal health-care systems by provinces interested in improving upon their health-care systems. In fact, many provinces have gone much further than the CHA in restricting various activities (like dual practice) in order to ensure that the federal government does not withhold transfer payments. In some cases, provincial governments—like the New Democratic Party (NDP) in British Columbia in the early 1990s—have even forced the federal minister’s hand in imposing penalties on their own province (Boychuk, 2008). The current federal government has also

displayed a desire to intervene in provincial decision-making through the CHA: the present federal minister of health has threatened to wield the CHA to prevent user fees in private facilities in Quebec and stop Saskatchewan's innovative partnerships with private MRI clinics (the province has been given a 1-year trial period) (*CBC News*, 2016). Regardless of whether provinces would eventually choose to incorporate policies commonly found in successful universal health-care systems elsewhere, or ban them outright, it is clear that the uncertainty resulting from interpretations of certain aspects of the CHA by the federal minister of the day is a serious impediment to the freedom of provincial governments to do what they consider best for their residents.

Constitutionally, health care is a matter of exclusive provincial jurisdiction. Further, the principle of subsidiarity also suggests that provincial governments are best placed to administer health-care policy for their residents, enhancing accountability to both patients and payers. The CHA as it is currently written and to the extent that it interferes with provincial policy on the delivery and financing of health care, and the excess taxation and exercise of the federal spending power that underlie it, are a violation of both.

A framework for sensible reform is available in the approach of the Chrétien Liberals to welfare transfers and welfare policy in the mid-1990s. The analogous nature of the two was most recently highlighted in *Less Ottawa, More Province: How Decentralization Is Key to Health Care Reform*, where the authors point out that:

[w]elfare, like health care, is a provincial responsibility but has historically received conditional funding from the federal government. Moving towards smaller, less prescriptive grants from the federal government gave the provinces better incentives to contain costs and provide better outcomes such as less reliance on welfare and more able-bodied people moving out of welfare and into the workforce. ... Canada's experience with welfare reform suggests reducing health-care transfers in real terms while, in exchange, reforming the Canada Health Act to allow provinces greater policy flexibility is a promising strategy for achieving these objectives. (Eisen, Barua, Clemens, and Lafleur, 2016: 33)

To the extent that the federal government is interested in seizing the opportunity to replicate the success of the welfare reform of the 1990s in the area of health care, 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 that are directly accountable to patients and payers. The necessary reforms can be categorized into two groups: 1. direct amendments to the CHA; 2. fiscal decentralization.

## 1. Direct amendments to the CHA

A 2012 paper by Clemens and Esmail examined each section of the CHA in detail, and proposed a set of potential amendments that would provide the provinces with greater flexibility without abandoning the noble goal of access to care regardless of ability to pay. While only minor changes were suggested for much of the Act, they proposed reforms to the *Public Administration* criterion and the requirements of extra billing and user charges so as to allow provincial governments to decide how best to structure the province's insurance plan. The authors also suggest amending the *Accessibility* criterion either to define more clearly the concept of "reasonable access" and the specific circumstances under which it is considered to have been compromised; or so that it specifically focuses on ensuring access for vulnerable populations who may experience financial barriers as a result of the introduction of copayments or premiums for the general population. Esmail and Clemens' proposed reforms are notable because implementing them would provide provinces with the flexibility to experiment with most (if not all) of the policies examined in this report, while maintaining a federal requirement of universality and portability, both of which would be more clearly defined and less likely to be subject to politically motivated intervention.

## 2. Fiscal decentralization

It is important to reiterate here that the Canada Health Act is a financial act, the enforcement of which is an exercise of the federal spending power. Since it does not directly govern the activities of any individual or health-care provider in Canada, the terms and conditions of the CHA are only important in so much as they dictate the degree to which provincial governments will retain access to their full portion of the Canada Health Transfer. The substantial financial cash transfers connected to compliance with the CHA clearly influence provincial policy decisions.

In the absence of a pool of cash connected to the strings of the CHA, provinces would *de facto* have much greater flexibility to pursue those policies they consider to be in the best interest of their residents whatever the opinion of the federal government of the day. In order to decentralize decision-making fully, a three-step process could be followed: first, the Canada Health Transfer in its present form would need to be held constant in nominal terms, significantly reduced, or eliminated entirely. Next, the federal government would need to reduce federal taxes (like the federal income tax) to the degree that would result in a loss of revenue comparable to a significant portion of the CHT payments it would have had to otherwise make to the provinces. Finally, provinces would be free to determine how additional revenues might be raised to compensate for the loss of the CHT, if required.

Either, or both, of these approaches would bring greater accountability to the Canada's health-care system. They would also free the provinces to innovate and experiment with policies commonly found in other countries with more successful universal health-care. The likely result would be improved timely access to quality care regardless of a patient's ability to pay.<sup>29, 30</sup>

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29. Blomqvist (2010) is also critical of the federal-provincial construct of Medicare. He makes a broadly similar recommendation to ours, suggesting provinces should have full responsibility for managing their health-care systems and not be subject to federal enforcement of the CHA (which could itself be simplified to its basic principles, in particular, *Universality* and *Comprehensiveness*).

30. An ancillary benefit to such reform might also be to improve upon the limited scope of provincial coverage, by freeing provinces to determine what health policies should be covered by a universal scheme and how they should be variously financed. For more on this, see Clemens and Esmail, 2012; and Emery and Kneebone, 2013.

# Conclusion

Canada has one of the most expensive universal health-care systems in the developed world. However, there is an imbalance between the value Canadians receive and the relatively high amount of money they spend on their health-care system. At the same time, Canada differs from other, more successful, universal health-care systems in its policies on private insurance or direct private payment for core medical services, private delivery of core medical services, dual practice by physicians, methods of remuneration for hospitals, and cost sharing for core-medical services. 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.

Although the provision of health-care services is primarily the responsibility of provincial governments, the substantial financial cash transfers connected to compliance with the Canada Health Act (CHA), valued at \$37.2 billion in 2017/18, enable the federal government to strongly influence provincial policy decisions about health care. The analysis presented in this publication suggests that 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 policies commonly found in other, more successful, universal health-care systems—for example, patient cost-sharing for publicly funded core medical services—are explicitly prohibited by the CHA with the threat of non-discretionary financial penalties. Some policies are only explicitly prohibited under certain conditions: for example, private parallel insurance for core medical services that shares the cost of medically necessary services with the public insurance plan, but not necessarily otherwise.

Most of the policies pursued by other, more successful, universal health-care systems, however, are not explicitly prohibited 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, dual practice by physicians, and activity-based funding 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 and 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 in relation to 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 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 lack of clarity for provincial policy makers but also questions about what policies 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 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 the success of the welfare reform of the 1990s in the area of health care, 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. The likely result would be improved timely access to quality care regardless of a patient's ability to pay.



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