TIME TO REFORM THE CANADA HEALTH ACT

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Canada's provincial health care systems have long suffered from a policy-driven confluence of high spending and poor performance. While some provinces have attempted minor reforms, all have largely remained committed to the status quo of monopolistic health care dominated by government. This lack of provincial policy innovation is at least partly driven by the federal government's involvement in provincial policy making through the Canada Health Act and substantial cash transfers tied to provincial compliance.

This federal constraint on provincial experimentation must be reformed to free up provinces to explore proven approaches to delivering universally accessible health care.

An international comparison of health care sheds light on the poor deal Canadian patients and taxpayers face with Canada's health care. In 2021, Canadian spending on health care as an age-adjusted share of GDP ranked highest among developed nations providing universal health care (Moir and Barua, 2023).

At the same time, Canadians had access to substantially fewer physicians, hospital beds, and advanced medical technologies than our peer countries. Perhaps not surprisingly, Canadians also endured wait times that are among the longest in the developed world—wait times that have nearly tripled since the early 1990s (Moir and Barua, 2023; Moir and Barua, 2022).

Canada's health policies, common to nearly all provinces, differ in a number of ways from those of other countries with universal-access health care—in particular, those that have the developed world's best performing universal systems. These include policies affecting private involvement in the insurance and delivery of medical services, patient cost-sharing, dual practice by physicians, and activity-based funding for hospitals. It is clear from examinations of each of these policy differences that much of Canada's underperformance is a function of poor policies, rather than any lack of funding or set of characteristics unique to Canada (see, for example, Barua and Esmail, 2015; Barua and Moir, 2022; Esmail, 2021; Globerman, 2016).

There are some notable differences to the policy approach in Quebec, particularly with regards to private provision of publicly-funded care, a recent move to activity-based funding, and limited availability of privately-funded alternatives (Labrie, 2023). This is in part the result of a narrowly-decided supreme court decision in 2005 which disallowed the provincial prohibition on private medical insurance for services covered by the public health care system, and in part a seeming reluctance for Ottawa to assert federal jurisdiction or power in any policy area in Quebec. Though the overarching policy approach in Quebec remains otherwise similar to that of other provinces, Quebec has managed to outperform other provinces both in terms of wait times and in overall comparisons of the provincial health system in general (Labrie, 2023; Barua, 2013; CHPI, 2016; Moir and Barua, 2022; CIHI, 2023).

The Constitution Act of 1867 defined the legislative powers of the federal and provincial governments with the provinces free to determine health policies, including decisions about what services will be provided, financing, delivery, and whether those services can be partially or fully funded privately. However, the federal government influences provincial decisions substantially through the combination of the Canada Health Transfer (CHT) and the Canada Health Act (CHA).

The CHA is a financial act that influences provincial decision making by setting the terms and conditions under which provinces receive payments under the CHT, valued at an estimated $49.4 billion in 2023–24 (Department of Finance Canada, 2022).[1]

The CHA is comprised of 23 sections, ten of which are most relevant in understanding the federal impact on provincial policy making. Five sections (8 through 12) outline the required program criteria (commonly referred to as principles) of Public Administration, Comprehensiveness, Universality, Portability, and Accessibility. Four sections (18 through 21) set out the non-discretionary dollar-for-dollar reductions in transfers that occur if provinces allow either user charges or extra billing. Section 2 contains definitions and some notable omissions.

These ten sections contain few clear restrictions on provincial health policy, aside from reasonably clear restrictions on user charges and extra billing for physician and hospital services, and a requirement that provincial plans be administered by a public authority under uniform terms and conditions.[2] There is, however, a problematic lack of clarity about what other policies might be disallowed, especially under the undefined requirement of "reasonable access."[3]

This vagueness leaves determinations of permissibility for a range of policies up to the federal government of the day, creating not only a lack of clarity for provincial policy makers but also questions about what might be disallowed by future governments (table 1). The federal government also maintains sole and final authority for interpretation and discretionary enforcement of the Act, up to a full withdrawal of federal cash transfers to a violating province.[4] It is perhaps not surprising then that the CHA has constrained provincial policy innovation and reform.[5]

Table 1: High-Performing Health Policy Approaches and Their Compatibility with the CHA

Policy commonly pursued in higher performing universal health care systems	Explicitly disallowed by CHA in Section	Could be Interpreted to be disallowed by CHA in Section
Private insurance or direct private payment for core medical services	–	Section 12
Private delivery of core medical services	–	Section 12
Dual practice by physicians	–	Section 12
Activity-based funding or other alternate funding approach for providers	–	Section 12
Patient cost sharing	Sections 18 through 21	Section 12

A framework for reform is available from the changes made to welfare policy in the 1990s. That approach moved the federal government towards smaller, less prescriptive grants for welfare, giving the provinces incentives to contain costs and provide better outcomes to their populations, alongside the ability to vary provincial policies to their unique circumstances. The resulting period of policy innovation reduced welfare dependency and government spending on public assistance (Lafleur, Li, Eisen, and Clemens, 2021).

The analogous approach for health care would first involve amending the CHA to remove ambiguity, minimizing uncertainty and the potential for politically motivated interpretations of the Act. The CHA should also be amended to allow provinces the ability to explore alternate policy approaches, while maintaining the foundational principles of universality and inter-provincial portability.

The second part of this reform focuses on the reality that the CHA is a financial act. In the absence of a pool of cash connected to the strings of the CHA, provinces would de facto have much greater flexibility to pursue those policies they consider to be in the best interest of their residents. Thus, the CHT should be either held constant in nominal terms, reduced, or eliminated entirely with federal taxes being concordantly reduced.

Reforming the CHA and reducing the provinces' reliance on federal transfers would bring greater accountability to the health-care system and free the provinces to innovate and experiment with policies commonly found in other countries with more successful universal health-care systems. The likely result would be more timely access to quality care regardless of a patients' ability to pay.