Chapter 3

The Development of the Canadian Health Care System

Chapter Outline

- **Learning Objectives**
- **Before Medicare**
- **National Medicare in Canada**
  - *The 1966 Medical Care Act*
  - *The 1984 Canada Health Act*
- **Recent Developments in Health and Health Care**
  - *National Forum on Health*
  - *Royal Commission on the Future of Health Care in Canada*
  - *Standing Senate Committee over Social Affairs, Science, and Technology (Kirby) Report*
  - *First Ministers' Accord on Health Care Renewal*
  - *Changing Political Winds over Federal and Provincial Jurisdictions*
- **Reforms and the Future of Medicare**

Learning Objectives

After studying this chapter, you will be able to:

1. Present a historical picture of the development of the current government-run, single-payer, Canadian health care system;
2. Discuss how various political forces, key stakeholders, and special interest groups shaped the current health care system;
3. Articulate the various federal initiatives that deal directly and indirectly with health and health services;
4. Frame the continuing discussions on health care reform, including privatization, in Canada, within the historical context of its development.

The Canadian Health Care system[1] constitutes the largest social service sector in the country. In the 1980s, it was the third-largest employer in Canada, next to manufacturing

[1]An earlier version of this chapter was published in Frankel, B. G., Speechley, M., & Wade, T. J. (1996). *The sociology of health and health care: A Canadian perspective*. Toronto: Copp Clark.

and trade (Iglehart, 1986). With the decline in the manufacturing sector in Canada over the past few decades, health care has become the second-largest industry after trade (Statistics Canada, 2012, October 5). The immense size and reliance upon public funds for support of a publicly funded health care system attract critical scrutiny, especially in times of fiscal pressures. Critical questions deal with the efficiency of the system, its cost-effectiveness, the distribution of its budget across services, and ways to improve the delivery of care. However, before we grapple with these questions, it is useful to examine the historical evolution of the current Canadian health care system.

We Canadians generally take our health care system for granted. When we go to the doctor or hospital, we expect to receive excellent care regardless of our ability to pay. This has not always been the case. In most provinces prior to the early 1960s, the health care system was very much a private system run like any business. If an individual did not have private health care insurance, he or she was asked to pay for services upon receipt. The cost of some care—emergency and complex medical procedures, chronic illness care, long-term care, pharmaceuticals, and so on—often resulted in financial ruin for a family. Canada has moved away from this "pay-as-you-go" structure to a system in which people are not "taxed" because they are in need of care.

This chapter provides a historical view of the development of the Canadian health care system from Confederation to today. It examines how various social and political forces moulded the system that exists today. Included is a detailed discussion of the legacy of the initial introduction of full public health insurance in Saskatchewan in 1962 and the resulting provincial doctors' strike. Finally, it discusses more recent developments at the federal, provincial, and judicial levels affecting the system and leading to change.

A timeline of the developments in health care in Canada is outlined in Box 3.1.

BEFORE MEDICARE

The original British North America Act (BNA, 1867) specified the jurisdiction of the federal and provincial governments with respect to health care. That is, according to the Constitution Act, 1982 that succeeded the BNA Act, the administration and delivery of health care is the responsibility of the provinces/territories (Section 92), whereas the federal government controls revenue transfers to the provinces (Health Canada, n.d.).

Since the beginning of the 1900s, groups had been advocating for some sort of public medical insurance program for Canadian citizens, with the strongest support traditionally being among labour and farming associations. For example, in 1914, the first municipal doctor plan in the country was introduced in Saskatchewan (Houston, 2002). In Ontario in 1914, when the Sarnia region was about to lose its only doctor, the community paid him a $1500 retainer to stay (Naylor, 1986). The practice of municipal contracts was the beginning of the Canadian movement toward public payment. Historically, the Canadian Medical Association (CMA) was against any type of intervention by the state, unless it

had to do with the payment of bills for people who were unable to pay themselves. It maintained its **fee-for-service** practice, with a hierarchical fee scale based on patients' income. Seeing a threat to their autonomy after the initiation of the British health insurance system in 1912, the CMA cautioned the Canadian government to avoid such a program in this country.

During the latter stages of World War I, interest in health insurance in Canada became more widespread. In British Columbia, a major push for some sort of government health insurance system began, in part, because British Columbia suffered some of the worst labour tensions in Canada with health insurance being a particularly contentious issue. As well, with veterans returning home after the war, there was a call for an improvement in domestic conditions as a reward for overseas service. At the same time, an epidemic of Spanish influenza swept through British Columbia, claiming 3000 lives and affecting many more. In 1919, a provincial commission was established there to study the possibility of public health insurance. Such a program was seen as one possible way to reduce tensions in the province. The governing Liberals chose not to proceed with the insurance program because of fiscal concerns and the opposition of the British Columbia Medical Association (BCMA).

By the early 1920s, the Canadian economy was thriving and there was less interest in state-supported health insurance. The medical profession was prospering along with the rest of the economy. Physicians in British Columbia initiated a movement to extend Workers' Compensation Board Benefits to pay for the medical bills of injured workers, mainly because these displaced workers could not afford to pay for services themselves. The goal of is effort was to reduce revenue losses for physicians. In 1920–1921, the British Columbia Medical Association (BCMA) struck a deal with organized labour to underwrite these claims at two-thirds of the BCMA fee schedule. Both physicians and workers perceived this action was necessary, since fewer than 5% of industrial workers had any type of health insurance (Naylor, 1986, p. 47).

The worldwide economic collapse beginning in October, 1929 (beginning on 29 October, also called Black Friday) and the onset of the Great Depression saw unemployment in Canada reaching levels up to 30%. Many Canadians were unable to pay for the basic necessities of life with health care being further out of reach for more individuals. Remember that many social safety-net programs we take for granted today, including Employment Insurance (EI), welfare (social assistance), disability insurance, and the Canadian Pension Plan (CPP), did not exist. Many people relied on family, neighbours, and the local community for assistance.

Since many patients could not afford to pay for their health care, physicians, especially in British Columbia, Ontario, Alberta, and Saskatchewan, called for some sort of government supported health care insurance plan. This support by physician organizations for public health care was unprecedented and came about because their members too were affected, albeit indirectly, by the economic collapse. In 1933, finding little support for publicly funded health care from the provincial governments, the CMA met with then Prime Minister R. B. Bennett to make a plea for a national health insurance program.

Bennett sympathized with the position of the doctors, but refused to act, arguing that health care was strictly a provincial matter. This was the first and only time ever in which the CMA actively supported and promoted the development of a national public health insurance system in Canada.

Discussions returned to the provincial level and once again the major impetus for change took place in British Columbia. In 1935, the BCMA submitted a proposal to the provincial government that included many of the principles articulated earlier by the CMA (Naylor, 1986). A committee appointed by the BC government toured the province to obtain feedback on the proposed plan. As a result of what it heard, the committee altered the proposal and the BCMA rejected the revisions. One of the strongest criticisms by the BCMA of the revised plan was that physician payment was amended to be on a **capitation** model instead of the existing, and professionally supported, fee-for-service system. A capitation model provides a set payment on a per-patient basis or on a roster of patients, regardless of the number of doctor visits. Amid a great deal of opposition, the new bill including the capitation clause was passed in the BC legislature on March 31, 1935 (Naylor, 1986). The Liberal government of the day claimed that the bill would provide health insurance to more than 275 000 people of the province; the CMA argued that it left out over 100 000 of those who were truly in need of the coverage (Naylor, 1986).

Even though the bill passed in the house, its implementation was delayed. The delay was viewed as a victory by the physicians. In 1936, as the economy began to show signs of improvement, the BCMA maintained its strong resistance to the new legislation. At the same time, the political commitment of the sitting government to public health insurance began to waver (Naylor, 1986). With the approach of a provincial election, the Liberals decided to suspend implementation of the bill, and to call for a referendum on the issue. Again the physicians claimed victory. Against strong criticism from the BCMA and the business community, the legislation was submitted to a referendum during the 1937 provincial election. The plebiscite for public health insurance was supported by 59% of voters, and the Liberals were returned to office. Even with majority support from British Columbia voters and support from the opposition in the legislature (the Co-operative Commonwealth Federation [CCF]) and labour groups, health insurance was stalled in the legislature, ultimately leading to the demise of this health initiative.

Parallel to these political movements, developments in medical technology and science also had a major effect on the health care system during the 1930s and 1940s. The discovery of "magical" drugs such as sulphates and antibiotics as well as the dramatic progress in surgical techniques provided a new-found confidence in and respect for the medical community and the scientific basis of health care. These circumstances helped to maintain the dominance of the medical profession as the major force in the health care field, and accorded physicians considerable leverage over the future of health care delivery in Canada.

In 1940, the Rowell-Sirois Commission, struck to review the division of powers between Ottawa and the provinces, concluded that a national health insurance scheme

might be an appropriate alternative to the current private system, but emphasized that administrative control should remain in provincial hands (Naylor, 1986). Even the CMA acknowledged that publicly funded health care was inevitable. In 1942 Jonathan Meakins, the CMA president, suggested this inevitability to members of the profession, but urged them to ensure that forthcoming legislation was tailored to their specifications. By that time, the CMA was involved in closed-door meetings with the federal government, meetings that profoundly influenced the Federal Advisory Committee on Health Insurance.

A final report was issued by the committee before the end of 1943. The economic feasibility of the plan was questioned by both the Department of Finance and the federal cabinet, and the plan was revised with input from the CMA. The revision was completed by the end of 1944, but its reading in the federal legislature was delayed by the governing Liberal party until after the election in 1945. After their re-election, the Liberals presented the final document to the provincial governments, but the two levels of government failed to agree on a mutually acceptable national health insurance program even though public support for the initiative remained high. A Gallup poll taken in 1944 found that over 80% of Canadians supported a government health insurance plan. This support was reaffirmed in another poll taken in 1949, in which respondents gave overwhelming support to the question: "Would you approve or disapprove of a national health plan whereby a flat monthly payment brought assurance of complete medical and hospital coverage by the federal government?" (Naylor, 1986, p. 135).

The next chapter of the story of the Canadian health care system was written in Saskatchewan. In the summer of 1944, Saskatchewan elected the Co-operative Commonwealth Federation (CCF) under the leadership of Tommy Douglas, the first "socialist" government to win power in North America. True to his election platform, Douglas promoted the development of Medicare in Saskatchewan. Based on his unrelenting effort, Saskatchewan led the way by implementing the first government-funded health care program in the 1940s. By January 1, 1945, a medical care plan on a fee-for-service basis was implemented across Saskatchewan that covered "2500 old age pensioners, recipients of mother's allowance, blind pensioners, and wards of the state" (Naylor, 1986, p. 138).

Refusing to stop there, the government implemented a pilot program in the Swift Current region to test the first universal hospital insurance plan. By 1947, two years after the federal failure, Saskatchewan established a universal hospital insurance program. By 1949, British Columbia followed Saskatchewan's lead with its own provincial hospital insurance plan and by 1950, two other provinces had followed suit (Houston, 2002).

In the 1950s, the general political climate in North America became much less favourable to state intervention. This turn against state involvement was, in part, a response to the McCarthy anti-Communist crusade in the United States and to the influence of the American Medical Association (AMA). In 1952, the public relations committee of the CMA launched a campaign to support alternatives to government-funded insurance from private enterprise. Not surprisingly, this campaign found a great deal of support in the business community.

Box 3.1

Timeline of Major Developments Affecting the Canadian Health Care System

1867	British North American Act (BNA Act) passed giving responsibilities for health care to provincial governments for hospitals, asylums, and charitable institutions and to the federal government for marine hospitals and quarantine.
1884	National Sickness Insurance implemented in Germany under Bismarck
1912	Britain implemented the National Insurance Act of 1911 that established its first unemployment benefit and national health insurance scheme
1914	First rural municipal health insurance plan introduced in Sarnia, Ontario, and in Saskatchewan
1919	British Columbia provincial committee established to study public health insurance
	Federal Department of Health created, removing health from the Department of Agriculture
1929	Beginning of the Great Depression of the 1930s
1933	Canadian Medical Association met with then-Prime Minister R. B. Bennett to make a plea for a national health insurance program
1935–37	British Columbia Insurance Act passed in provincial legislature and was subsequently supported by a provincial referendum but never implemented; a similar act in Alberta passed but also was not implemented
1940	Rowell-Sirois Commission recommended a national health insurance program as feasible
1944–45	Health insurance program based on Rowell-Sirois Commission proposed by Liberal government under Mackenzie King but failed to secure agreement from provinces
1945	Saskatchewan, under the CCF government, implemented pilot project for universal hospital insurance program in Swift Current region
1947	Saskatchewan implemented the first provincial universal hospital insurance program in Canada
1948	The federal government, through its *National Health Grants Program*, provides grants to provinces and territories for hospital and health care facility construction
1949	British Columbia, following the lead of Saskatchewan, implemented its own universal hospital insurance program
1957	Federal government passed the *Hospital Insurance and Diagnostic Services Act* (HIDS) based on the Saskatchewan model.
1958	HIDS implemented nationally by Diefenbaker's Progressive Conservative federal government
	BC, Alberta, Saskatchewan, Manitoba, and Newfoundland enter national HIDS agreement
1959	Ontario, Nova Scotia, New Brunswick, and Prince Edward Island enter HIDS agreement
1961	Quebec enters HIDS agreements and, for the first time in Canadian history, all Canadians are covered under a public hospital insurance program

(continued)

Box 3.1 (*Continued*)

	Royal Commission on Health Services chaired by Mr. Justice Emmett Hall to study universal health insurance appointed by the federal government at the request of the CMA
	Saskatchewan legislature passes the Saskatchewan Medical Care Act to provide universal health insurance to all residents of the province
1962	Saskatchewan Medical Care Act implemented providing universal health care coverage to all provincial citizens (July 1, 1962)
	Saskatchewan physicians go on a three-week strike in an attempt to force the provincial government to rescind the Act (July 1—July 22, 1962)
1964	Royal Commission on Health Services final report recommends support for a Saskatchewan-based model of public health insurance for nation
1966	Federal Medical Care Act based on Saskatchewan model introduced in the House of Commons by the Lester B. Pearson Liberal government
1967	Medical Care Act passed in House of Commons
1968	British Columbia joins the National Medical Care Insurance Program (NMCIP)
1969	Alberta, Manitoba, Ontario, Nova Scotia, and Newfoundland join the NMCIP
1970	Quebec and Prince Edward Island join the NMCIP
1971	New Brunswick and Northwest Territories join the NMCIP
1972	Yukon Territory joins the NMCIP and for the first time in Canadian history, all Canadians are covered under universal health insurance program
1977	Federal government changes its financial commitment under the 1967 Medical Care Act from a 50/50 split with provinces to a system based on block grants and transfer payments based on the Gross National Product (GNP)
1979	Federal Conservatives appoint a Royal Commission on the current status (crisis) of the health care system to be chaired once again by Mr. Justice Emmett Hall.
1980	The Royal Commission recommends banning extra-billing practices
1983	Federal Government, under Pierre Elliot Trudeau's Liberals, introduce the Canada Health Act to Parliament to ban extra-billing practices by physicians, hospitals, and provinces through penalizing transfer payments
1984	The Canada Health Act banning user fees and extra billing passed
	Saskatchewan, Manitoba, and Nova Scotia pass bills to eliminate extra-billing practices
1986	Ontario government introduces legislation to eliminate extra-billing practices and Ontario doctors go on an unsuccessful strike to oppose change
	Federal Government, now under Brian Mulroney's Conservatives, reduce transfer payments to provinces in addition to previous ban on extra-billing, further compounding the financial pressure on provinces to maintain health insurance program; reductions in transfers continue until 1994
1994	Royal Commission established under the federal Liberal government by Prime Minister Jean Chrétien (National Forum on Health) to improve health systems and assess

Box 3.1 (*Continued*)

	financial needs. Interestingly, this coincided with the beginning of the Federal government's cuts to address the federal deficit and Canada's reduced credit rating. The report was released in 1997.
	Federal government implemented a coordinated, national population health surveillance initiative, including both the Canadian Institute for Health Information (CIHI) and the ongoing national health surveillance survey program
1995	Canadian Health and Social Transfer (CHST) federal funding mechanism for provinces further reduces health transfers and combines them for the first time with funding for social services.
2000	Establishment of the Canadian Institutes of Health Research (CIHR), successor to the Medical Research Council of Canada (MRC) and the National Health Research and Development Program (NHRDP)
2001	Royal Commission on the Future of Health Care in Canada was established, headed by Roy Romanow, former Premier of Saskatchewan.
2002	Two seminal (and some argue opposing) reports on the current state of health care in Canada are released: the Romanow Report based on the Royal Commission on the Future of Health Care in Canada, and the Kirby Report, which was the final report from the Senate Committee on Social Affairs
2003	First Ministers' Accord on Health Care Renewal
	Establishment of the Health Council of Canada to monitor Accord
	Canadian Patient Safety Institute established
2004	Liberal Prime Minister Paul Martin provides an additional $40 billion to provinces over 10 years and guarantees a 6% increase until 2016
2005	Establishment of the Public Health Agency of Canada as a result of the inquiry into the management of the SARS outbreak
2007	Establishment of the Mental Health Commission of Canada
2011	The new federal-provincial funding arrangement for health care mandated by the federal Conservative government to take effect after the expiry of the 2003 Health Accord
2013	Expiration of the First Ministers' Accord on Health Care Renewal
2014	Dissolution of the Health Council of Canada established to monitor the First Ministers' Accord on Health Care Renewal

NATIONAL MEDICARE IN CANADA

In 1957, the Federal Government unanimously passed the Hospital Insurance and Diagnostic Services Act (HIDS) based on the Saskatchewan model, paving the way for the entire country to adopt a government-funded hospital insurance plan (Health Canada, n.d.). The legislation provided for a 50/50 cost-sharing agreement between provinces and

the federal government. John Diefenbaker and the Progressive Conservatives implemented the national health insurance program on July 1, 1958. In 1959, Ontario, Nova Scotia, New Brunswick, and Prince Edward Island joined the plan. With the entry of Quebec on January 1, 1961, all Canadians were covered under public hospital insurance. The 50/50 split in costs, in addition to federal grants established in 1948, funded a boom in construction of hospital and acute care centres across provinces that continued until the late 1970s when the federal government revised the cost-sharing arrangements.

Saskatchewan then turned its attention to fight for even greater health care coverage. The province began to press for a universal health care program for all residents. The plan met with resistance from the Saskatchewan College of Physicians and Surgeons (SCPS). As a delay tactic, the CMA requested a federal commission as a tactic to defuse the growing tension between the province of Saskatchewan and its physicians over the proposed universal health care plan. In 1961, the Royal Commission on Health Services, chaired by Mr. Justice Emmett Hall, was appointed by the federal government to study the concept of universal public health care insurance. Despite resistance from physicians and from some residents of the province who feared that the government plan would destroy their health care system, the Saskatchewan Medical Care Act was passed on November 17, 1961.

Members of the Saskatchewan Medical Association refused to cooperate with the province in the implementation of the new law. They argued that the legislation would turn physicians in the province into salaried servants of the state and would interfere in the doctor–patient relationship and the autonomy of physicians to provide appropriate care. Implementation was delayed until July 1, 1962, because of the lack of cooperation from the medical profession. Anticipating a strike from the doctors upon implementation, the Saskatchewan government secured replacement physicians from other provinces, Britain, and the United States to ensure a continuation of health care delivery in the province.

During the final days before the July 1 deadline, provincial physicians, with the support of the CMA, devised a strike plan. On July 1, 1962, the Act took effect and the majority of doctors closed their offices in protest. Some Saskatchewan doctors provided emergency service at hospitals, but only 35 of over 500 members of the Saskatchewan Medical Association actively practised under the Act. This number was augmented by the replacement physicians.

The striking physicians, with support of the press, managed to gain some public support for their position, but it remained problematic; they realized that the Saskatchewan public was expecting some sort of comprehensive public health insurance. The striking physicians and their supporters organized a rally on July 11, 1962, on the steps of the provincial legislature to show their strength in opposing the Act. Despite a great deal of publicity, the rally to demonstrate support for the striking physicians failed, drawing a crowd of less than 10% of how many had been expected. The physicians resumed negotiations with the province. The former made some concessions and the government agreed to some amendments, including a fee-for-service reimbursement structure and allowing

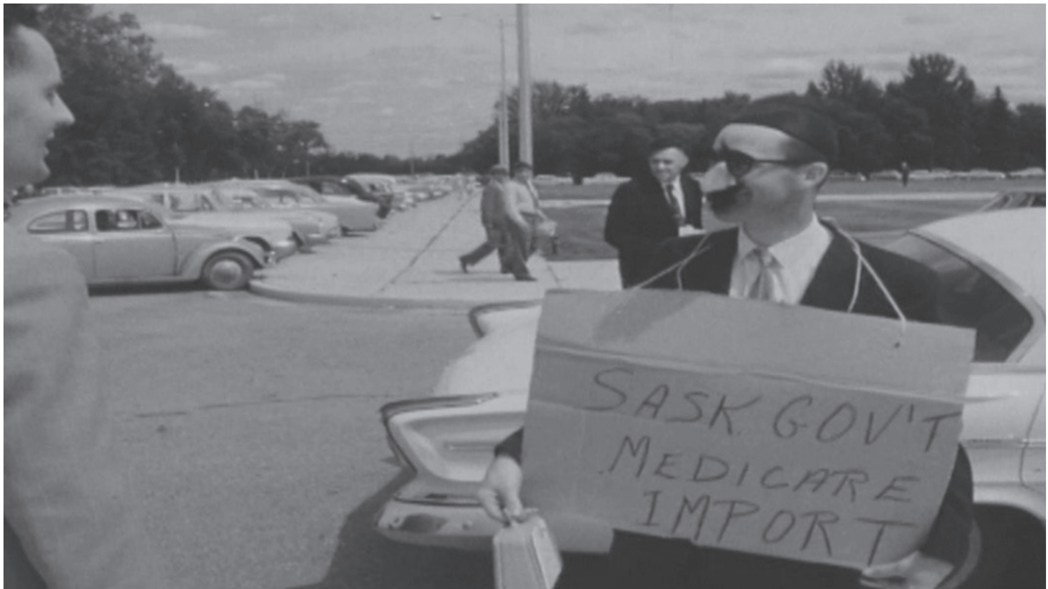

Figure 3.1 Protester Picture

This protestor of the Saskatchewan Medical Care Act depicts a stereotypically racist image—with a large nose and long ponytail—of the imported doctors whom the Saskatchewan government would allegedly recruit to replace striking physicians.

Source: The Canadian Broadcasting Corporation

individual physicians to opt out of the program and bill patients directly. The physicians began their return to work on July 23, 1962. Badgley and Wolfe (1967) wrote a detailed analysis of the Saskatchewan strike (see Researcher Profile 3.1).

Other provinces were examining alternatives to the Saskatchewan plan. Alberta, British Columbia, and Ontario considered working in conjunction with private insurance companies and using subsidies. Members of the medical profession endorsed the idea of multiple insurance carriers. Such a scheme would allow physicians to protect their fee structure since no single agency could exert sufficient power to control the market for their services (Starr, 1982). Because of initiatives subsequently undertaken by the federal government, this approach never really gained much currency in Canada.

In 1964, the Royal Commission on Health Services released its report. Although originally requested by physicians as an attempt to hold back the growing tide of public health insurance, the report supported the government plan whole-heartedly. The report recommended a wide-ranging health insurance program based on the Saskatchewan model, disagreeing with the contention of the CMA that any type of universal public insurance would erode the autonomy of practising physicians. Opposing most of the recommendations of the CMA, the commission did support a fee-for-service payment system and the dominance of the medical profession over competition from podiatric, optometric, and chiropractic services.

Researcher Profile 3.1

Robin Badgley

Photo courtesy of the Ontario Honours Awards Secretariat, Ontario Ministry of Citizenship, Immigration and International Trade

Robin Badgley (1931–2011) received his Masters' degree from McGill and his PhD from Yale. He began his formal career at the University of Saskatchewan in 1959. At that time the CCF government in the province was planning to introduce a government-run medical plan, the forerunner of Medicare. Badgley was a great proponent of Medicare and provided much needed support to the pro-Medicare movement. Badgley and Sam Wolfe, a physician from the United States, later wrote the famous and definitive analysis of the doctor's strike in their book, *Doctor's strike: Medical care and conflict in Saskatchewan*, published in 1967.

In 1968 Badgley became the founding chairman of the Department of Behavioural Science at the University of Toronto, the major initial task of which was to teach social sciences to medical students. He made the department a major national resource for social science and health research training a new generation of scholars in the social sciences and health area in Canada.

Badgley chaired two royal commissions, the first on the functioning of the law on abortions and the second on the sexual abuse of children and youth. He ended his formal university career in 1996 receiving the Order of Ontario in 2005, he continued to publish scholarly work until his death in 2011.

Source: Excerpted from the biography written by David Coburn for the Canadian Society for the Sociology of Health website www.cssh-scss.ca

The 1966 Medical Care Act

In 1964, the federal Liberal government of Lester B. Pearson recommended the creation of a national medical plan based on the Saskatchewan model. The plan was presented to the provinces in 1965 at a federal–provincial conference. Some of the provincial premiers viewed the proposal as an intrusion into provincial jurisdiction. There was even some trepidation within the Liberal party itself, but with a minority government and the New Democratic Party (NDP) holding the balance of power, the government was committed to see the Hall plan through to fruition. In 1966, the Medical Care Act, Bill C-227, was introduced in the federal House of Commons for its first reading.

The principles of the Medical Care Act of 1966 included:

1. **Universality**—one of the five principles of Canadian Medicare—guarantees health care coverage for all Canadian citizens regardless of age, condition, or ability to pay for service;
2. **Accessibility**—refers to the ability to access services regardless of geographic location or financial means;

3. **Comprehensiveness**—covers all necessary services provided in hospital or by physicians;
4. **Portability** across the provinces/territories; and
5. **Public administration** by a non-profit entity responsible to the provincial/territorial government.

As the bill moved to second and third reading, the CMA described it as a threat to the autonomy of physicians and as bringing to an end the traditional doctor–patient relationship. On December 8, 1967, by a vote of 177 to 2, the bill was passed by the Canadian parliament. The CMA warned that the legislation would impose difficult restrictions. The only part of the legislation the doctors supported was the opt-out clause that allowed physicians to bill their patients directly, leaving patients to seek reimbursement from the province (Blishen, 1991). In this way, physicians were not restricted to the provincial fee-schedule.

In 1968, British Columbia joined the National Medical Care Insurance program, followed in 1969 by Alberta, Manitoba, Ontario, Nova Scotia, and Newfoundland. In 1970, Quebec and Prince Edward Island joined. By 1972, when the Yukon Territory entered the plan, Canadians had universal health care coverage that was portable across the country. Under the plan, the federal government continued to share the costs of providing health care with the provinces, contributing about half the cost. While there is some debate as to the underlying political motive for implementing Medicare, it was now a national, universal program (see Box 3.2). (The term *Medicare* is unofficial in Canada, even though it is used on Health Canada's website. Our plan officially is the National Health Insurance Plan. Medicare is an official term only in the United States.)

By 1977, the federal government, finding the financial commitment of a fifty-fifty split too burdensome, revised the cost sharing arrangement with the provinces. Through the Federal-Provincial Fiscal Arrangements and Established Programmes Financing Act, the federal government changed the cost-sharing arrangement to a system based on block grants and transfer payments of personal and corporate taxes. This linked the financial commitment of the federal government to the growth of the Gross National Product (GNP), and created financial pressure for the provinces to meet the extra costs of a burgeoning medical system.

Interestingly, despite their outspoken opposition, the introduction of the Act increased the incomes of physicians immediately in seven of the ten provinces (Iglehart, 1986). However, physicians continued to express concern about the system. Over the next decade, with rising inflation and the continued dissatisfaction of physicians, the main focus for physician discontent was the right to extra-bill. The Medical Care Act gave physicians the right to bill patients directly but, sometimes, the amount they billed was in excess of what the provincial plan would reimburse the patient. Although limited in amount to the fee schedules negotiated by provincial medical associations, **extra-billing** was practised by over 20% of Canadian physicians. The argument by physicians was that extra-billing only helped them to recoup income lost to inflation and to provincial restrictions on fees. This did little to defuse growing public resistance toward extra-billing in the late 1970s (Blishen, 1991).

Box 3.2

Two Views on Class and Medicare

There are two main positions regarding the conflicts and accommodations that led to the creation of the Canadian health care system. Swartz (1977) argued that it was a response to working-class pressure and a resolution of class conflict. This was reflected in the collective lobbying efforts of farmers and labourers in Saskatchewan to establish publicly funded hospital and medical care and the responsiveness of the social democratic party in power in the province over those years—the Cooperative Commonwealth Federation, which later evolved into the New Democratic Party. By way of contrast, Walters (1982) argues that there was little evidence of major class conflict or massive pressure by labour. One could equally interpret the accommodations made by the government as acting in the long-term interests of the capitalist class to increase the productive capacity of labour, to reduce the economic costs of illness, and to appease the working classes.

Whatever the case, there are two key outcomes of the negotiations to establish publicly funded health care in Canada. Medicare has helped to reduce the crippling financial burden of serious illness and to equalize access and utilization. However, these repercussions are far from equal in a system across such a large geographic area. A recent Alberta inquiry has also made it clear that there is considerable queue jumping through the utilization of social network ties.

Structurally, Medicare includes coverage of the costs of some of the most expensive forms of care—hospitals and physicians' services. There is little or no consistent coverage of extended health services that include residential long-term care, home care, adult residential care, and ambulatory health services across provinces. This leaves a much more fragmented and privatized system of health care for those in need of long-term care, which has a broad range of consequences for an aging population.

The accommodations made to establish Medicare in Canada serve to institutionalize, or as Larkin (1983) argued in the case of the British National Health Service, crystallize the status quo of medical dominance with doctors as the gatekeepers to access many aspects of the system. That is, there is a structural embeddedness of medical dominance in the various forms of legislation that govern health care (Bourgeault & Mulvale, 2006). With no comprehensive changes to the organization and delivery of health care, this increases the difficulty to implement changes to make the health care system more responsive to changing population health needs.

Source: Republished with permission of Wiley-Blackwell, from Canada: Healthcare Delivery System, Encyclopedia on Health and Illness. Excerpted from Bourgeault, I.L. (2014); permission conveyed through Copyright Clearance Center, Inc.

The 1984 Canada Health Act

In 1979, the federal government established another commission, this time to study the effects of extra-billing. The commission concluded that extra-billing by physicians along with hospital user charges (another form of extra-billing at an institutional level), posed a direct threat to the integrity of universal health care, because it eroded equal accessibility to health care. By this time, health care was a cherished Canadian institution. As a result of public support, the Liberal government under Pierre Trudeau used the extra-billing issue to

gain voter support. In 1980, the government proposed compulsory arbitration to resolve fee-setting disputes between physicians and provincial ministries of health, a proposal rejected by the physicians. In 1983, with an election imminent, the Liberals made extra-billing an election issue. The proposed ban on extra-billing practices and hospital user fees was rejected by the CMA and by all the provinces. The CMA argued that such a ban would infringe on the professional rights of its members while the provinces reminded the federal government that health was a matter of provincial jurisdiction (Blishen, 1991). Still suffering from changes in federal-provincial transfers that had moved from a cost split to block grants based on GNP, some of the provinces saw extra-billing as a way to offset lost revenue.

Despite the rejection by the provinces and the CMA, the Liberals pursued their plan, introducing Bill C-94 to Parliament under the Minister of Health, the Honourable Monique Bégin (see Researcher Profile 3.2). The Canada Health Act banned extra-billing and punished provinces that did not comply by penalizing them one dollar in their block grant funding transfers for each dollar taken in by physicians and hospitals in extra-billing charges. The bill was also designed to reassert federal power over provincial health plans. The Progressive Conservative opposition under Brian Mulroney supported the physicians and the provinces, fighting unsuccessfully against the bill in committees and the house. Once the bill was submitted

Researcher Profile 3.2

Monique Bégin

Courtesy of Dr. Monique Bégin

A sociologist by training (Université de Montréal, Sorbonne), Monique Bégin served as executive secretary of the Royal Commission on the Status of Women in Canada from 1967 to 1970. In 1972, she became the first woman from Quebec to be elected to the House of Commons as a member of the Liberal Party. Re-elected in 1974, 1979, and 1980, she went on to become the Minister of National Health and Welfare from 1977 to 1984. She remains best known as the Minister responsible for the 1984 Canada Health Act.

Mme. Bégin left politics in 1984 to move to the world of academe. She became the first holder of the Joint Chair in Women's Studies at Ottawa and Carleton Universities from 1986 to 1990 and Dean of the Faculty of Health Sciences at University of Ottawa from 1990 to 1997.

She is a fellow of the Royal Society of Canada and has received 18 honorary doctorates in recognition of her contribution to human rights and to public policies. In 1998, she was invested as Officer of the Order of Canada. Named professor emeritus in 1997, she taught until recently in the Masters of Health Administration program at the University of Ottawa.

Source: Memorial University President's Report 1999–2000, http://www.mun.ca/president/report/1999-2000/honor/honorary_begin.html. Reprinted by permission.

for final reading, the Progressive Conservatives voted unanimously to pass the bill, even though they opposed its principles. The fact that the bill passed unanimously in the house is a reflection of the mood of Canadians at the time, and the sensitivity of Canadian politicians to the voters in an election year. Since the Liberals had turned the Canada Health Act into an election issue and the Act had strong public support, the Conservatives were not willing to jeopardize their chances in the upcoming election by opposing it.

In response to the legislation, Saskatchewan, Manitoba, and Nova Scotia took immediate steps to eliminate extra-billing, which in Saskatchewan provoked rotating strikes by physicians. The resistance by physicians was greatest in Ontario (Iglehart, 1986). The Ontario government implemented legislation to prohibit extra-billing in that province on June 20, 1984. If extra-billing was not stopped by April, 1987, the province would be ineligible to "recoup the $4.4 million per month being withheld by the federal government as a consequence of physicians' use of the practice" (Iglehart, 1986, p. 208). The Ontario Medical Association (OMA) and the Ontario Liberal government could not agree on this issue. The OMA argued that it was a direct threat to their autonomy as professionals, and to demonstrate their opposition, most of the physicians in Ontario launched a two-day strike on May 29 and 30, 1984, refusing to perform any non-emergency services. Physician support for the OMA position was very high, but the support had no effect on the provincial government. On June 9, 1984, the OMA called on its 17 000 member physicians to strike once again on June 12. Only about half of the members responded to the strike call. Despite attempts to explain their side of the issue, there was little public support for the physicians. The overwhelming majority of people in Ontario approved of the ban on extra-billing and saw the strike as a fight over money as opposed to a fight over professionalism and autonomy. The strike ended 25 days later. The bill was passed in the Ontario provincial parliament by a vote of 69 to 47, ending the right of Ontario physicians to extra-bill.

The provinces, while required to eliminate extra-billing, were dealt another blow by the new federal government. After winning the 1984 federal election, the Progressive Conservatives, under the leadership of Brian Mulroney, during their first year in office reduced transfer payments to the provinces in an effort to address the growing fiscal deficit. This double-barrelled attack on block grant funding to provinces and health care funding specifically created a huge financial burden for the provinces, leaving them no way to recoup losses short of raising taxes or cutting services. (The law prohibiting extra-billing pertained only to government-insured services. Physicians and other health professionals were still able to bill patients directly for other services, such as medical notes and insurance forms, and continue to do so.)

RECENT DEVELOPMENTS IN HEALTH AND HEALTH CARE

Despite the central role that the federal government played in establishing universal Medicare, under the BNA Act, 1867, and continued under the Constitution Act, 1982, the federal government still does not have jurisdiction over the delivery of health care services to most Canadians. The only health care services falling under federal control

focus on Aboriginal peoples, members of military services, new immigrants and refugees, and those in the federal penitentiary system. Other than that, the federal government *coordinates* the provision of health care and partially funds the system. The federal government has taken on additional roles in health, some of which are outlined in Box 3.3. Because of the historical distribution of responsibilities between the federal and provincial levels, provincial governments have considerable autonomy in all matters related to delivery of health care services, leading some scholars to suggest that Canada has not one, but 13 health care systems (Fierlbeck, 2011). Provinces have no *legal* obligation to adhere to the Canada Health Act of 1984. The only leverage that the federal government has to ensure adherence is the threat of financial penalty by reducing block transfer grants for a breach in the obligations outlined by the Act (Fierlbeck, 2011).

Box 3.3

Additional Federal Health Initiatives and Organizations

Although the federal government is only a funder for provincial health care, it does have an important role to play in health and health care in Canada. Specifically, it helps maintain the national health infrastructure, invests in research and development, and promotes public health initiatives. Due to the structure of the system existing across 13 jurisdictions, successive federal governments have implemented a number of initiatives in the past few years to facilitate the exchange of information and to invest in health promotion and public health.

Canadian Institute for Health Information (CIHI)

Until recently, health service information across jurisdictions was often scattered, and the standardized collection and exchange of information was not easy. To address this deficit, the Canadian Institute for Health Information (CIHI), a federal-provincial-territorial initiative, was established in 1994 as an independent, arms-length organization to facilitate the sharing and distribution of health utilization information. It collects, collates, and synthesizes Medicare data on billing, hospital and physician visits, diagnoses, and so on for all billable claims across all jurisdictions. This provides information for the oversight of delivery of services across provinces and policy decisions.

National Health Surveillance Survey Initiative

Beginning in 1994, the federal government also initiated a coordinated, on-going, national population health surveillance initiative (discussed in detail in Chapter 2 on methodology) to collect and track Canadians' health status and health utilization based on self-report surveys. Before the survey, there was no coordinated, on-going national initiative to track health and health care at a population level. This survey initiative, in concert with CIHI, provides important population data to assess how changes to the health care system affect Canadians.

Canadian Institutes of Health Research (CIHR)

Created by legislation passed by Parliament in June, 2000, the Canadian Institutes of Health Research (CIHR) became the national funding

(continued)

Box 3.3 (*Continued*)

agency for health research in Canada. The focus of CIHR is based on four pillars of research: basic biomedical, clinical, population health, and health systems and services. It grew originally from the amalgamation of two previous national research funding agencies, MRC (Medical Research Council of Canada) and NHRDP (National Health and Research Development Program). One of its primary goals is to assist in the knowledge transfer of research into improving health and health services for Canadians.

Health Council of Canada (HCC)

Established by the First Ministers [the provincial and territorial Premiers and the Prime Minister of Canada] in 2003 through the First Ministers' Accord on Health Care Renewal, the HCC provides a coordinated voice to defend and strengthen health care in Canada. The Council's focus is on identifying innovative and best health care practices for health care improvement.

Public Health Agency of Canada (PHAC)

Another relatively new development in Canadian health care policy was the establishment of the Public Health Agency of Canada. During the 2003 SARS outbreak, it became evident that poor coordination of public health care can pose a very real threat. In 2005, the Public Health Agency of Canada was established to coordinate initiatives aiming to control the spread of infectious diseases, address health emergencies at a national level, and to promote health and reduce health inequalities.

Mental Health Commission of Canada (MHCC)

The 2006 Kirby Report on mental health, *Out of the Shadows at Last*, was the first comprehensive look at mental health status and health care services in Canada. The report made 118 recommendations on how to improve the current situation in mental health and called for a national, coordinated strategy to address the needs of Canadians (Standing Committee on Social Affairs, Science and Technology, 2006). As part of the recommendations in the report, in 2007 the federal government established the Mental Health Commission of Canada. The goals of the commission are (1) to develop a national mental health strategy; (2) to share the knowledge across provincial jurisdictions; and (3) to promote public campaigns that will fight the stigma attached to mental illness (Standing Committee on Social Affairs, Science and Technology, 2006). In 2009, the Commission published the very first Canadian mental health strategy (Mental Health Commission of Canada, 2009).

But the federal threat of financial penalty was beginning to lose its effectiveness. In 1986, 1989, and 1991 under the Conservative government, there were successive reductions in provincial transfers. As the national debt closed in on 72% of Canadian GDP with continued annual deficits, and in response to various credit downgrades by international credit rating agencies because of the increase in the Canadian national debt between 1992 and 1995, further budget cuts were implemented by the Liberal federal government under Jean Chrétien. The credit rating downgrades forced the hand of the government. Under the direction of Paul Martin as finance minister, in 1995 the government introduced a new block funding transfer mechanism, the Canadian Health and Social Transfer (CHST), to gain control over the country's fiscal problems. After severe spending cuts and some tax increases, the government successfully eliminated the federal

deficit and began to run surpluses by 1998, reducing the accumulated national debt from about 72% of national GDP in 1995 to less than 50% a few years later. The reductions in transfer payments reduced the effect of the federal financial lever used to ensure provincial adherence to the Canada Health Act. Some provinces began to explore additional ways to reduce costs that flouted the Act, including privatization of some services.

National Forum on Health

In 1994, to address the ongoing concern over Medicare, Prime Minister Jean Chrétien established a National Forum on Health (NFH). It identified two important aspects for innovation in health care: (1) to improve health information systems and (2) to provide cash transfers to the provinces that would address their health needs. Released in 1997, it recommended funding for pharmacare and home care. As a result of the improved fiscal landscape in Canada, in 2000, the Liberal government negotiated a new health accord with the provinces to inject $23 billion dollars of new funding into health over five years (Rachlis, 2005). The government drew upon the 1997 NFH and targeted resources to help begin to refocus the health care system away from expensive, acute hospital care to home care, primary care, and diagnostics. However, there was little federal control over the funding in the first few years and much of it went to increases in salaries and physician fee-for-service schedules.

Royal Commission on the Future of Health Care in Canada

To address the funding directions, in 2001, the federal government and Governor General Adrienne Clarkson appointed Roy Romanow to head the Royal Commission on the Future of Health Care in Canada. This Royal Commission was an extensive, fact-finding mission costing over $15 million dollars and involving coast-to-coast-to-coast public consultation, expert hearings, contracted research, reports, presentations, and discussion papers. In 2002, the *Romanow Report* was released proposing widespread changes to the system to ensure both short- and long-term sustainability. Reaffirming the five principles of Medicare, it contained 47 recommendations addressing the federal–provincial fiscal relationship, its public nature, and the need to shift the system to address long-term, non-acute care based on three themes: the need for strong leadership and improved governance to keep Medicare a national asset; the need to make the system more responsive, efficient, and accountable to Canadians; and the need to make strategic investments over the short term to address priority concerns, as well as over the long term to place the system on a more sustainable footing (Romanow, 2002). While not opposing privatization directly, the report did recommend that diagnostic services (such as MRIs and CAT scans) be defined as medically necessary and be covered under the Act, and proposed that Workers' Compensation Boards be prohibited from purchasing medical services privately (Rachlis, 2005).

One of the specific recommendations of the *Romanow Report* for the creation of the Health Council of Canada was to depoliticize federal–provincial relations regarding health and to ensure monitoring, performance evaluation, and public accountability:

> To provide national leadership, the mandate of the Health Council of Canada should be to:
>
> - Act as an effective and impartial mechanism for the collection and analysis of data on the performance of the health care system;
> - Provide strategic advice and analysis to federal, provincial and territorial health ministers and deputy ministers on important and emerging policy issues; and
> - Seek ongoing input and advice from the public and stakeholders on strategic policy issues. (Romanow, 2002, p. 54)

Standing Senate Committee on Social Affairs, Science, and Technology (Kirby) Report

In addition to the Royal Commission, the federal Senate also produced a report to achieve a better coordination of health care services provided to Canadians, and to some degree re-establish the leadership of federal government in health care. The Standing Senate Committee on Social Affairs, Science, and Technology undertook to review the provision of health services in Canada. The Kirby Report, named after the chair of the commission, Michael Kirby, argued that the five principles of health care outlined in the 1984 Canada Health Act were not consistent with the two overarching federal objectives of health care, namely:

- To ensure that every Canadian has *timely* access to all medically necessary health services *regardless* of his or her ability to pay for those services.
- To ensure that *no* Canadian suffers *undue* financial hardship as a result of having to pay health care bills. (Standing Committee on Social Affairs, Science and Technology, 2006, pp. 307–308)

The Kirby report identified some of the gaps in the provision of health care services, including poor coordination of human resources and competition among provinces in planning and delivering health care services. Kirby recommended building a pan-Canadian health human resources strategy. The federal government was to take leadership in health human resources planning and work with the provinces to ensure that we have information about their human resources needs; that we train sufficient health care providers; that Canada addresses the health care needs of Aboriginal and remote/rural communities; and that there is better coordination in training and licensing of health care professionals. The report outlines that before any expansion of public funds for coverage of current gaps in services, such as pharmacare and homecare, additional principles need to be followed, specifically transparency and accountability. Moreover, it argues that there is an obligation to specify how any new program will be financed and that the government should not necessarily follow the "first dollar coverage" model, but keep the principle

objectives in mind (Kirby, 2002). Some have criticized the report as opposing the Romanow report by supporting private health care. This criticism is based, in part, on Senator Kirby's business connections to private health care. (At the time, Senator Kirby was on the board of directors of Extendicare Inc., a for-profit health corporation that owns a major home-care division called ParaMed (McBane, 2002).)

First Ministers' Accord on Health Care Renewal

These two reports laid the groundwork for the subsequent 2003 First Ministers' Accord on Health Care Renewal. The Accord provided $34.8 billion in funding to the provinces over five years, even though there was debate between levels of government as to whether this constituted new money or some of it was money that had already been promised in the 2000 Accord (Rachlis, 2005). The 2003 Accord established federal–provincial priorities for the health care system and identified a number of areas in which the provision of health care services should be improved. While the needs of each province may have been somewhat different, all provinces were struggling to sustain their health care systems and improve the quality of health care. The Accord identified primary care, home care, and drug coverage as especially challenging issues, but it also highlighted the need to invest in diagnostic services and establish better information technology. Other important goals of the Accord were to establish a better system of communication among the provinces in setting the course for the health care system and to make the decision making in health care more transparent to the public. First Ministers agreed to produce annual reports, available to the public, in which they would use indicators that demonstrate how the health care systems are working and if they are achieving the established goals.

In 2004, the new Liberal Prime Minister Paul Martin promised an additional $42 billion over 10 years and a guarantee to increase health care spending by 6% until 2016/17 in the "10 Year Plan to Strengthen Health Care" (Health Canada, 2004). While there was fanfare about how this would address issues such as wait times and home care, there were very few restrictions on these additional monies. This agreement suffered from the same deficits as the previous 2000 and 2003 accords with respect to lack of accountability and transparency (Canadian Health Coalition, 2004). As such, it is questionable as to how much this new money, coupled with the previous accords, assisted in helping the system evolve to address the changing health care needs of Canadians versus retaining the status quo (Rachlis, 2005). The Canadian Health Coalition (2004) argued, moreover, that the new plan did not address the on-going move toward privatization of health care.

In the 2006 election, the new Conservative Party of Canada, under the leadership of Stephen Harper, won a minority government replacing the Liberals who had been in power since 1993. The Conservatives have remained in power since then, gaining a majority government in 2011. Stephen Harper had been an elected Member of Parliament (MP) for the Reform Party (which changed its name to the Canadian Alliance Party and then amalgamated with the Progressive Conservative Party to form the new Conservative Party of Canada in December, 2003) and also was the leader of the National Citizen's Coalition

(NCC), a conservative think tank, from 1998 to 2002. As leader of the NCC, Harper actively argued in support of private health care as a solution for problems with Medicare.

Changing Political Winds over Federal and Provincial Jurisdictions

The new governing Conservative Party changed the focus of the federal government. Whereas the Liberals dealt more with social programs, the Conservatives have focused more on tax cuts and crime, being careful not to step into provincial jurisdictions. Although the Conservatives have honoured the previous financial agreement of a 6% increase in spending until 2016/17, their approach to health care and federal–provincial negotiations has been quite different. In fact, in a First Ministers' meeting in December, 2011, instead of negotiating with Premiers as had been done in the past, the Federal Minister of Finance Jim Flaherty provided a non-negotiable provincial health care funding arrangement pegged at the economic growth rate of the country, but not to drop below 3%. Romanow criticized the new approach, arguing that the federal government was abandoning health care by not getting more involved in negotiations with the provinces to ensure the adherence to the 1984 Canada Health Act and its five principles (Romanow, 2012).

REFORMS AND THE FUTURE OF MEDICARE

The Canadian health care system is a source of pride for many Canadians, but it is also often criticized for being too expensive and unresponsive to people's needs. Many individuals are dissatisfied with long wait times and lack of access to certain services. In recent years, we increasingly hear the criticisms levelled against the Canadian health care system and the need to reform the system to be more cost-efficient and accessible.

These sentiments are reflective of a new vision of management of public health care systems that is rooted in the **New Public Management** reforms (NPM) implemented by the Thatcher Conservative government in the United Kingdom in the 1980s. The United Kingdom health care system, National Health Services (NHS), was established in 1948. Just like Canadians, most Britons are very proud of their health care system, but they were also concerned with raising health care costs. Seeking to reduce the spending on health care and make it more efficient, the NPM reforms introduced a new model of managing health care. These reforms adopted a businesslike model of management of health care services that sees the free market as the ideal set of relations that help to increase competition, to reduce costs, and to increase efficiency (Fierlbeck, 2011).

The NPM reforms identified three major routes for restructuring health care. First, it called for the detachment of policy making from health services delivery. Those who promote NPM see competition in service delivery as an essential step for reducing costs and providing services more efficiently. NPM reformers believed if two hospitals are competing for patients, the hospitals would have to strive to provide better services at reduced costs. The second goal of NPM was to establish a service delivery business model that

highlights transparency and accountability. As with business, the health care sectors are expected to produce business plans and to develop a set of performance indicators that allow evaluation of the achievement of goals identified in the business plans. The final goal of NPM was to empower citizens as consumers of health care services. Citizens are expected to take an active part in health policy making and to participate in decision making related to health care policy (Fierlbeck, 2011).

The NPM resonated in many developed countries that were starting to look for ways to increase efficiency and reduce costs in health care and other social services. The cuts in health care services and other social programs are a hallmark of a *neoliberal* economy. Another hallmark is the adoption of a market model and market ideology in the provision of health care and social services. Canada has not been immune to those changes. When we discuss the health care system today, there is talk about “annual reports,” “benchmarks,” “performance indicators,” “efficiency,” “consumers,” and “managers.” Some argue that we have to privatize health care services or allow a two-tier health care system—one tier to provide free-of-charge services to Canadians and another to offer private services to those who can afford to pay for it (see Box 3.4 on a recent Canadian Supreme Court ruling on private services). Many provinces in Canada implemented the NPM approach to varying degrees and increased the amount of contracted-out health services based on the premise of cost savings. The provinces established the benchmarks for waiting times and compare these based on jointly agreed-upon performance indicators (such as waiting times in certain areas).

Box 3.4

Supreme Court Case for the Privatization of Health Care in Quebec and Canada

Chaoulli v. Quebec (Attorney General) [2005] 1 S.C.R. 791, 2005 SCC 35

In 1997, Jacques Chaoulli, a physician from Quebec, and his patient, George Zeliotis, who had to wait almost a year for his hip replacement, launched a case against Quebec’s government. They claimed that a ban on private health insurance results in long waiting times for essential medical services (such as hip replacement), and ultimately, violates the constitutional rights of Canadian citizens.

The Quebec court, and later an appeal court, suggested that they did not see a violation of the constitutional rights by the ban on private insurance. Furthermore, the judges in Quebec saw this violation, even if it existed, as necessary for the benefit of all the people of Quebec who have a right to receive universal health care services. Appealed to the Supreme Court of Canada, and after much deliberation and testimony, the court ruled in favour of Chaoulli on violation of Quebec’s Charter of Rights and Freedoms but was evenly split on any violation of Canadian Charter of Rights and Freedoms. The Supreme Court agreed with the claimants that the ban on private health insurance contributes to long waiting times, and thus, ultimately, violates the rights of Quebecers.

The proponents of privatization saw the Chaoulli case as a pioneering case for legalizing private

(continued)

Box 3.4 (*Continued*)

health insurance. Those who were critical of the decision referred to the language ambiguity of the ruling, which did not really "ban" the exclusive right of public insurance, but conditioned it on "adequate care and waiting times." The court never properly defined what actually constitutes "adequate care" (Fierlbeck, 2011). Moreover, since the ruling was framed in conditional terms (e.g. if/when . . . then), it was open for interpretation (e.g., If the provinces do not reduce waiting times, then it should provide private health insurance—but what if they do reduce waiting times?).

Another problem that critics saw in Chaoulli's case ruling was the assumption that private health insurance would actually reduce wait times. While some experts on health policy testified that was the case, other expert witnesses argued that a two-tier system (public and private health insurance) does not reduce waiting time, and can even increase it. Finally, the ruling of the court implied that the private health care system would benefit individuals who have the right to receive necessary medical treatment. Looking at the US, however, we witnessed that sick people are often denied medical coverage by private insurance companies. Moreover, when public health insurance is a viable option, private insurance principally benefits the wealthiest among the population. Ironically, Mr. Zeliotis, an older man with limited means and serious medical conditions, would probably not benefit from the implementation of private insurance (Fierlbeck, 2011).

So far, however, the implications of the Chaoulli case have been minimal. Since the judges did not agree on whether or not there was a violation of Canadian Charter of Rights and Freedoms, the decision of the Supreme Court only concerns Quebec. Already working with other provinces on reduction of waiting times, Quebec released a statement guaranteeing reduced waiting times for certain treatments. It allowed the establishment of private insurance for some medical services but at the same time it prevented physicians from practising in public and private health care systems. Thus, if physicians decide to work for private sector, they would be unable to work for the public system as well (Fierlbeck, 2011). However, it is possible that the true implications of the case are yet to follow. In recent years, legal actions have been launched in British Columbia, Alberta, and Ontario to challenge the monopoly of public health insurance and the Chaoulli case is often cited in support of private health care in these matters.

Source: Chaoulli v. Quebec (Attorney General) [2005] 1 S.C.R. 791, 2005 SCC 35. Reproduced with the permission of the Supreme Court of Canada, 2013.

Whether these reforms are actually beneficial to our health care system is being hotly debated among scholars, politicians, and stakeholders. Some argue that these reforms will improve the health care systems while others see it as a move toward the privatization of health care services that will threaten public health care, the social solidarity of Canadians, and the safe working conditions of health care professionals (Armstrong & Armstrong, 2002; Fierlbeck, 2011; Gibson & Fuller, 2006). Robert Evans, one of the nation's leading health economists, argues that the recent push toward privatization is based on a series of myths regarding the efficiency, quality, and sustainability of the current system (see Box 3.5). The views of Canadians over the next decades might certainly change, but today the majority of Canadians see our publicly funded, universal health care system as an important part of Canadian identity.

Box 3.5

Current Myths about the Sustainability of Canadian Public Health Care

Myths	Facts
Our aging population will make health care unaffordable.	Private health care services, not an aging population, are driving health care spending. (Only 0.8% of increasing health care spending is due to an aging population. Private spending on services not covered such as prescription drugs, dental care, and home care is responsible for the increase.)
The cost of health care is eating up provincial budgets and crowding out other services.	Medicare spending takes up about the same share of provincial revenues as it did 20 years ago. (The drop in provincial revenues due to large tax cuts increases the percentage of health care on overall budgets.)
Public health care spending is skyrocketing and out of control.	Public health care spending is stable. Spending on private health care, as described above, is driving up costs. (From 1975 to 2009 Medicare spending has been stable, from 4 to 5% of GDP.)
Privatization of health services will control health care costs.	Public health care is the best way to control health care spending. Privatization is not sustainable. (Shifting from public to private spending shifts the cost burden from the wealthy to the sick. "Unsustainable" public spending cannot be magically sustainable when shifted from taxpayers to patients.)

Source: Evans, Robert. (2010, June). Sustainability of health care. Myths and facts. Published by the Canadian Health Coalition, *Just the Facts* newsletter, June, 2010.

SUMMARY

One of the principal concerns expressed by physicians about a publicly administered health care system was that the profession would lose its ability to set fees. They viewed this as a first step in reducing the profession to the status of government employees, with no control over the labour process. Not only would such a status reduce their autonomy, it would also reduce their power within the system. Despite the sometimes intense opposition of the medical profession, none of the developments related to the implementation of the public system or the ban on extra-billing appear to have jeopardized professional autonomy or the sanctity of the physician–patient relationship. In fact, the organization of the health care system in Canada under public control may be one of the major factors that prevented the erosion of the position of members of the medical profession (Naylor, 1986).

It is interesting to compare their position with their American physician counterparts. American physicians have been very successful in resisting any type of national health insurance. Starr (1982) suggests that there are consequences to the failure to rationalize physician services under the public umbrella in the United States. Ultimately, physician's services were rationalized under a corporate umbrella, creating conflicts between corporate demands for profit and physicians' right to practise medicine. Conversely, the health care system in place in Canada has removed the corporate profit motive, and this may be the major factor that has maintained physicians' autonomy in Canada. While negotiating fees with the province is difficult, the provinces do not interfere in any physician decision-making. If a test or treatment is recommended by the physician, there is no second guessing or approval required at the administrative level, which is often done private health care companies because their primary motives are profit and shareholder return. It appears that members of the Canadian medical profession have been successful at maintaining both their autonomy and their income.

The report by the Royal Commission on Medicare chaired by Hall in 1964 concluded that the private insurance industry would be unable to provide adequate, affordable health care coverage to the entire Canadian population. Specifically, the commission believed that the poorest and unhealthiest groups would be excluded from private health insurance programs. Thus, the federal and provincial governments would have an obligation to insure the highest-risk categories without being able to take advantage of cost averaging by including low-risk groups.

Finally, we must remember that social policy will always be influenced by the values and priorities of the policy makers and society at large (Sutherland & Fulton 1990). The development of a health care system takes place within the larger arena of the social structure. As Starr (Starr, 1982) notes, those with power have the ability to impress their agenda upon others, whether or not that agenda is consistent with the common good. In the case of the Canadian health care system, we can see this play out over time as various groups and political ideologies influence the decision-making process. The only constant over time has been the ongoing support by the overwhelming majority of Canadians for public health care.

Key Terms

Accessibility—one of the five principles of Canadian Medicare, each province must provide reasonable access to health care services regardless of geographic location or financial means

Capitation—the payment of a set (negotiated) annual flat fee per patient to a physician for providing all necessary health care

Comprehensiveness—one of the five principles of Canadian Medicare, all services defined as medically necessary will be provided in hospital or by physicians

Extra-billing—additional fees charged on top of what was reimbursed by the province for health care services

Fee-for-service—the payment of a set (negotiated) fee for every individual health care service provided by a physician

New Public Management—a model of managing health care that adopts a business-like model of management of health care services. The free market provides the ideal model: by increasing competition, costs are reduced and efficiency increased

Portability—one of the five principles of Canadian Medicare, coverage will be accepted across any province or territory without cost to the patient

Public administration—one of the five principles of Canadian Medicare, Medicare is to be managed by a non-profit entity responsible to the provincial/territorial government

Universality—one of the five principles of Canadian Medicare, guarantees health care coverage for all Canadian citizens regardless of age, condition, or ability to pay for service

Critical Thinking Questions

1. What are the positive and negative aspects of having a single-payer, public health care system?
2. How did various key stakeholder groups influence the shape of the Canadian public health care system and what are some of the consequences?
3. How might the system have evolved differently if other stakeholder groups had been more influential?
4. Discuss how the health care debate in Canada is has evolved since the inception of Medicare.
5. Is privatization a solution for the reorganization and reform of the Canadian public health care system?

Further Readings and Resources

Badgley, R., & Wolfe, S. (1967). *Doctor's Strike: Medical Care and Conflict in Saskatchewan*. New York: Atherton Press.

Canadian Institute for Health Information. (2013, May). *Lifetime distributional effects of publicly financed health care in Canada*. http://bit.ly/10Mn9sp

Canadian Museum of History. (2010). *Making medicare: The history of health care in Canada, 1914–2007.* www.civilization.ca/cmc/exhibitions/hist/medicare/medic00e.shtml

Marchildon, G. (Ed.) (2012). *Making medicare: New perspectives on the history of medicare in Canada*. Toronto: University of Toronto Press.

Marchildon, G., & Campbell, B. (Eds.) (2007). *Medicare: Facts, myths, problems, promise*. Toronto: James Lorimer and Company Ltd.

Rachlis, M. (2005). *Prescription for excellence: How innovation in saving Canada's health care system*. Toronto: HarperPerennialCanada, HarperCollins Publishers.

Shandel, T. [Director]. (1983). *Bitter medicine, Part 1: The birth of medicare*. [Motion picture]. Available from the Canadian National Film Board and the Canadian Broadcasting Corporation, www.nfb.ca

Canadian Health Coalition
http://healthcoalition.ca/

Health Council of Canada
www.healthcouncilcanada.ca