RE-EXAMINING PUBLIC FUNDING AND NOT-FOR-PROFIT HEALTH CARE

BACKGROUNDER

Foreword

The Canadian Nurses Association supports publicly funded, not-for-profit health care for all Canadians. But medicare in this country has been evolving for more than 50 years. Economics, world-wide trends, government priorities and shifting political values have radically changed everything from financing to political thinking. Over the same period, technological breakthroughs have revolutionized the way we deliver care — and taken it far beyond the reality in which medicare was designed.

Does that make a commitment to publicly funded, not-for-profit health care out of date? We don’t think so. But it does make it the topic of ongoing debate — a debate that is made more complicated when the many stakeholders involved don’t necessarily share common definitions or an understanding of the system we are committed to defending. The board of the Canadian Nurses Association wanted to bring clarity to this critical issue. To do that, it commissioned Raisa Deber to prepare a background paper on the subject. Professor Deber is an eminent University of Toronto expert in health policy and financing. Her paper for CNA explores various models of funding health care, the history and evolution of universal health care in Canada and the nature of the Canada Health Act and its influence.

Dr. Deber’s paper is both a useful primer and a guide to understanding the continuing evolution of our publicly funded, universal health-care system. For nurses, for patients, for anyone with a stake in health care in Canada, we offer this condensed version of her paper to inform thinking and debate.
Publicly funded, not-for-profit health care: Clarifying Canada’s complex reality

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Health-care systems are complex, offering a wide variety of services, delivered in different settings by different providers. In Canada, health-care delivery is primarily the responsibility of 10 provincial and three territorial governments. However, those separate systems are shaped and guided by the Canada Health Act, the federal legislation that spells out the terms and conditions provinces and territories must abide by if they want federal funding for health care. Because the act does not have a set of regulations detailing how it is to be applied, interpretations can differ and disagreements arise.

Debate over health care usually focuses on how services are financed, how they are delivered and whether they are public or private (Madore & Tiedermann, 2005; Deber, 2004). Let’s start by defining those terms.

Public health care is operated by government, whether that’s a national government or a lower level. There is some public care in Canada such as federal, provincial and municipal public health programs, the federal government’s programs for Aboriginal Peoples and veterans, and some psychiatric hospitals. However, it’s important to note most care in Canada is actually private. That’s because, although we think of them as public institutions, most hospitals and community agencies are private, not-for-profit corporations. As well, many providers who collect fees from either public or private sources (and sometimes both) are, technically, small businesses. That includes most physicians, as well as many physiotherapists and other professionals running private practices. Finally, there are private for-profit corporations such as pharmacies and medical laboratories.

The Organisation for Economic Co-operation and Development (OECD) identifies four main types of financing for health services: public payment through taxation or general revenues; public payment through social insurance; payment by private insurance; and direct (out-of-pocket) payment by individuals (Docteur & Oxley, 2003). Here are those models presented in a table:

Table 1: Models of financing and delivery

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The federal role

Under Canada’s constitution, health care has been interpreted by the courts as largely under provincial or territorial jurisdiction. But because some parts of Canada are more affluent than others, successive Canadian governments have provided funds to encourage equal levels of health care for all citizens, regardless of where they live. This support started with the national health grants program in 1948, when the federal government provided cash to provincial and territorial governments for things like building hospitals and training key health-care personnel. It was followed by the federal government offering to share the costs of setting up publicly-funded insurance for hospital and diagnostic services in 1957 and for physician services in 1966. Before the federal government intervened, only five provinces had hospital insurance programs; all of them were participating by January 1961. All were participating in the physician payment program by 1971.

These cost-sharing programs had considerable impact on how care was delivered; for example, since only community-based care provided by physicians got federal matching funds, Ontario’s experiments with nurse practitioners in the early 1970s failed to become mainstream because they were not eligible for federal funding. Cost-sharing also encouraged building long-term care hospitals rather than developing home care.

In 1977, the funding model was modified with passage of the Federal-Provincial Fiscal Arrangements and Established Programs Financing Act (known as EPF), which grouped together the earlier health funding programs and cost-sharing for post-secondary education. EPF was a block-funding program, giving an equal per capita amount to each province and territory. It also transferred some of the money in equalized tax points — the federal government lowered its personal income and corporate income tax rates, which allowed provincial and territorial governments to increase theirs without increasing the overall tax rates. The amount yielded by these equalized tax points was subtracted from the overall per capita entitlement, and the federal government paid only the residual difference in the form of cash. The difference with EPF was that provinces were free to deliver services as they thought best — so, for instance, they could pay nurse practitioners to deliver insured services.

One unintended consequence of that shift was the erosion of the cash contribution, since the equalized value of the tax points continued to grow even though total entitlements were frozen. That erosion decreased federal influence, since withholding cash was the main means of enforcing the provisions of the Canada Health Act. In 1996, to preserve federal cash transfers (and federal ability to influence provincial policy and enforce the Canada Health Act), EPF was combined with the Canada Assistance Plan transfer and renamed the Canada Health and Social Transfer (CHST). In 2004 the CHST was split into two transfers, renamed the Canada Health Transfer and the Canada Social Transfer. They retained a similar model (overall per capita entitlement, met through tax points and residual cash) although this is scheduled to change in 2014.
The **Canada Health Act**

While the various forms of transfers have shifted over the years, the federal government’s role in health-care funding has been defined by the *Canada Health Act* (CHA) after it was passed in 1984. The act’s “five principles” set criteria provinces must meet to receive cash transfers to help pay for health-care programs. Those criteria are as follows:

**Public administration**: This requirement says each provincial or territorial health insurance plan must be administered and operated on a non-profit basis by a public authority designated by the province. However, it says nothing about how care should be delivered.

**Comprehensiveness**: This condition requires public insurance plans to cover all insured health services (see the list in Appendix 1) provided to “insured persons” by hospitals and doctors (provinces can approve similar or additional services by other health-care practitioners).

**Universality**: This condition means provinces and territories must cover all insured health services for all their insured persons under uniform terms and conditions.

**Portability**: This requirement specifies what happens when someone insured in one province needs care elsewhere in Canada. If a person has taken up residence in another province, there can be up to a three-month waiting period to become eligible for insured health services. Medically necessary care while visiting other provinces is covered by the home province.

**Accessibility**: This condition requires that the provincial plan provide health services on uniform terms and conditions (that is, making medically necessary care similarly available to all insured people). These insured services must be “reasonably” accessible to all, and direct or indirect impediments (including user fees) are explicitly prohibited.

Perhaps the most hotly debated issue in health care is the question of defining what is meant by medical necessity, because only services meeting this test need be insured (Charles, Lomas, Giocomini, Bhatia, & Vincent, 1997; CFHCC, 2002). As it stands, once care not directly delivered by physicians shifts from hospitals, it is no longer required to be insured, even though it may still be viewed as medically necessary. That has proved problematic as health care evolves from institutional to community care. Outpatient care — including pharmaceuticals (drugs for inpatients are covered under the act) rehabilitation, primary care by non-physician providers and many forms of home care — are not necessarily covered. Provinces are free to extend such coverage but do not have to. Many provinces have viewed the CHA as a shield to avoid pressures to expand coverage, particularly for home care and pharmaceuticals. The result has often been passive privatization — where a government’s decision not to pay for a service moves it into the private sector (Tholl, 1994; Tholl & Bujold, 2012).
Other issues that arise as the *Canada Health Act* reaches its 30th anniversary are (1) its failure to focus on services (rather than on where and by whom they are delivered) and the potential erosion of coverage as more and more services are delivered at home and in the community rather than in hospitals; (2) the role of corporate for-profit providers; (3) the need to recognize that more treatment is not always better and to emphasize appropriateness; and (4) attention to issues of equity and fairness, particularly given trends to minimize a direct federal role.

As one key informant said, one reason these issues have occurred was that the government did not promulgate regulations under the CHA, largely because they could not get agreement from all provinces. Under the CHA a hospital “includes any facility or portion thereof that provides hospital care, including acute, rehabilitative or chronic care, but does not include (a) a hospital or institution primarily for the mentally disordered, or (b) a facility or portion thereof that provides nursing home intermediate care service or adult residential care service, or comparable services for children” (p. 3). The intention was to define the concept of what constituted a facility broadly, which would have given more flexibility to fund community care — perhaps following the example of New Brunswick’s “extramural hospital,” which provided community services. It opened in 1981 and was designated a hospital with fully insured services (Ferguson, 1987). But because there was no definition of facility attached to the CHA, the provinces are free to narrow their interpretation of what must be funded. Both Romanow (CFHCC, 2002) and Kirby (SSC, 2002) suggested a need to clarify this provision, but that has not happened.

Similarly, the definition of “comprehensiveness” in the CHA includes the provision “and where the law of the province so permits, similar or additional services rendered by other health care practitioners” (p. 6). Although this provision allows provinces to designate other providers for coverage, it has rarely been done (some provinces have designated midwifery). If designated, providers are publicly paid wherever they work. Note that this provision is a floor, not a ceiling; provincial and territorial governments can and have allowed other providers to provide insured services (such as pharmacists giving flu shots) while still permitting them to bill for non-insured services.

Exceptions and interpretations over the years have led to confusion over both the nature and the future of Canadian health care. Most scholarly analyses of the CHA have long recognized that delivery is largely private, and that the provinces and territories are able to determine which providers they wish to fund. For example, in an analysis for the Romanow commission that strongly defends the importance of continuing to ensure that health care is allocated on the basis of need, Prémont (2002) wrote: “It is important to remember that not only is the provision of services by the private sector not prohibited by the *Canada Health Act* or provincial legislation, but that, on the contrary, the private sector already plays a predominant role here” (p. 11) (she specifically notes physicians and pharmaceuticals). Similarly, Boychuk (2012) has written: “Most strikingly, despite presumptions in public debates and media coverage of health issues, the CHA very clearly does not
mandate the public delivery of services, ban or otherwise regulate in any way the private purchase of health services or third-party health insurance, or create a set of justiciable obligations on the part of government that are enforceable by the courts” (p. 3).

Policy issues continue to arise, however, often related to financing, including debate on which alternative types of care delivery are cost effective. There is a considerable literature suggesting that corporate for-profit delivery may not be as efficient under many circumstances as is often suggested (Deber, 2004). The question is how these organizations make their profits. Depending on the ethics of the providers and the regulatory structure, they may come from combinations of higher prices, lower quality and/or overtreatment. Private providers are often accused of “cream skimming,” that is, focusing on the clients and services that will generate the most profit (avoiding the chronically ill, for example, and offering only services with few complications).

Another, related issue has been how the workforce is treated. In some provinces, including Alberta, increased use of the private sector (whether that means contracting out jobs or moving care from unionized hospitals to private clinics) has been conflated with laying off unionized workers (McCormick, 1995). Provincial and territorial governments vary in how they deal with corporate for-profit providers. For example, Saskatchewan created legal barriers that severely restricted how such organizations could operate (McIntosh & Ducie, 2009).

**Trends, issues, threats, opportunities**

One key issue is who should pay for what. This in turn is related to the concept of “risk pooling.” In a report for the World Bank, Smith and Witter (2004) discussed four types of risk pooling. These ranged from no risk pooling at all (where people pay their own way) to a single national pool. As Deber and Lam (2009) have noted, different funding models reflect different views about which costs should be borne collectively, and which are the responsibility of individuals and their families. One approach argues that costs should be borne by society, on the basis of ability to pay. Actuarial fairness, in contrast, assumes that costs should be distributed based on the expected payouts — e.g., arguing that those with a higher likelihood of incurring costs should pay more, and those with a lower likelihood should pay less. This view rejects “cross-subsidization” — those with a clean driving record should pay lower rates than those with a history of accidents — and assumes that risks should be pooled only among relatively homogeneous populations. The libertarian viewpoint would argue that fairness not only precludes requiring individuals to subsidize others, but precludes mandating coverage at all. To the extent this debate reflects underlying values about individual vs. mutual responsibility, data is irrelevant (Deber & Lam, 2009).

Over time, more and more care in Canada has escaped from the terms of the CHA. This has been fuelled by a combination of factors, including changes in technology which have shifted care from
hospitals to home and community, economic pressures causing governments to try to curb expenditures and the (resulting) tendency to shift costs from public to private payers. Both the Romanow and Kirby reports stressed the importance of focusing on services rather than on who is delivering them and where (CFHCC, 2002; SSC, 2002). Others have echoed these recommendations, but little has been done. This is one policy issue ripe for action. (It is beyond the current scope to suggest every possibility, but they could include such options as clarifying the Canada Health Act conditions; providing federal funding for new programs to cover all or some of the costs of such services as pharmacare, home care or long term care for various subsets of the population; encouraging best practices to ensure that services are delivered in the most appropriate and cost-efficient manner, etc.)

The role of corporate for-profit providers

Under the terms of the CHA, governments are permitted to contract for-profit corporations to provide health care, but the international literature suggests the prospect of inefficiencies and inequities arising from efforts to maximize profits. A series of studies have noted problems, particularly additional out-of-pocket charges and high markups (Donaldson & Currie, 2000; Armstrong, 2003; Gibson & Clements, 2012). In one study, Armstrong (2003) commented on “the strategy of ‘unbundling’ the components of an insured service (e.g., health workers, facility settings and products) in order to shift payment responsibilities for previously insured care to patients” (p. iii). As one example, Mehra (2008) attempted to find and analyze “all the for-profit diagnostic, surgical and ‘boutique’ physician clinics across Canada” (p. 7). The report suggested there were increasing wait times, eroding equity and fairness, and increasing costs (to both public and private payers), often through co-mingling medically necessary care (insured under the CHA) with unnecessary services. They attributed this in part to a change in the ownership of such clinics from small locally-owned companies to chains, often linked to U.S.-led multinational companies.

Appropriateness

More care is not always better for patients. The Institute of Medicine (2001) in the U.S. warns that quality problems include what they call overuse, underuse, and misuse, and analysts increasingly recognize that fee-for-service payments often result in overuse. As a result, the issue of “appropriateness” — whether care is really needed and is the right choice for the patient — is receiving increasing attention (Deber, 2008). For example, as the number of diagnostic and screening tests has been increasing — many of which can be performed in private for-profit clinics — the clinical benefits for many recipients has been called into question (Petch, Latourell, & Laupacis, 2012; Moynihan, Doust, & Henry, 2012; Cassels, 2012).
Equity and fairness

There is widespread agreement that all Canadians should be able to receive comparable levels of key services, regardless of where they live. However, recent changes to funding formulas may make that more difficult to ensure. Compliance with the Canada Health Act is voluntary — if a province or territory is willing to accept the consequences. The CHA asserts that if a provincial health-care plan does not meet the above-stated criteria it will be subject to reduced or complete withholding of cash contributions or any amounts payable to them by Canada.

In 2007, the federal budget shifted from the system used by EPF and the Canada Health Transfer (whereby provinces received equal per capita entitlements met through a combination of tax points and residual cash) to a new cash-based model, effective April 1, 2014. The Parliamentary Budget Office says this will result in redistribution, with more money going to “have” provinces (particularly Alberta, Saskatchewan and Newfoundland), at the expense of “have not” provinces (Bartlett, Cameron, Lao, Matier, & Tapp, 2012). Other changes are likely, and may affect the fiscal capacity, particularly of poorer provinces (Matier, 2012). Determining the best formula is clearly controversial, as different approaches have different winners and losers. One cause for concern is that revisions to the formula, particularly if the federal government decides to move to greater reliance on tax points, could make the Canada Health Act permanently unenforceable. That could mean a future where health costs are higher, outcomes and equity worse, and where more costs have been shifted to the private sector.

Conclusion

As noted above, the Canada Health Act says nothing about delivery. Its terms and conditions specify insured persons and insured services and do not allow user fees for them. However, care delivered outside of hospitals by providers other than physicians does not fall within its definition of insured services, and provinces and territories can allow charges for them. That can lead to heavier reliance on user fees and a greater role for private health insurance, which may prove penny-wise and pound foolish. Attractive in the short term, as governments struggle to manage fiscal challenges, shifting costs to individuals and employers may make Canada less economically competitive by placing more costs on payroll. It could also undermine people’s health, by discouraging some of them from getting treatment they need or by discouraging preventive care, both of which can ultimately increase health costs if people only seek care when they become more severely ill. Private financing can also erode governments’ ability to control costs.
Appendix 1: Insured services as defined in the *Canada Health Act*.

**Hospital services** include any of the following services provided to in-patients or out-patients at a hospital, if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability, namely

- accommodation and meals at the standard or public ward level and preferred accommodation, if medically required;
- nursing service;
- laboratory, radiological and other diagnostic procedures, together with the necessary interpretations;
- drugs, biologicals and related preparations when administered in the hospital;
- use of operating room, case room and anesthetic facilities, including necessary equipment and supplies;
- medical and surgical equipment and supplies;
- use of radiotherapy facilities;
- use of physiotherapy facilities; and
- services provided by persons who receive remuneration from the hospital but not services that are excluded by the regulations.

**Physician services** are any medically required services rendered by medical practitioners.

**Surgical-dental services** means any medically or dentally required surgical-dental procedures performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedures (Marchildon, 2005). In practice, almost no dental services meet this criteria; dental care is almost entirely privately financed in Canada.
References


