HEALTH CARE DELIVERY IN A FEDERAL SYSTEM: STRENGTHS AND WEAKNESSES OF THE CANADIAN APPROACH[1]

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INTRODUCTION

This paper presents the key aspects of the institutional and financial arrangements provision of health services in Canada. This is of interest to scholars examining health provision in a federal system .The paper is divided in three part. The first summarizes the constitutional/ legal framework and the relevant inter governmental financial arrangements. The second examines outcomes and the third looming challenges.

1 THE CONSTITUTIONAL/ LEGAL FRAMEWORK AND FINANCIAL ARRANGEMENTS

This part of the paper is divided between the constitutional/legal framework and the financial arrangements.

1.1 THE CONSTITUTIONAL/LEGAL FRAMEWORK

The Canadian constitution (the British North America Act or BNA) is almost silent on health; the only mention is that *the establishment and maintenance of marine hospital* [2](article 91.11) is an area federal responsibility It is as a result of an interpretation of the clause stating that *all Matters of a merely local or private*

[1] Paper prepared for the Decentralization of Health Care in Federations: Recent Trends and Lessons from Spain International seminar, Zaragoza June 2010 organized by the Manuel Giménez Abad Foundation (Zaragoza) and the Forum of Federations. We thank the participants for their question which helped us prepare the final version of this paper.

[2] None are in operation in Canada in 2010; they were to be used as quarantine facilities to prevent

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Nature are provincial (92.16) that health can be seen as a provincial responsibility. From 1867 to 1957, the provision of health services was carried out mainly by private organizations both for profit and non profit. Hospitals were mainly non profit institutions operated either by civic bodies or religious orders with in some cases ethno linguistic dimensions added .For example in Montréal, along or close to the Côte des Neiges Road, one finds within three kilometers or so the St-Justine hospital (francophone-catholic), the Jewish General, the St Mary's(anglophone – catholic) and the Montreal General.[3]

Historically, federal funding for the Canadian health care system goes back to the late 1940s with the creation of the *National Health Grants*, mainly used for health infrastructure.[4] In 1957, a major program was introduced with the federal government financing the establishment of provincial hospital insurance plans with the adoption of *Hospital Insurance and Diagnostic Services Act*.[5] Under this Act, admissible costs were split 50/50 between the two levels of government using the provincial shares in the calculation. This meant that a province could spend more than the others and still have a 50% subsidy. Ten years later, the federal government introduced the *Medical Care Act* in 1966 or Medicare. That covered medical fees in and outside of hospital[6] .Under this new Act "the federal contribution was set at 50 percent of the average national per capita costs of the insured services, multiplied by the number of insured persons in each province and territory".[7]

Why did these changes take place? There were both demands from the population inspired in part by observations of practices in one mother country (NHS in the UK) and in one neighbor (Medicare in the USA) and the fact that an internal agent of

[3] And in Kingston ,Ontario, the Kingston General Hospital and the Hotel Dieu (catholic) within 1 kilometer of each other.
[4] Health Canada, *Canada Health Act-Federal Transfers and Deductions*, 2007, http://www.hc-sc.gc.ca/hcs-sss/medi-assur/transfer/index_e.html.
[5] *Idem*.
[6] *Idem.*
[7] *Idem.*

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change was at work. The province of Saskatchewan governed by the New Democratic Party introduced first hospital insurance then Medicare. There were also the rising costs of health care as new medication made it feasible to cure various diseases. The introduction of Medicare was resisted by the medical establishment with strikes in two provinces Saskatchewan and Québec .In the early eighties, cutbacks in federal financing combine with high inflation resulted in provinces reducing in real terms payments to MDs. This led them to introducing/ increasing user fees (allowed then everywhere except in Quebec) and to the federal government discouraging them by linking the amount of user fees collected in a province to an equivalent reduction in federal transfers. It cannot ban them as such as this is a provincial jurisdiction.

The provincial and territorial governments are responsible for the administration and the delivery of health services with the financial help of the federal government. The latter also established the *Canada Health Act* which sets the national guidelines in the field of health. In order to receive federal funding the provinces and territories have to meet five criteria: comprehensiveness, universality, portability, accessibility and public administration.[8] The first criterion "requires that the health care insurance plan of a province or territory must cover all insured health services provided by hospitals, physicians or dentists" and according to their own laws; additional services can be offered by other health care practitioners.[9] The second criterion requires that health insurance be available to all (with some minimum residency requirements). The portability criterion allows a Canadian citizen who is either absent from Canada for a predetermined period or moves to another province or territory to continue to be covered by its "home" province/territory. In the second case, the waiting time to obtain a new health care plan must not exceed three months.[10] Accessibility is somewhat related to universality, since all individuals must have equal access to health insurance. However, the former specifies that exclusion on a financial, discrimination or any

[8] *Idem*.
[9] Health Canada, *Canada Health Act, Annual Report 2005-2006*, p.12.
[10] *Idem*.

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other basis is illegal. Finally, the last criterion requires public sector administration of a provincial or territorial health care insurance plan on a non-profit basis.[11] There are no federal/national standards as to what services should be offered, what waiting times should be, what salaries or working conditions should and so on. However, health professionals can fairly easily move from one province to another;[12] this allows provinces to attempt to attract high demand professionals such as nurses through higher wages. This is also true for American states that can thus recruit health professionals in Canada.[13]

Private providers also offer health services that are provincially regulated suchas dental services, physiotherapy and so on. However, "those who do not qualify for supplementary benefits under government plans pay for these services with individual, out-of-pocket payments or through private health insurance plans".[14] Beyond its financial (through Canada Health Transfer and the equalization process – available for all other publicly funded services) and legislative participation in the health care system, the federal government directly provides services to certain groups like "First Nations people living on reserves, Inuit, serving members of the Canadian Forces and the Royal Canadian Mounted Police, eligible veterans .[15]

Thus one can conclude that the Canadian health care system is mostly publicly funded and "provides access to universal, comprehensive coverage for medically necessary hospital and physician services".[16]

[11] *Idem*.
[12] For a discussion of labour mobility in Canada, see François Vaillancourt''Canada's Internal Market. Legal, Economic and Political Aspects'' in *The EU Internal Market in Comparative Perspective ;Economic, Political and Legal Analyses* (Eds Jacques Pelkmans, Dominik Hanf & Michele Chang)Brussels:P.I.E. Peter Lang, 2008, p281-314
[13] While Canada can recruit health workers abroad such as South Africa or the Philippines(nurses).
[14] See Health Canada, *Canada's Health Care System*, p.4.
[15] *Idem*., p.1.
[16] Health Canada, *Canada's Health Care System,* 2005, http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2005-hcs-sss/2005-hcs-sss_e.pdf, p.1.

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1.2 THE FINANCIAL ARRANGEMENTS

Turning to financial matters, in 1977 the *Federal-Provincial Fiscal Arrangements and Established Programs Financing Act* (EPF) changed the funding method for health and post-secondary education from the cost sharing described above to block funding by taking the 1975-1976-period as the base for contributions that had to be adjusted by the rate of growth of nominal Gross National Product and increases in population size.[17] The federal government now offered equal[18] amounts per capita to provinces and territories and the transfers comprised two parts: direct cash transfers and tax points transfers. In 1995, EPF funding was combined with welfare funding (*Canada Assistance Plan* funding) to become the *Canada Health and Social Transfer* (CHST)

In 2004, the CHST was divided in two parts: the *Canada Health Transfer* (CHT) and the *Canada Social Transfer* (CST). The CHT provides federal health funding according to the five criteria mentioned above and the CST provides federal funds labeled as being for post-secondary education, social welfare and childhood services.

Funding comes from governments' (federal, provincial and territorial) general revenues, namely from all different types of taxes. Only one province, British Columbia levies health care premiums in 2010 (Alberta and Ontario no longer do) but not paying them does not limit one's access to necessary services.[19] While the private sector can offer supplementary health care insurance, it cannot offer health insurance for publicly provided services. As a result, there is almost no private provision of such services[20].There is also 'health tourism' with Canadians going abroad often the United States to consume health services.

[17] *Idem*.
[18] Strictly speaking from 1982 onwards
[19] *Idem*., p.5.
[20] We say almost since there are a very small number of clinics such as one in Montreal providing hip replacement.

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So how important are health expenditures in Canada? Table 1 provides a first set of information. It shows the following:

1. A fifteen fold increase in nominal spending on total health over 35 years while population barely doubled;
2. An increase by about 50% in the share of GDP allocated to total health spending; we say about since the 2009 % is the result in part of the drop in GDP associated with the 2008-2010 economic shock and exaggerates the long term trend in our opinion;
3. An increase of about 25% in the share of private health spending (on items like medication, dentists, …) in total health spending;
4. A steady and dominant role of provinces in the public provision of health services

But Canada is a federal country .How do provinces differ from one another? We examine this in table 2 and figure 1

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Table 1 Four indicators of the importance of health spending ,Canada, 1975-2009, eight selected years

Year	Total Health spending 000 000$ (Can) current	Total Health spending as % GDP	Private spending as % of total health spending	Provincial health spending as % of public health spending
1975	12,199	7,0%	23,8%	93,6%
1980	22,298	7,1%	24,5%	93,8%
1985	39,841,	8,2%	24,5%	93,7%
1990	61,022,	9,0%	25,5%	93,5%
1995	74,089,	9,1%	28,8%	92,8%
2000	98,427,	9,1%	29,6%	91,9%
2005	141,061	10,3%	29,7%	91,7%
2009	183,120	11,9%	29,8%	92,3%

Source: Total Health Expenditure, Canada, 1975 to 2009—Summary table A-1Canadian Institute of Health Statistics
http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=PG_2490_E&cw_topic=2490&cw_rel=AR_31_E

Table 2 and Figure 1 show the following:

- Differences in the share of GDP spent on health between provinces. One should note the important variation in the Alberta share : this is explained in part by the important contribution of petroleum products to the GDP of that province and the variability of their prices ;
- Differences in per capita spending which are smaller than differences in % of GDP in terms of the relevant coefficient of variation;
- A downward trend in the divergence between provinces as shown in figure 2 with the evolution of the coefficient of variations of both indicators.

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Table 2 Two indicators of the importance of health spending, 10 provinces, Canada, 1975/1981-2009, 7/ 8 selected years

	N.L. T.-N.-L.	P.E.I. Î.-P.-É.	N.S. N.-É.	N.B.N.-B.	Que.Qc	Ont.	Man.	Sask.	Alta.Alb.	B.C.C.-B.	Canada
% total health spending as share of GDP											
1981	12,1	12,8	9,9	10,7	8,6	6,8	8,5	6,4	4,9	7,6	7,3%
1985	11,8	12,5	9,9	10,9	9,3	7,6	9,3	8,5	6,1	8,7	8,2%
1990	11,9	11,8	11,0	11,4	9,3	8,4	10,3	10,6	7,8	9,3	9,0%
1995	11,9	12,3	10,7	11,1	9,8	8,9	10,8	9,2	6,6	9,6	9,1%
2000	12,1	11,9	11,5	11,0	9,6	8,8	11,9	9,3	6,6	10,2	9,1%
2005	10,2	13,9	12,9	13,3	11,0	10,6	13,5	10,0	6,9	10,8	10,3%
2009	10,3	16,7	16,1	15,0	12,7	12,7	14,0	9,9	8,2	12,3	11,9%
Per capita health spending $ current											
	N.L. T.-N.-L.	P.E.I. Î.-P.-É.	N.S. N.-É.	N.B.N.-B.	Que.Qc	Ont.	Man.	Sask.	Alta. Alb.	B.C.C.-B.	Canada
1975	475	503	463	410	534	532	533	481	549	553	527
1980	922	989	771	797	905	873	939	843	982	1 050	910
1985	1 356	1 419	1 393	1 418	1 505	1 553	1 595	1 491	1 694	1 559	1 542
1990	1 897	1 963	2 052	2 072	2 043	2 311	2 247	2 236	2 257	2 240	2 203
1995	2 237	2 436	2 221	2 423	2 406	2 675	2 582	2 408	2 228	2 677	2 528
2000	3 191	2 944	3 024	2 956	2 937	3 336	3 526	3 131	3 200	3 313	3 207
2005	4 348	4 183	4 309	4 393	3 929	4 509	4 776	4 469	4 652	4 293	4 366
2009	5 969	5 768	5 841	5 506	4 891	5 530	5 812	5 813	6 072	5 254	5 452

Source: Total Health Expenditure, Canada, 1975 to 2009—Summary table B-1.2 Canadian Institute of Health Statistics http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=PG_2490_E&cw_topic=2490&cw_rel=AR_31_E

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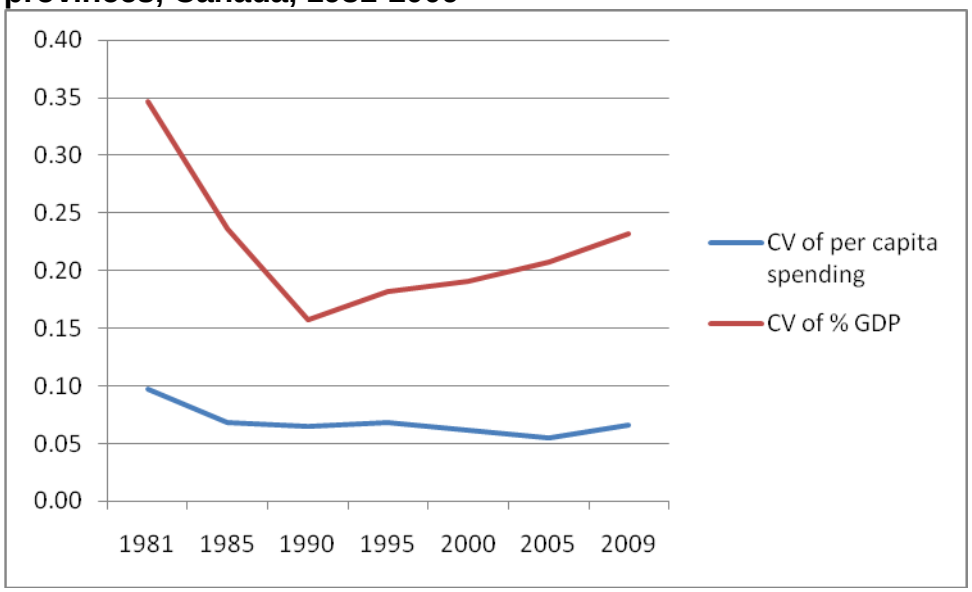
Figure 1 Two indicators of the variability of health spending accross 10 provinces, Canada, 1981-2009



Note: CV= coefficient of variation (standard error/ mean)
Source: Total Health Expenditure, Canada, 1975 to 2009—Summary table B-1.2 Canadian Institute of Health Statistics

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What is the impact of health spending on provincial expenditures and how do provinces finance themselves? Figure 2 provides an answer for Canada as a whole.

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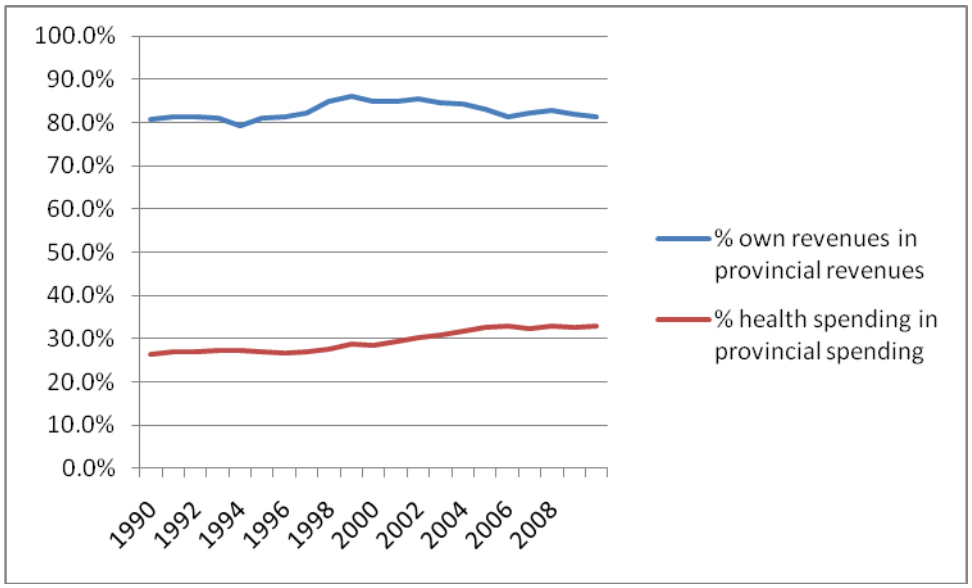
Figure 2 Two financial indicators of the importance of health spending, Canada, all provinces, 1990-2008



Source: calculations using data from table 385-0001 CANSIM

Figure 2 shows that provinces finance themselves mainly using own revenues and that health spending has increased as a share of total provincial spending; it has gone from 26 %(1989) to 33 %(2009) in 20 years. How does this vary by province?

Figure 3 provides evidence for a 20 year period for the starting ,mid-point and end year for each of the ten provinces ; all show an increase in their share of health spending in that period.

The highest share in 2009 is in Ontario at 37% and the lowest in Québec at 28% ; the largest increase from 1990 to 2009 is observed in Manitoba and Saskatchewan (tied) , it is 13 % points .

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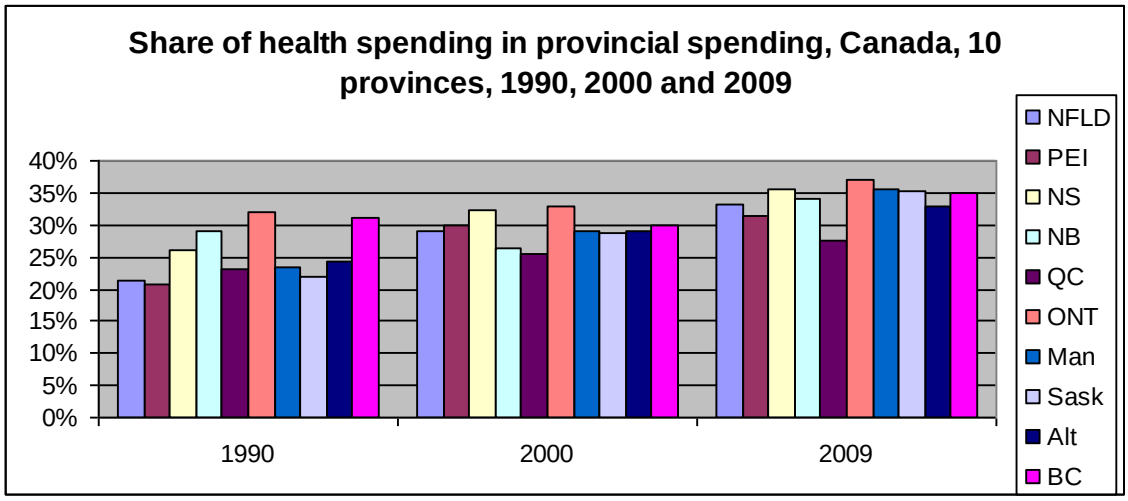
Figure 3



Source: calculations using data from CANSIM table 385-0001

Hence, the various indicators found in tables 2 and 3 and figures 1 and 2 show differences in financial health statistics between provinces. But are there also differences in health outcomes between provinces? We turn to this question in the following section.

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2 FEDERALISM, HEALTH POLICY AND HEALTH OUTCOMES IN CANADA;

The federal nature of the arrangements for the delivery of health services in Canada should normally lead to diversity in both public policy and health outcomes. We examine each issue in turn

2.1 HEALTH POLICY

There are numerous aspects of health policies that can differ between provinces such as the use or not of sub provincial regional bodies, the use or not of integrated public health centers. We present evidence on one item the provision of abortion services; we selected it since the issue of differences between Spanish ACs was raised at the conference. In Canada, abortions are not regulated by law since 1988 when the existing law was found unconstitutional by the Supreme Court and no law was adopted to replace it[21]. Thus abortion is a health matter. Table 3 shows variability in the number of entities offering abortion by province and thus geographical coverage. It also shows a fair amount of differences in the cut-off point after which normal abortions are no longer offered. The province with the second highest cut-off and the greatest availability is Québec, the province where support for abortion rights is the strongest. Thus health policy reflects in part regional differences in preferences with respect to abortion.

[21] http://www.cbc.ca/canada/story/2009/01/13/f-abortion-timeline.html

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Table 3 Differences in abortion policies, 10 Canadian provinces, 2010

	Available in hospital setting Number were offerd/ total number of hospital in provicne	Available in private setting	No abortions after # of weeks of pregnancy	% who agree that women should have the right to an abortion
Nfld	3/14	1 clinic	15	69
PEI	0/7	No	15	69
NS	4/30 hospitals	No	15	69
NB	1/28	1 clinic	16	69
Quebec	31/129 +23 CLSCs (public clinic),	4 private clinics	23	89
Ontario	33/194	9 clinics	24	69
Manitoba	2/52	2 clinics	16	70
Sask	4/68	2 in Alberta	14	70
Alberta	6/100	2 clinics	20	70
BC	26/88	4 clinics	20	77

Source: http://www.theglobeandmail.com/news/abortion-province-by-province/article1609885/

Notes: PEI will pay for off island procedures % support are for five regions: Atlantic(4 provinces) , Quebec, Ontario, Prairies(3 provinces) and BC.

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2 Health outcomes

There are various ways of measuring health outcomes:

- Inputs such as the number of MDs available per capita ;
- Intermediate outcomes such as waiting time for a visit
- Final outcomes such as health status

Table 4 presents evidence for Canada as a whole and the ten Canadian provinces for six such indicators and for life expectancy.

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Table 4 Seven indicators of health outcomes, Canada and ten provinces, 2005-2007

Indicator/ Area	Canada	Nfld	PEI	NS	NB	QC	Ont	Man	Sask	Alt	BC	CV
Family physician per 100000	**98**	**107**	**98**	**116**	**99**	**111**	**85**	**92**	**92**	**107**	**106**	0,10
% individuals with a family physician	**85**	**89**	**93**	**88**	**92**	**74**	**90**	**85**	**84**	**82**	**87**	0,06
Average # of consultation per person	**3.9**	**4.4**	**3.9**	**4.8**	**3.9**	**2.9**	**4.2**	**3.7**	**4.5**	**4.0**	**4.5**	0,13
Wait time in weeks for non urgent appointment	**2.7**	**1.4**	**1.7**	**1.4**	**2.2**	**6.6**	**1.6**	**2.7**	**1.5**	**1.6**	**1.2**	0,74
% reporting unmet health need	**11.3**	**10.8**	**9.3**	**10.4**	**10.4**	**11.6**	**11.4**	**12.4**	**11.3**	**10.9**	**11.7**	0,08
Hospitalization rate for long term health conditions per 100 000	**464**	**616**	**655**	**481**	**631**	**429**	**447**	**481**	**536**	**518**	**371**	0,18
Life expectancy at birth(2004)	80.2	78.5	79.2	79.1	79.7	80.1	80.6	78.9	79.3	80.2	80.9	0,1

Note: CV= coefficient of variation (standard error/ mean)
Source: calculations by Jamie Ronson for Harvey Lazar using data from *The Canadian Community Health Survey (CCHS) (2005 & 2007) and CIHI Health Indicators Database (2005)*

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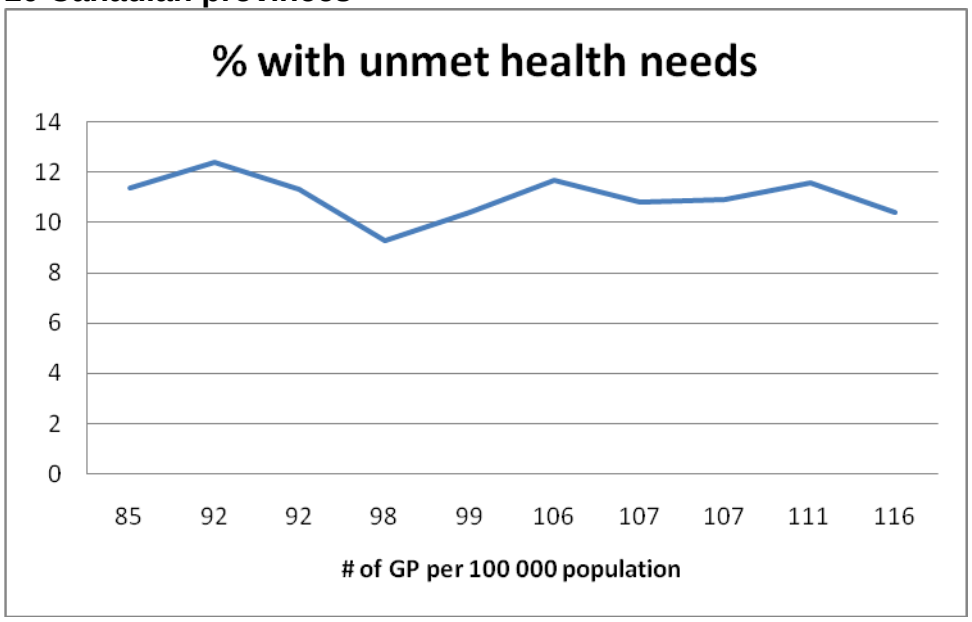
Table 3 shows:

- differences between provinces as measured by the CV for the six indicators with the largest for the waiting time one driven by the very high number for Québec;
- life expectancy varies by 2.4 years between the lowest Newfoundland and the highest BC; this reflects in part lifestyle differences;

Is there a relationship between the inputs and outputs? Figure 4 plots the relationship between number of family physicians per 100 000 and unmet health needs; it shows no obvious relation.

Figure4 Relationships between availability of GPs, and unmet health needs, 10 Canadian provinces



Source: calculations using data from table 3 with provinces ordered according to GPs per population (line 1 of table 3).

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The debate on inter provincial differences in the health sector in Canada has not centerd on inidcaors such as those presented in table 3.They tend to gravitate around two items recently .First the differences in availability between provinces of specific services,usually new and high cost drugs, that target a small number of individuals or that may prolong or not the life of patients suffering from incurable diseases such as some types of cancers. This is referred to ,using a British analogy, as postal code inequity. This happens because each province has its own approval process for allowing specific drugs for both the public prescription plan,available to elderly or welfare recipients mainly (except in Québec where it covers all individuals not privately covered) and on the list of medication to be paid for by private health plans that are provincially regulated. Second the lack of national standards in this or that field and thus of national strategies in those fields. For example, the last issue raised was the lack of a national birthing strategy to reduce the rate of Cesarians.

3 THE CHALLENGES AHEAD

The well known challenge of an aging population will be faced by Canada in the first half of the 21st century. What matters from a federalism perspective is the differences between provinces and how they are accounted for.

Figure 5 presents a summary view of the age structure of the ten provinces,observed for 1975and predicted for 2030.

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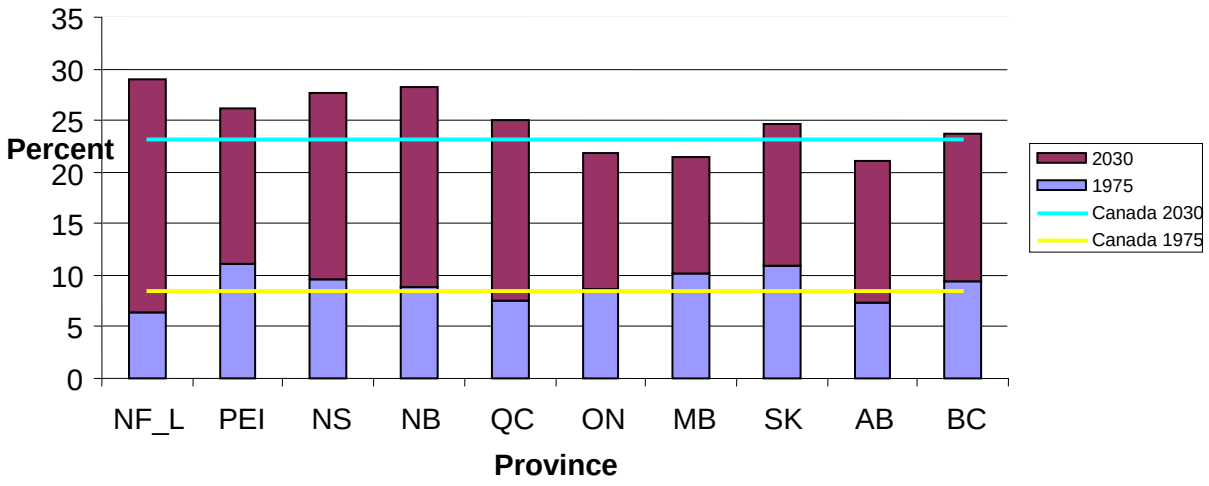
Figure 5- Proportion of the population aged 65 and older, Canada and provinces, 1975 and 2030



Source: calculations by the author using CANSIM tables 051-0001 and 052-0004

Figure 5 shows important differences in the provincial shares of the 65+ population in Canada for both years. This means that the burden faced by each province in terms of health spending is not the same now or in the foreseeable future. Yet the formula for equalization only indirectly accounts for this, with taxable capacity being lower in provinces with an older population since retirement is associated with a drop in personal income and personal income differences are an important driver of equalization. And the health block grants do not take into account the age structure of the population, only its absolute size. Interestingly, in the United States, one finds similar differences between states with sunshine states such as Florida or New Mexico specializing in welcoming older Americans (and Canadians in the winter).But since Medicare which covers Americans aged 65 + is a 100% federal program, this has a smaller impact on the health spending of states, although long term care of the poor is paid for by Medicaid and not Medicare.

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More generally, there are fewer differences in the age structure of the population between American states than Canadian provinces.

This aging challenge is compounded by the technology challenge with ever increasing cost of one unit of health intervention, be it a surgical procedure or medication. Thus in the Canadian context of mainly publicly provided health care, health costs are seen as a Pac man eating up an ever increasing share of provincial budgets.

The question is thus what solutions. One possibility quickly rejected by the Canadian politicians and public is privatization of the system as it is not obvious that the United States health system yields better outcomes. Another solution which is increasing the share of the private sector at the margin, the UK model with NHS and a small private sector is already in place as noted above for some procedures in Canada and through the practice of medical tourism to the USA or elsewhere. But this is done by a small minority of high income users 1% at best – no firm data is available).

Thus one is left with:

- rationing access ,something done by waiting times for surgery and major treatments (cancer therapy) that are argued to be longer than for insured Americans .If uninsured Americans that do not use and thus wait forever, the ranking in terms of waiting time may be different;
- improving the funding of the system; this was the main recommendation of the Romanow report (Romanow gap) but it is not clear if the required inputs (nurses ,MDs) are available to be hired;

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- improving the efficiency of the system by changing the way hospitals and MDs are paid .For example, one can replace the global budget of hospitals by funding based on episode of care. This sends resources where they are used and can encourage efficiency gains;
- reducing the demand by pricing the access to some /all services. This, however, while formally allowed by the Canada Health Act, is costly as it reduces federal transfers to provinces

The present government of Canada (conservative minority since 2006, reelected in 2008) promised in the electoral campaign of 2005 a reduction in the Canadian VAT (GST) from 7% to 5% and kept its promise. This gives tax room to provinces to increase their own VAT (Québec in 2011) or to switch from a retail sales tax to a provincial VAT (Ontario, BC) increasing their revenues. It does not allow individuals to purchase more privately provided health services and in particular insurance since it is not offered on the market. It may well be that the funding of future health expenditures will require provinces to increase their tax burden, occupying the tax room vacated by the federal government.

CONCLUSION

Publicly provide health in Canada is highly decentralized both in terms of what is provided, how it is provided, and how it is financed. This is in agreement with the Canadian Constitution but there is popular demand for more similar outcomes across provinces. Thus one can expect some convergence in the next ten years but more likely as a result of yardstick competition than the imposition of federal standards.

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