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THE EMERGING PARADIGM IN HEALTH CARE POLICY: THE CASE OF CANADA

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Abstract

The model of health care financing and delivery for which Canada is best known internationally is its universal, single-payer, first-dollar system of coverage for physician and hospital services. For several decades following its establishment in the late 1950's and 1960's, this model provided public finance from the general tax base (like the UK), at levels of generosity, relative to GDP, like those of continental Europe, all the while maintaining a system of delivery based on private fee-for-service medical practice and independent not-for-profit hospitals (like, historically, the US). This is a remarkable combination of qualities; and for a time, Canada appeared to have found a model that was extraordinarily popular with the public, and supported by providers as well.

In fact, the total health care system is much broader and more complex than this sketch would imply; and in the past 15 years the system has been under great fiscal and political pressure. Much experimentation is underway. While the single-payer model for physician and hospital services is still essentially intact, it represents a diminishing share of the system and is being challenged at the margins by private alternatives. Meanwhile, non-physician and non-hospital services, especially out-of-hospital pharmaceuticals, are growing in clinical importance and financial share, and exhibit a miscellany of organizational and financial arrangements. In this context, questions of the "organization and management of care consumption" (albeit not under that rubric) are squarely on the policy agenda.

Key words: Government expenditure and health, regulation, intergovernmental relations, Canada.
JEL Classification: I18, H2, H51, H7.

Introduction

Background

Canada's geography, demography, political economy and governmental structure form the broad context in which health policy is formulated.

Canada is the second largest country in the world in total area, occupying the northern portion of North America, sharing a border with the United States to the south and to the northeast. (As we will see, the proximity of the US presents particular challenges to Canada with respect to the health care system, given the prevalence of US media and the potential for labour mobility.) Canada is a federal constitutional monarchy with a parliamentary democracy. A union of former French and British colonies, Canada has two official languages, English and French. Canada's constitution divides powers between the central federal government and the ten provincial and three territorial governments that comprise the federation. The population of Canada is over 32 million, as of the most recent (2006) census.

It is a geographically vast (almost 1 billion square kilometers) but highly urbanized country; hence health care services tend to be concentrated with the mass of population in urban centres, and there significant challenges in ensuring that the thinly spread population outside these centres has appropriate access to health care. According to the 2006 census, more than 80 percent of the population live in urban centres,[1] making Canada one of the most urbanized countries in the OECD. Indeed, the six largest Census Metropolitan Areas (CMAs) in Canada - Toronto, Montreal, Vancouver, Ottawa-Hull, Calgary and Edmonton - together account for 45 percent of the Canadian population. The three largest CMAs are also the principal sites of immigration, with increasingly multicultural populations. One province, Quebec, is home to the great majority of the francophone population, which dates from the earliest European settlement of the country beginning in the seventeenth century. Since the mid-twentieth century, Quebec has had a politically assertive independence movement that is a constant factor in political competition and policy development within Canada's federal government structure.

Canada's population is relatively young in international perspective, but, like most advanced nations, it projects a growing proportion of elderly persons and an increased dependency ratio in the coming decades. In 2000, Canada was tied with Australia and New Zealand as having the fourth lowest "old-age dependency ratio" (the ratio of persons 65 and older to those 20 to 64), of 25 OECD nations, after Korea, Ireland and Iceland. But Canadians also have relatively long life expectancies, meaning that among the senior population the ratio of those over 80 to all those over 65 was the 8th *highest* in the OECD. Moreover, by 2050, the old-age dependency ratio is expected to worsen to 9th lowest in the OECD.[2]

[1] Defined as centres with more than 1,000 population and population densities of at least 400 per square kilometer.

[2] As calculated by an OECD study, Canada's old-age dependency ratio was 20.4% in 2000. Of those 65 or older, 23.8 percent were 80 years of age or older. By 2050, the old-age dependency ratio is projected to be 45.9 percent (Casey et al. 2003).

Canada's economy is the smallest of the "large" economies that comprise the G8 advanced nations, and the second most prosperous: its GDP per capita of just over US$34,000[3] in 2005 was second only to that of the US (http://www.oecd.org/dataoecd/28/17/36396820.xls) Its rich endowment of natural resources has historically been a mainstay of the economy. Although the resource-based industries currently constitute only about 6 percent of GDP, they exercise substantial leverage on other sectors of the economy such as finance and transportation, and continue to be of great significance in geopolitical terms. Like other advanced economies, a large and increasing proportion of Canada's GDP (70 percent in 2006) is accounted for by service industries. The economy also exhibits strong regional variations, creating "have" regions (principally the oil-and-gas-rich province of Alberta and the industrial heartland of Ontario) as well as "have-not" regions (principally the Atlantic provinces with their historic reliance upon fisheries). Other provinces tend to exhibit highly cyclical economies given their base in resources other than oil and gas.

Canada's governmental structure attempts to comprehend this diversity within a federal structure than is markedly decentralized in international perspective. In 1999, the federal government accounted for about less than 40% of total public spending, although it raised 47% of total government revenues, reflecting that fact that transfers to the provinces form a substantial proportion of federal government expenditure (Boadway 2001). The federal government's constitutional authority to tax is almost unlimited; but the areas in which it has explicit authority to develop programs are much more circumscribed. Most relevant in the current context, the constitution assigns responsibility for health care to the provinces: hence the federal government's authority in this area is largely exercised by transferring funds to the provinces for health care and attaching conditions to those transfers. Given regional economic disparities, those transfers have also included an "equalization" factor, in addition to the overall federal program of equalization transfers.[4] In the mid-1990s, federal transfers were sharply curtailed, as further discussed below, and despite augmentations of the transfers in the 2000s, the level of transfer remains a matter of considerable federal-provincial dispute.

Basic health indicators and 'performance' (compared with developed OECD nations)

Like most OECD countries, Canada has enjoyed large gains in life expectancy over the past 40 years, thanks to improvements in living conditions, public health interventions, and advances in treatment of serious diseases such as heart disease and cancer. In 2003, life expectancy at birth in Canada stood at 79.7 years, about two years above the OECD average. The infant mortality rate in Canada, as in other OECD countries, has fallen greatly over time. It stood at 5.4 deaths per 1,000 live births in 2003, lower than the OECD average.

[3] Measured in Purchasing Power Parity.
[4] The 2007 federal budget promised to remove this equalization factor in favour of a straight per-capita transfer, as part of a comprehensive overhaul of equalization arrangements.

On measures of health status that arguably have more to do with the performance of the health care system *per se*, Canada's record in comparison to other OECD countries ranges, as Marchildon has pointed out, "from very good to mediocre." In 2000, Canada ranked 7th in the OECD in terms of years of potential life lost per 100,000 population and 2nd in mortality from cerebrovascular disease; but with respect to other diseases (ischemic heart and respiratory disease and malignant neoplasms) it ranked 10th, 12th and 15th respectively (Marchildon 2006:127).

With regard to preventive measures, Canada's record is mixed. Canada provides an example of a country that has achieved remarkable progress in reducing tobacco consumption, with current rates of daily smokers among adults down from 34% in 1980 to 17% in 2003, the lowest rate among all OECD countries along with Sweden. Much of this decline in Canada and in other countries can be attributed to policies aimed at reducing tobacco consumption through public awareness campaigns, advertising bans and increased taxation. At the same time, the obesity rate among Canadian adults stood at 14.3% in 2003, up from 12.7% in 1994/5. It remains much lower however than that of the United States (30.6% in 2002), the United Kingdom (23% en 2003) and Australia (21.7% in 1999). The cost of obesity to health care systems has been estimated to account for about 5.5% to 7% of total health expenditure in the United States in the late 1990s, and 2% to 3.5% in other countries such as Canada, Australia and New Zealand (Thompson and Wolf, 2001).

Of great concern is the relatively poor health status of aboriginal populations. The Royal Commission on Aboriginal Peoples reported that the infant mortality rate, although having declined over the last few decades, is still twice as high for First Nations peoples and three times as high for Inuit in the Northwest Territories as for other Canadians.[5] Rates of chronic diseases such as diabetes and hypertension, as well as heart disease, tuberculosis and fetal alcohol syndrome are also disproportionately high. Most of this sorry record is attributable to factors well beyond the health system, notably social exclusion: rates of health care utilization and cost are in fact higher for the aboriginal population than for the population in general (Canadian Institute for Health Information 2007; Marchildon 2006:7).

1. The Health System

1.1 Organization and finance[6]

Canada's health care system is based on privately-organized providers who are funded through a mix of public and private finance, the particular mix depending upon the sector in which they operate. Hence public programs have been marked by a form of "purchaser-provider split" since their inception in the mid-twentieth century. About 98 percent of Canadian hospitals are organized

[5] Royal Commission on Aboriginal Peoples, "Report of the Royal Commission on Aboriginal Peoples, vol. 3", (Ottawa: Supply & Services Canada, 1996) at 127.

[6] In addition to the overview provided here, the reader is referred to the excellent concise but comprehensive profile of the Canadian system provided by Marchildon (2006).

on a not-for-profit basis – owned either by corporations without share capital, or by religious orders or municipalities. Similarly, physicians operate for the most part in private practices owned by individual practitioners or groups of practitioners. Effectively, however, the huge preponderance of funding for hospitals and physicians comes from public sources (an estimated 91% of hospital funding and 99% of funding for physician services, as of 2006).[7] Funding for services other than those provided by physicians and hospitals exhibits much greater variety.

Canada does not have a single national health insurance plan; rather, it has a common policy framework for certain core services. The Canadian Constitution makes health care a provincial object; hence the provinces and territories have control over the administration of health care and have enacted their own legislation for health care delivery, public health, and health insurance plans. The role of the federal government in direct funding of health services is limited to specific populations (aboriginals, armed forces, veterans, inmates of federal penal institutions). It does, nonetheless, transfer funds to the provincial governments for the purpose of contributing to their health care costs, and makes those transfers conditional on provincial compliance with certain principles. All thirteen provincial and territorial health insurance plans hence share common features and basic standards of coverage. The *Canada Health Act (CHA)* is a federal statute which requires that in order to qualify for federal transfers, a province must operate a government insurance plan that meets five criteria:

(a) public administration: the insurance plan must be operated by on a non-profit basis by a public authority (i.e. one accountable to the provincial government and subject to provincial audit);

(b) comprehensiveness: all "medically necessary" physician services and all "medically required" hospital services must be covered;

(c) universality: all residents of a province must be entitled to coverage (In practice, there is some minor variation across provinces in duration-of-residency requirements necessary to establish "resident" status);

(d) portability: residents who move from province A to province B must continue to be covered by province A throughout any waiting period necessary to qualify for coverage in province B. The waiting period may not exceed three months;

(e) accessibility: all eligible recipients must be entitled to coverage to services "where and as available" on "uniform terms and conditions," and in particular must not face any barriers to access through financial charges, age or health status.

Private insurance exists for a number of goods and services not covered by public plans, most notably prescription drugs outside hospital as well as some hospital amenities such as private rooms, as will be more fully described below. But in all provinces, private insurance as an alternative to public coverage for the great bulk of physician and hospital services is effectively non-existent, since provincial governments have created strong disincentives to the emergence of

[7] Calculated from data available from the Canadian Institute for Health Information, at http://qsat.cihi.ca.

markets for private insurance for publicly-covered services. Five provinces formally ban such coverage; the rest discourage private markets by measures such as requiring providers to be fully in or fully out of the public system or by banning charges in excess of the public rate. Beginning in 2007, Quebec will allow private insurance for a limited number of procedures that are publicly insured (primarily joint replacements and cataract surgery). At the same time, however, it has introduced wait time guarantees for these services in the public sector, and it is not clear that a private market for insurance for these services will develop.

The principal organizational change in the health system since the mid-twentieth century has occurred in the hospital sector. Despite the fact that hospitals are privately organized, they are effectively controlled by provincial governments through a combination of regulatory and fiscal instruments. Hospitals are regulated under provincial legislation, and more than 90 percent of their funding comes from provincial government sources. This effective control is most clearly demonstrated by regionalization programs in all provinces, discussed below (s.5.2). Beginning in the 1970's in Quebec, and then in other provinces (except Ontario) in the 1990s, provincial legislation established Regional Health Authorities (RHAs) constituted as not-for-profit corporations. In all these provinces except Quebec, RHAs replaced individual hospital boards (as well as the governing bodies of a variety of community care agencies). In Quebec, reforms beginning in 2003 replaced Regional Health Boards with regional agencies charged with developing and then funding "Local Health and Social Service Networks," incorporating local hospitals and community agencies into single management and governance structures. In Ontario, regional authorities known as Local Health Integration Networks were established in 2006, and began to take over the function of allocating budgets to hospitals and community care agencies in April 2007. Notably, physician services, as well as prescription drugs outside hospitals, remain outside the purview of regional authorities in all provinces.

The organization and finance of Canadian health care can be schematically represented as shown in Figure 1. Despite the complexity of this graphic representation, it is nonetheless a stylized over-simplification of the diverse arrangements that exist across provinces and sectors. These arrangements are sketched out in the following section on eligibility and coverage. (It should also be noted that Figure 1 omits a growing plethora of advisory, coordinating and information-gathering bodies provincial and inter-governmental levels, such as the Canadian Institute for Health Information, the Canadian Agency for Drugs and Technologies in Health, the Health Council of Canada, and "health quality councils" in several provinces.

1.2 Entitlement

Roughly, entitlement to public coverage for health services in Canada falls into three categories:

a) Fully public – most physician and hospital services: Financing for the almost all of these services falls under the ambit of the *Canada Health Act,* and is represented in Figure 1 by the solid thick arrows. Private payments to hospitals and physicians, represented by the thinner arrows, are confined largely to physician and hospital services not deemed "medically

necessary," and hospital amenities such as semi-private and private accommodation.

The terms "medically necessary" physician services and "medically required" hospital services are stated but not defined in the CHA. Historically, the scope of this coverage has been determined through the negotiation of physician fee schedules by provincial governments and medical associations, and through the negotiation of hospital budgets by provincial governments and individual hospitals.

b) Public-private mix - out-of-hospital prescription drugs, home and long-term care, dental and vision care, physiotherapy, speech therapy, audiology and select physician services: All provinces operate programs that cover some services that fall outside the *Canada Health Act,* although the range of services covered and the terms of eligibility vary considerably across provinces. Often, for example, eligibility is limited to social assistance recipients and the elderly, and deductibles and/or co-payments may be required.

Prescription drug coverage is the largest component of this range of service, and the one in which costs are growing most rapidly. Each province establishes its own formulary listing the drugs that it will cover outside hospital, and there is variation across provinces in this regard. In 2003, the provinces agreed to establish a Common Drug Review (CDR) as part of the Canadian Agency for Drugs and Technologies, one of several federal-provincial-territorial coordinating agencies. CDR decisions are not binding on provincial governments: while provinces are not likely to list a drug in the wake of a negative CDR recommendation, a positive recommendation by the CDR is no guarantee of provincial coverage.

For in-hospital drugs, individual hospitals or, more rarely, regional health authorities maintain their own formularies, within the scope of their overall budget allocations. Cancer drugs, (the category which includes most new drugs that are highly expensive per case) are an exception: five provinces (British Columbia, Alberta, Saskatchewan, Manitoba and Ontario) have established cancer care agencies that among other things cover cancer drugs in hospitals and maintain their own formularies. In BC, Alberta and Saskatchewan the cancer agencies also cover drugs outside hospitals, while in the other provinces such drugs are covered under the provincial drug plans. These differences across these various provincial formularies mean that there is considerable unevenness in the range of drugs covered by public plans, depending on one's province of residence.

Moreover, eligibility for coverage under public plans also varies considerably across provinces. All provinces operate plans covering social assistance recipients, although some require co-payments and/or deductibles. In addition, six provinces provide coverage to all those aged 65 and older, again often with some form of co-payment or deductible, and one (Newfoundland) provides coverage to low-income seniors. In the past decade, three provinces (British Columbia, Saskatchewan and Manitoba) shifted from age-based coverage to income-based coverage for the entire population for drug costs above a certain deductible (based on percentage of household income) and one (Ontario) combines such coverage for the entire population with more comprehensive programs for the elderly and social assistance recipients. One province, Quebec, mandates all residents to have comprehensive insurance for prescription drugs, and offers a public program with an income-based premium in addition to its coverage of seniors and social assistance recipients; and Alberta complements its coverage

for seniors and social assistance recipients with a voluntary public program to all open to all with an income-based premium (Standing Senate Committee on Social Affairs, Science and Technology 2002: 130-137; Morgan 2006).

As for other services, most provinces include dental and vision care, within limits, within their social assistance programs. In addition, all provinces have over time reviewed the range of physician services considered "medically necessary" and have de-listed certain services as a result – either removing public coverage entirely or restricting it to social assistance recipients. By and large, the completely de-listed services have been concentrated in the categories of cosmetic surgery and reproductive technology; those covered only for social assistance recipients tend to be certain non-physician services such as physiotherapy and audiology.[8]

c) Fully private - all other services: Finally, there is a mixed bag of services that fall completely outside the scope of public programs and into entirely private markets. These include those few physician and hospital services that were never covered under public plans as "medically necessary or have subsequently been de-listed, plus a variety of services provided by non-physician practitioners and providers of alternative medicine, as well as home and long-term care beyond the scope of public programs.

1.3 Supply of personnel and facilities

Historically, Canada had a relatively large number of hospital beds, reflecting in part the dispersion of the population which spurred the construction of hospitals and numerous small communities. A number of factors, however - including the concentration of facilities in urban areas given the increasing urbanization of the population, technological developments moving services outside hospitals and 1990s cost constraint agendas – not only the number of hospital beds per 1000 population but also the age-adjusted hospital admission rate have declined steadily from a peak in the late 1960s. By the mid-2000s, hospital supply in Canada was well below that in most European nations but still higher than that in the US.

Constraints on the supply of physicians and nurses in Canada in the 1990s, as further discussed in section 4.1 below, have also had their effects. Reviewing data for the 1990s, an OECD study noted that, "the number of practicing physicians and nurses per capita [at 2.1 and 7.5 respectively in 1999] is generally low by OECD standards, and this gap has widened during the cost-containment period of the 1990s. Between 1992 and 1997, the number of practicing physicians remained unchanged, while the number of nurses per capita actually declined. In most other OECD nations, these numbers continued to go up, albeit at a slower pace than in recent years" (OECD 2001). By the mid-2000s, with new infusions of public finance, the number of nurses per capita had

[8] See discussion below, s. 5.1

rebounded considerably. Enrolments in medical schools were increased again in the early 2000s, but given the long timelines of medical education, the number of physicians per capita given unchanged. Most recently, licensure requirements for foreign-trained medical graduates have been relaxed. In Ontario, for example, the Ontario College of Physicians and Surgeons issued a record number and proportion (42%) of new licences to physicians trained abroad (not including the USA), although almost two-thirds of these licences were for academic settings in post-graduate and faculty positions (College of Physicians and Surgeons of Canada 2007).[9] This was three times as high as the proportion of new licences issued annually to foreign-trained medical graduates in the mid-1990s.

The geographic proximity of the United States and the relative mobility of highly skilled personnel across the border also means that Canada risks losing health care personnel if terms and conditions of employment diverge too sharply from those south of the border. The Canadian Medical Association tracks numbers of physicians leaving Canada and those returning from abroad, and found that the net out-migration of "leavers" vs "returnees" peaked at about 500 in 1996. By the mid-2000s, this pattern had reversed, and Canada was experiencing a modest gain of "returnees" over "leavers."[10] These are relatively small flows compared to the total physician stock of about 32,000. Nonetheless, they tend to have a disproportionate political and economic impact in signaling to governments that they incur risks in tightening employment conditions in Canada.

As for the supply of technological advances such as imaging equipment, Canada's constraint in the 1990s put it well below the OECD mean in the acquisition of computed tomography (CT) scanners and magnetic resonance imaging (MRIs). In 1995, Canada was forth lowest in the OECD in MRI units per million population. In the period of re-investment in the 2000s, purchase of diagnostic equipment and reduction of waiting times for diagnostic services were areas of priority; and by 2003, Canada ranked close to the OECD median on this measure (OECD 2006).

2. Sources and Means of Finance

Overall, public finance accounts for about 70 percent of health care expenditure, out-of-pocket payment about 15 percent, private insurance about 12 percent, and the remaining three percent represents miscellaneous sources of non-patient revenue such as investment income (Marchildon 2006:41).

The national health insurance framework in Canada was created in the late-1950s and 1960s as part of the establishment of the modern Canadian welfare state. Taken as a whole, the programs

[9] Another 37% of new licences were issued to physicians trained in Ontario, with the remaining 21% to physicians trained in the rest of Canada and the United States.
[10] www.cma.ca/multimedia/CMA/Content_Images/Inside_cma/Statistics/19-Abroad_Returns.pdf.

that make up the Canadian welfare state exhibit a mix of universal, contributory and means-tested elements and hence a mix of solidaristic and market-oriented principles. In the case of health care, a universal model was followed at the federal level, influenced by experience in some provinces, notably but not exclusively the programs adopted by social democratic governments in Saskatchewan (Tuohy 1999:50-56). The model was adopted on a successive sectoral basis, beginning with hospital insurance under the *Hospital and Diagnostic Services Insurance Act* of 1957 and extending to physician services under the *Medical Care Act* of 1966. (The two pieces of legislation were consolidated in 1984, with the passage of the *Canada Health Act.)* Consideration was given to including universal coverage for prescription drugs as well as physician services in the 1960s; but the advice of a government commission was to defer such coverage until such time as drugs costs reached a more stable and predictable plateau (in retrospect, a remarkably optimistic projection!) (Morgan 2006):7). This sectorally-based model of financing has remained essentially in place, with the result that public/private division of health care finance varies markedly across sectors as shown in Table 1.

2.1 Sources of public finance

General revenues: Of the 70 percent of total health care funding that flows from public sources, the bulk comes from general taxation. Two provinces, British Columbia and Alberta, levy flat-rate mandatory premiums (from which low-income individuals are exempted in whole or part) in addition to general taxation, and have increased these premiums substantially in recent years (Marchildon 2006:41-43). In 2004, the Ontario government introduced what is in effect an additional tax, graduated by five income levels, which it termed a health premium. Four provinces levy a payroll tax, from which small employers are exempted, labeled either as a health tax (Ontario and Quebec) or as a health and post-secondary education tax (Manitoba and Newfoundland). In all these cases, however, these additional revenues are not ear-marked for health – rather, they flow to consolidated revenue, and are allocated as part of the general budgetary process of government. They amount to a relatively small proportion of overall public health expenditures.[11]

The general taxation revenues from which health care is financed are raised by both federal and provincial/territorial levels of government, although under a tax collection agreement the federal government collects provincial income tax (for all provinces except Quebec) and flows it through to the province. The federal government also transfers funds from its own resources to the provinces for the purpose of funding their health care plans, but these transfers also flow to provincial general revenue, not earmarked funds.

Federal transfers: Upon the establishment of the federal programs for hospital and medical care insurance in the late 1950s and 1960s, federal transfers to the provinces for hospital and

[11] For example, premium revenue amounted to less than 13% of total health expenditures in the early 2000s (Marchildon 2006:43).

medical insurance were based on national average per capita costs. Beginning in 1977, however, federal policy was essentially to reduce gradually the share of its financial contributions to provincial health insurance programs, while retaining sufficient fiscal leverage to ensure provincial compliance with the five "principles" identified above. The reduction of the federal share occurred over time through the operation of a highly arcane formula, modified over time either through federal-provincial negotiations or unilaterally by the federal government.

The process began in 1977 when federal transfers were shifted from a shared-cost basis of funding to combination of unconditional "tax points"[12] and a conditional block grant. The federal government still retained considerable financial leverage in the early years of this arrangement. This was nowhere better demonstrated than with the passage of the *Canada Health Act* in 1984, which reinforced the five principles for federal transfers and made explicit the requirement that there be no direct charges to patients for publicly-insured physician and hospital services. Even so, federal transfers continued to decline as a share of provincial health expenditures. Then, in 1995, driven entirely by a deficit-reduction agenda, the federal Liberal government consolidated transfers for health, social assistance, and postsecondary education transfers to create a new "Canada Health and Social Transfer" (CHST), and set out a new schedule for the reduction of those transfers over time.

Calculating the effects of these various changes on the fiscal balance between the federal government and the provinces in health care is not straightforward, since provinces have come to view the original "tax point" transfer as their own-source revenue. A credible calculation has been made by Banting and Boadway (2004:17), who show that federal transfers (including cash transfers as well as "tax points") declined from about more than 40% in the early 1970s to about 30% in the late 1990s. Of this, however, the full amount before 1977 but only about 13% in the late 1990s was in the form of a conditional cash transfer, with attendant fiscal leverage.

In 2000, 2003, 2004, as the fiscal situation turned around, the federal government committed to substantially increased cash transfers to the provinces for health care. Arguably, however, it did not regain commensurate fiscal leverage. Much of the increase was initially targeted at primary care reform, reducing waiting times for designated services, increased coverage for catastrophic drug costs and home care, and diagnostic equipment and information technology, and the 2004 agreement committed the federal government to a multi-year schedule of increased base transfers. As a condition for the receipt of these increased transfers, the provinces for their part undertook to report publicly on comparable measures of performance, to be facilitated by a Health Council of Canada, which was initially conceived as an impartial body, but which later emerged from the machinery of intergovernmental relations with its membership (half "government," half "non-government") determined by federal/provincial/territorial ministers of health. The reporting commitments made by provincial governments had by and large not been met by the time the Health Council issued its third annual report in 2007, which noted its concern at this failure, and at the disbanding of the federal/provincial/territorial committee charged with overseeing the work (Health Council of Canada 2007).

[12] Essentially, this was the revenue generated by a specified number of percentage points of the income tax yield of the federal basic tax in a given province.

Tax expenditures: In addition to direct expenditures, an often overlooked source of federal and provincial financial support for health care takes the form of "tax expenditures:" that is, the various deductions from taxable income that individuals and corporate employers may claim under the tax system. For example, in 2001 federal personal income tax deductions and credits related to health costs totaled C$2.473 million, and exemptions and rebates from the federal sales tax related to health care goods and services accounted for another C$1.33 million. This is larger than total direct federal expenditures on health care of C$2.325 million in 2001, but far less than federal transfers to the provinces of $C18.5 billion (Banting and Boadway 2004:7).

2.2 The regulation of private finance

Those who do not qualify for coverage under government programs, or who seek services outside the scope of benefits of public plans, must pay privately, either out-of-pocket or through private insurance. Much private insurance is employment-based, and the scope of benefits varies considerably across plans. As of 2004, about 95 percent of dental care, 93 percent of vision care and 54 percent of prescription drugs was privately financed, with private insurance accounting for 54 percent, 23 percent and 34 percent of these categories respectively (Marchildon 2006:50).

Beyond the bans on private insurance for publicly-covered services in some provinces and the regulation of private charges by physicians and hospitals as noted above (s.2.1), there is very little regulation of privately-financed care *per se.* Beyond solvency regulation, there are few regulatory constraints on private insurers as to whom they may enroll (for example, there are no "community rating" or open enrolment requirements) or what they must (as opposed to what they must not) cover. Private laboratories, clinics and long-term care providers must meet regulatory quality and safety requirements whether or not they receive public funding for any of their services.

The ban against levying any direct charge to patients for publicly-insured services means that additional services that are privately financed must not be "bundled" with publicly financed services as a condition of access. That is, if a private clinic wishes to bill a public plan for services rendered to a patient, it cannot demand that in order to access that service the patient must pay privately for related services. Various clinics, notably in British Columbia, Alberta and Quebec, are testing these regulatory limits and raising significant enforcement issues for provincial governments.

3. The Policy and Politics of Health Care in Canada – Recent Trends

3.1 Fiscal swings, 1990-2000

The heavy reliance on general taxation to finance health care in Canada has several important political as well as financial consequences. First, it renders much of the health care system, and especially two core sectors (physicians and hospitals) very vulnerable to the fiscal swings of governments. This was never more starkly demonstrated than in the 1990s (Figure 2). Between

1992 and 1996, real per capita public health care spending declined by about 8 percent. Between 1996 and 2000, spending rebounded, increasing by almost 18 percent. These fiscal changes were part of broad governmental agendas, at both federal and provincial levels, of deficit-cutting and subsequent re-investment. In 1993, combined federal and provincial deficits in Canada peaked at over $65 billion. By 2000, the combined total of provincial and federal budgets was back in the black, with a surplus of over $16 billion. Throughout this period, program spending had to compete not only with deficit reduction but also with tax cuts at both levels of government (Conference Board of Canada 2001; 85-95).

The depression in public spending on health care yielded a fiscal saving of about $30 billion collectively for Canadian governments over the 1992-2000 period, as compared to what would have been spent if spending had followed a pattern of steady secular increase to the point it reached in 2000 (Tuohy 2002). Health care spending, then, was a casualty of broad deficit-control and tax-reduction agendas. But as budgets turned around, the first priority for program spending in all provinces was health care, and that escalation continued through the early years of the next decade.

This dramatic fiscal swing severely tested the stability of the system and the resiliency of the accommodations within it. It further exacerbated the growing acrimony between federal and provincial governments and reduced the possibility of achieving intergovernmental agreement on either the reinforcement or the modification of the system. It fuelled conflict between provincial governments and health care providers over resources, and placed provider organizations, especially medical and hospital associations, under extreme pressure to manage internal conflicts, and laid the ground for demands for "catch-up" increases as the first call on any new investment. These demands related not only to income but to numbers of personnel. As noted by the OECD, "The number of practising physicians and nurses per capita [at 2.1 and 7.5 per 1000 population, respectively, in 1999] is generally low in Canada by OECD standards, and this gap has widened during the cost-containment period of the mid-1990s. Between 1992 and 1997, the number of practicing physicians remained unchanged, while the number of nurses per capita actually declined. In most other OECD countries, these numbers continued to go up, albeit at a slower pace than in previous years" (OECD 2001:2).

The resource constraint also reduced redundancy in the system, an essential condition for phasing in reforms in health care delivery. And although the limited evidence available suggests that measures such as the re-structuring of hospitals did not have a negative impact on health outcomes (Brownell et al. 1999), they created an atmosphere of crisis that shook public confidence in the health care system and in the ability of governments to manage it. Polls in the late 1990s and early 2000s consistently and dramatically demonstrated this erosion. The proportion of Canadians in a cross-national survey reporting the view that the health care system needed "only minor change," plunged from 56 percent to 29 percent between 1988 and 1994, and declined further to twenty percent between by 1998. Perhaps even more significant, public confidence did not rebound with increased public investment after 1997: by 2001, the proportion viewing "only minor change" as necessary still stood at 21 percent; and it remained lodged there in 2004, despite the continuing upward trajectory of public funding. The proportion believing that the system needed to be "rebuilt completely," however, subsided somewhat from 23% in 1998 to 14% in 2004, but still remained well above the negligible level of 5% in the late 1980s (Blendon et al. 2002; Schoen et al. 2004).

Regarding their own interactions with the health care system, Canadians continued to present a somewhat more positive picture. They were more likely than respondents in Australia, New Zealand, the UK or the US to be somewhat or very confident that they could get quality and safe care when they needed it, and less likely than those in any of these nations except the UK to report problems in accessing health care for reasons of cost. The pressures on the system were apparent, however, in reports about the "safety valve" of emergency room (ER) care. Canadians had higher rates of ER utilization than respondents in any of the other four nations in the 2004 survey cited above; and were most likely to have waited for two hours or more in an ER visit (Schoen et al. 2004).

At the same time, however, changes in the broad political system were coalescing to create the conditions for significant policy change. In the early 2000s, the apparent waning of the separatist threat in Quebec and associated constitutional wrangling, and the success of tax- and deficit-reduction strategies, diminished the salience of items that had dominated the policy agenda of the 1980s and 1990s and stymied any progress on health policy in the federal-provincial arena. With the rise in public concern about health care in the wake of fiscal constraint, and the growing alarm of provincial governments at the escalating share of their budgets consumed by health spending, health policy now came to define the climate of federal-provincial relations rather than being constrained by that climate as in the past. Meetings of "First Ministers" (the thirteen provincial and territorial Premiers and the federal Prime Minister) were dominated by health care negotiations. For politicians at both levels of government, moreover, the changing public mood meant that the risks of inaction on health care were seen as higher than the risks of action. As for relations between provincial governments and medical and hospital providers, fissures that deepened within both medical and hospital communities under the pressure of constraint created some footholds for support of reform, especially in primary care. An era of re-investment allowed, at least in theory, for flowing funding in such a way as to provide for some redundancy in transitional periods.

3.2 Re-affirming the Canadian model, 2000-2004

Accordingly, the first few years of the twenty-first century were a time of policy ferment in Canadian health policy. Governmental commissions in Alberta, Quebec and Saskatchewan, and at the federal level explored a greater range of options than had been in play since the inception of Medicare in the 1960s. The system seemed poised for significant change. The key question was whether this change would occur within the parameters of the Canadian universal single-payer model, or whether the model itself would be changed. More specifically, increased roles for market instruments (by opening up the possibility of competition between private clinics and public hospitals for the provision of publicly-funded services) and for private finance (by allowing for privately-purchased alternatives to publicly-funded services) were actively debated.

Nonetheless, although the rhetoric varied considerably, all of these reports in their substance made recommendations that would maintain and enhance the essential features of the Canadian model. In Alberta, an option which would open the door to a greater degree of private finance as a matter of policy design – namely, the possibility of establishing Medical Savings Accounts (MSAs) – was seriously considered. But even there MSAs were presented as an option that "warrant[s]

further study" (Premier's Advisory Council on Health 2002:61). Other reports, after canvassing a range of possibilities, rejected those that would enhance the role of private finance, although the Senate Committee report saw the current model as sustainable only if key changes to improve performance are made. The Senate Committee and the Alberta report advocated greater competition within Canada's publicly-financed "internal market" through more explicit contracting between public authorities and a range of not-for-profit and for-profit providers; other reports, notably the federal Romanow report, argued against for-profit delivery. Both federal reports advocated increased federal funding, primary care reform (bringing primary care providers together in groups to provide 24/7 care to defined populations, with population-based budgets), and building upon provincial drug plans and home care programs to provide more comprehensive and uniform coverage. As noted above, federal funding in the early 200os was increased in several stages, and initially targetted at these areas of concern.

In short, the Canadian model of health care finance passed a crucial test in the early 2000s. Some key conditions for major change had coalesced; yet decisions were made to re-affirm the essential features of the single-payer system. Yet these decisions failed to address the underlying fiscal pressures that continued to build over the first half of the decade. Although the proportion of GDP accounted for by public health care spending has remained fairly constant at between 9 and 10 percent since the early 1990s, and the public share has hovered around 70 percent, health care has consumed a growing proportion of provincial government budgets. This reflects the decline in public revenue as a proportion of GDP in an era of tax reduction, and the high priority assigned to health care. Moreover, all governments view with trepidation the projections of costs into the future.

These projections, of course, depend upon the time frame chosen as the base for projection, and various assumptions about other variables, notably the impact of an ageing population. A paper by federal finance department officials in 2004 projected public health care spending as a share of GDP to 2040, taking into account the effects of an ageing population on both health care expenditures and GDP. They found that ageing alone will raise public spending from 6.3% to 9.8% of GDP by 2040. Additional growth would depend on the "enrichment-to-productivity" ratio of health care spending (that is, the rate of growth in per-capita age-adjusted health care spending to the rate of growth in per-capita GDP). Projections based on the experience of the 1980s (a period of rapid increase in the enrichment-to-productivity ratio) would see public health spending rise to over 30% of GDP by 2040; while using the1975-2001 period (which includes periods of both expansion and constraint) as base would project public health spending to about 16% of GDP. Keeping public spending to 10% GDP by 2040 would require replicating the enrichment-to-productivity ratios of the 1990s, a period that included several years of dramatic cost constraint.

A 2006 working paper from the Organization for Economic Cooperation and Development (OECD 2006) projected that public health spending in Canada would increase from 7.3 percent of GDP to 13.5 percent by 2050, taking into account demographic change and assuming that, over and above demographic effects, health costs increase at an annual rate one percent faster than income. If the rate of utilization increased were to be progressively constrained so that health costs grew only in line with income by 2050, public health spending would grow to 10.8 percent of GDP. The OECD study also makes it clear that Canada is not alone in facing these prospects, although it is above the OECD mean: on average, health care expenditures are projected to increase

from 6.7 percent of GDP in 2005 to 12.8 percent (under the "cost pressure" scenario) or 10.1 percent (under the "cost containment" scenario) by 2050 across all OECD nations.

3.3 A resurgence of private finance? – 2005

In June 2005, the system was shaken by a major exogenous shock – a shock, that is, that had its source outside the federal-provincial and provider-state accommodations of the health policy arena. The Supreme Court of Canada, having unexpectedly agreed more than a year earlier to hear an appeal of a case challenging the Quebec legislation banning private insurance for publicly-covered services as contrary to both the Quebec and the Canadian charters of rights and freedoms, issued an even more unexpected ruling. In a 4:3 decision (there were at the time two vacancies on the nine-member court) the Supreme Court reversed the decisions of lower courts in Quebec, and struck down the legislation. Three of the four judges in the majority found that the provisions violated s. 7 of the *Canadian Charter of Rights and Freedoms* [guaranteeing a right to "security of the person"]; the fourth ruled that is violated the *Quebec Charter of Rights and Freedoms,* and did not rule with respect to the Canadian Charter. The question of whether similar cases in other provinces would succeed with a full nine-member Court and under the Canadian Charter alone remains open, but such challenges are almost inevitable.

In response, the Quebec government passed legislation, to be implemented in 2007, that establishes "wait time guarantees" for specified services, and allows for private insurance for a very restricted scope of services (currently limited to hip and knee replacements and cataract surgery) for individuals who wish to pay privately to access care for faster than can be done in the public system. It requires, however, that providers function wholly within or wholly outside the system of public payment. This legislation, even though it is intended to limit the role of private finance, has been interpreted as legitimizing that role. In response, even before the legislation was implemented, some providers began to signal that they intended to test its limits by offering "bundled" publicly- and privately-financed services. The government responded forcefully, and so far, these challenges have amounted to skirmishes at the boundaries of the public system. Nonetheless, the role of private finance appears far from settled. Quebec is a bellwether province in this regard; but related developments are occurring in Alberta and British Columbia.

4. The Organization and Management of Care Consumption (OMCC)

Historically, third-party payers for health care in Canada, whether public or private, played an essentially passive role. Because it was established in a period of fiscal and economic buoyancy in the 1960s, the Canadian model of public health care finance was premised on achieving universal access to physician and hospital services, with considerably less attention to the control of costs. Essentially, governments underwrote the costs of the existing system and made no substantial

organizational changes. Private insurers, for their part, were relegated to what were then the less costly areas of the system, notably prescription drugs and hospital amenities, and had little incentive to manage costs actively.

The focus on physicians and hospitals providers bound these providers into a close accommodation with the state, and that accommodation has formed the central political and economic axis of the system ever since. When the period of fiscal tightening occurred in the 1990s, it was through negotiations between provincial governments and medical and hospital associations that the implications of fiscal constraint were worked out (Tuohy 1999:ch.7).

In the period of re-investment and growing concern over health costs as a rising share of public budgets in the 2000s, attention has increasingly tumed to potential candidates to perform a more active OMCC role in budget-holding and sophisticated purchasing. In the Canadian context, these candidates are shown as shaded boxes in Figure 1 above. The extent to which this role has so far been realized, however, is limited and varied across provinces. Most of these actors play a role much more akin to "commissioning" than to "contracting" in the British sense of these terms: there is little real competition among providers for allocations from these bodies. The following discussion briefly summarizes developments with respect to each of these potential candidates for the OMCC role.

4.1 Provincial governments

With the advent of universal health care in the 1950s and 1960s, provincial governments became the principal locus of for the holding and allocation of budgets of physician and hospital services. At the beginning, these "budgets" were essentially open-ended - provincial health insurance plans functioned on a simple indemnity model, underwriting the costs of hospital and physician services and certain other health services provided in accordance with decisions made by the providers themselves. Indeed, the central political and economic axis of public health care in Canada is an accommodation or grand bargain between the providers of hospital and medical services and the provincial government in which the providers gave up discretion over the price of their services on a per-unit basis and retained their clinical autonomy to decide which services to provide, while governments exercised broad budgetary control but refrained from intervening in provider decision-making (Tuohy 1976, 1992, 1999; Naylor 1986). As provincial governments later added or expanded programs of coverage for out-of-hospital pharmaceuticals and home and long-term care, they initially adopted a similarly hands-off stance. When a cost-constraint agenda took hold in the 1990s, governments by-and-large sought to limit costs through blunt instruments such as budget caps and supply constraint (notably by reducing enrolments in medical schools and closing hospital beds) rather than attempting more finely-tuned instruments.

Over time, provincial governments have moved slowly to adopt some measures that allow them to play a more active OMCC role. In the hospital arena, a model of historically-based budgeting (either line-by-line or global, with annual adjustments either as a matter of ministerial discretion or through an across-the-board multiplier) remained the predominant one through the early 2000s,

even as these budgets were transferred to regional bodies as discussed below (McKillop, Pink and Johnson 2001). In some cases, however, provincial governments contract with providers for certain types of services. In Ontario, for example, a number of "priority areas" are funded outside of global budgets through contracts with hospitals for agreed-upon volumes of service. Contracting for these services, which include dialysis, joint replacements, organ transplantation, access to MRIs and a number of others, remained with the provincial government after authority for allocating global hospital budgets was devolved to regional authorities.

In all provinces, funding for physician services rests with the provincial government, and is negotiated between the government and the provincial medical association. For physicians in independent fee-for service practice, (historically the predominant mode remuneration and still accounting for more than half of practicing physicians in the country as a whole,[13] with cross-provincial variations), remuneration is based on a Schedule of Benefits listing fees for every publicly-insured physician service. Periodically, beginning in the 1990s (slightly earlier in Quebec), governments have instituted caps on the total physician services budget and/or caps on individual physician remuneration, either through negotiation or on occasion unilaterally. These caps have been broadly categorical and not finely-tuned instruments: utilization management of physician services in Canada has been very limited, largely delegated to medical bodies themselves, and focused on "outliers" (that is, physicians whose overall practice profiles differ greatly from those of their peers). In the 2000s, provincial governments increasingly moved to negotiate modes of remuneration other than fee-for-service with groups of physicians who would then administer their own internal mechanisms for remunerating individual practitioners. These mechanisms, together with salaried and capitation mechanisms established earlier for a minority of physicians, now apply to just over 40% of the practicing profession.

The focus of provincial governments in carrying out their OMCC functions for physician services has been on the price or total cost rather than the volume and mix of services provided. As noted earlier, the *Canada Health Act* requires provinces to cover all "medically necessary" physician services and all "medically required" hospital services, but does not define the term. Hence, as Evans and his colleagues (2007:16) have put it, the definition of the basket of publicly-insured services is "inferred from observed clinical practice," and effectively takes place in the context of province-by-province negotiations between the provincial government and providers. The scope of coverage is broadly similar across provinces, although there are differences at the margin.

In this regard, there is a marked asymmetry in decision-making around the "de-listing" of services that have historically been covered and the listing of new procedures for coverage. This asymmetry is driven by a degree of inertia in the system, and means that new services that are candidates for listing are subjected to much more critical scrutiny that is the vast range of services that are already listed. Beginning in the period of sharp cost constraint in the mid-1990s, most provinces moved to delist some physician services, largely working within the framework of fee

[13] According to data from the Canadian Medical Association. "Percent Distribution of Physicians by Mode of Remuneration, 1990, 2003." Available at www.cma.ca/multimedia/CMA/Content_Images/Inside_cma/Statistics/pwr-percent2.pdf.

negotiations with the medical profession. Most de-listed services fell into the following categories: services that may be provided by health care practitioners other than physicians (such as audiology, chiropractic, physiotherapy, and eye examinations); cosmetic procedures (such as otoplasty and wart and tattoo removal); and reproductive procedures (such as the reversal of sterilization and in-vitro fertilization) (Banting and Boadway 2004:42). But provinces varied in the range de-listed services and the scope of the de-listing: for example, Ontario reduced coverage for routine eye exams from 1 every year to 1 every other year in 1998), and restricted coverage for audiology and physiotherapy outside hospitals to social assistance recipients in 2004.

Decision-making regarding the listing of new procedures arising from technological development also exhibits considerable cross-provincial variation. In theory individual hospitals could decide to fund new procedures from within their global budgets, particularly if such procedures substitute for established procedures; but in practice their ability to do so is constrained by separate decision-making procedures for the physician service component of the procedure, the cost of such new devices as may be involved, and the capital cost of any new technology. Accordingly, decisions about whether or not to fund newly-developed procedures performed by physicians in hospitals involve multiple intersecting decision processes, often with different results in different provinces.

As a coordinating mechanism, provincial ministers of health established the Canadian Coordinating Office for Health Technology Assessment in 1989, an intergovernmental body with a relatively limited mandate focused on medical devices. Over time, the scope of its inquiry expanded, and in 2006, CCOHTA was renamed the Canadian Agency for Drugs and Technologies in Health (CADTH) and given an expanded budget to reflect its broader mandate, which includes drugs as further discussed below. CADTH is intended to provide national information exchange, resource pooling, and coordination of the assessment of health care technologies to ensure their appropriate use, and could provide a significant resource to those who perform OMCC roles in Canada.

Indeed, decisions about most capital investments in health care rest with provincial governments. About 82% of capital expenditures for health care are publicly funded; and hospitals (and now regional health authorities) require provincial approval to raise private funds for new facilities and equipment. The provincial government in Ontario, and sub-provincial health authorities in Alberta, British Columbia and Quebec, have entered into "public-private partnerships" with private firms for the construction of health care facilities. Under the terms of these arrangements, similar to "private finance intitiatives in the UK, the private firm or consortium finances, builds and in some cases operates the non-clinical dimensions of the facility, in return for annual pyments form the public authority. In some cases formal ownership of the facility rests with the public authority, either from the beginning or after a period of time. These arrangements have been highly controversial in Canada, and vociferously opposed by health care unions. Critics draw upon evidence from the UK suggesting that over time they prove more costly than the publicly-financed alternative (Marchildon 2006:76). Experience with these initiatives is likely to be closely watched in Canada.

4.2 Regional bodies

Various types of "regional" authorities have been established in all Canadian provinces. Each province has followed a somewhat different model of regionalization; and indeed regional structures within each province have undergone considerable re-organization over the course of their existence. The characteristics common to all models are a focus on the horizontal and vertical integration of hospital and community services, (including social services in Quebec and PEI) and an exclusion of physician services and prescription drugs from the purview of regional authorities. All derive their budgets from the province; none has an independent revenue base. Although most provinces have announced the intention to move to population-based funding for regional authorities, only three had done so by the early 2000s (McKillop, Pink and Johnson 2001:46), and another (Ontario) had done so only in the home care arena, as discussed below. Mechanisms for adjusting the population for age, sex and other variables relating to projected health needs are at different stages of development in different provinces, and are most fully developed in Saskatchewan. In the other provinces, budget allocations to regional bodies are driven by historical patterns, with annual adjustments at the discretion of the Minister or, less commonly, by an across-the-board multiplier (idem).

The financial latitude of regional authorities is quite constrained. In seven provinces they are prohibited from running deficits; the other three allow deficits to be run under certain conditions. In all provinces but one, regional bodies may retain all or part of any surplus, although in two provinces provincial approval is required as to how the surplus is to be spent (McKillop, Pink and Johnson 2001: 61,64). Except for the potential use of any surplus for capital expenditures, regional authorities are entirely dependent upon their provincial governments for capital – the province is the primary source of capital funding, and must approval any additional private fund-raising by regional bodies.

There is considerable variation across provinces in the number of regional authorities, their functional scope, the size of population served, and the mechanism of appointment or election to their boards. Table 2 summarizes these characteristics, including changes over time. As apparent in this overview, there has been considerable organizational "churn" and transitional dislocation of key personnel in the move to regional systems, arguably compromising the ability of regional authorities to perform a key OMCC role.

For the most part, regional authorities have undertaken direct management functions. Contracting with competing independent providers for particular services is a relatively marginal aspect of their activity, and there is considerable cross-provincial variation in the extent to which regional authorities engage in contracting at all. Nonetheless, all have attempted in various ways to move to a model of management that is focused on performance.

From all of the provincial diversity, three distinct models of regionalization can be abstracted. The most prevalent model is one in which regional health authorities own and operate hospital and community facilities, and in some provinces also contract with independently owned and operated facilities as well. This model is most elaborately developed in Alberta, but all other provinces except Quebec and Ontario exhibit some variant of it. Quebec and Ontario, for their part, each exhibit a distinct model, with regional authorities having planning and allocation but not direct

managerial responsibilities. The difference between the Quebec and Ontario models lies in the degree of horizontal and vertical integration at the sub-regional level, which is much greater in Quebec.

4.2.1 Regional health authorities: the Alberta example

The role and potential of regional authorities can be illustrated by experiences in Alberta. There, nine Regional Health Authorities (RHAs) are responsible to the Minister for ensuring the provision of acute care hospital services, community and long-term care services, public health protection and promotion services and other related services to their defined populations. (Cancer and mental health services are outside their mandate, and are managed by the Alberta Cancer Board and the Alberta Mental Health Board respectively.) In carrying out these roles, RHAs also perform planning and reporting functions, as summarized in Table 3, which is illustrative of similar requirements in other provinces.

In addition to their direct management function, RHAs contract with specialized facilities under private ownership and management for a range of services, including surgical services such as cataract surgery, hip and knee replacements, and abortions. (Such contracting also occurs in two other provinces, British Columbia and Manitoba, and may soon develop in Quebec as noted below.) All non-hospital providers of surgical services must be designated by the provincial Ministry of Health and Wellness and accredited by the Alberta College of Physicians and Surgeons in order to be eligible for contracts with RHAs, and all contracts must be approved by the Ministry. As of 2004, there were 54 accredited non-hospital surgical facilities in Alberta. After controversy arose in the late 1990s about conflicts of interest involving members of the RHA Boards who were also receiving RHA contracts as health care providers, a provincial regulation was passed in 2004 deeming as ineligible for membership on an RHA Board any health care providers in receipt of funding from that RHA or any directors or employees of a corporation receiving 50 percent or more of its funding from that RHA.

In addition to population-based funding, regional health authorities receive funding on a province-wide basis for high-cost, specialized services, such as cardiac surgery, organ transplant surgery and renal dialysis. This funding is concentrated in the two major urban RHAs, Capital (in Edmonton, the provincial capital) and Calgary.

In 2005, in response to mounting concerns about wait times for hip and knee replacement surgery, Alberta undertook a pilot initiative to better manage these services. The Alberta Bone and Joint Health Institute was founded as a joint venture of the two largest RHAs (Capital and Calgary), the Universities of Alberta and Calgary and the Alberta Orthopaedic Society with dedicated funding from the provincial government. It involved the establishment of centralized assessment clinics, concentration of procedures in particular facilities, and systematic involvement of family physicians in pre- and post-surgical care. The pilot program was dramatically successful in reducing average wait times (from 35 weeks to six weeks to receive the first orthopaedic consultation and from 47 weeks to 4.7 weeks from first consultation to surgery) and is being rolled out on a continuing basis (Alberta Bone and Joint Institute 2005).

4.2.2 Regional agencies and health and social services centres (Quebec)

As in a number of other areas of health care, Quebec was a pioneer in developing regionalization structures for hospital and community care. In 1971 (coincident with but not tied to its entry into the federal regime of universal medical care insurance) Quebec established regional councils to oversee the planning and coordination of hospital and community care and social services. The members of these councils, as consistent with a distinctive "corporatist" streak within Quebec's institutional and political culture, were elected by regional assemblies whose members were drawn from four "electoral colleges" — municipalities, community health and social service organizations, socioeconomic groups including business and labour organizations, and health care institutions. They were, nonetheless, effectively dominated by physicians and health care administrators. In some cases, in addition to their planning functions, they were granted a measure of executive authority over the organization of home care and emergency services. Under the planning aegis of the regional councils, local "health and social service centres" were established, each with its own representative board. They were not, however, extensive in their scope: for example, fewer than 10 percent of physicians practiced in such centres by the late 1980s (Tuohy 1992: 123-24).

The regional council structure remained more or less in place until 1991, when it was transformed into a system of regional boards with authority for holding budgets and allocating funding to institutions and agencies within their respective geographic areas: the first example in Canada of the performance of an "OMCC" function at the regional level. In 2003, the board structure care underwent another transformation: the 15 regional boards were replaced with 16 regional agencies, appointed by the Minister of Health and charged with developing local health and social service "networks," including hospitals, community care and social services organizations, within their jurisdictions. In 2004 a new structure of 95 such local networks was unveiled, each network with a governing board, appointed by the Minister on a transitional basis, which replaced the governing boards of the constituent organizations. The appointed boards were to be replaced in the fall of 2006 with boards elected in categories specified in the enabling legislation, and would chose their own CEOs. The respective RHA and the Ministry have two of the five representatives on the CEO selection committee.

The greatest structural transformation brought about by the 2003-2004 reforms was thus at the sub-regional level, replacing formerly independently-organized hospitals and other entities with networks each governed by a single board. The networks are responsible for delivering integrated hospital and community care within a geographic area. For specialized tertiary and quaternary care services, four overarching networks were established, each anchored by one of the four medical schools in the province. Local networks contract with these university-based networks for more specialized treatments. The regional agencies themselves continue to perform regional planning, resource management and budget allocation functions similar to their predecessor boards.

This set of reforms is meant to strengthen greatly the OMCC function. Each level in the hierarchy exercises its responsibilities under performance-based contracts from the level above – the regional agencies under contracts with the Ministry, and the networks under contracts with their respective agencies. The role of the regional agencies and local networks may be further

elaborated as they come to contract with specialized private clinics. This is a new and as yet nascent possibility in Quebec; and it follows in the wake of a successful legal challenge to Quebec's ban on private insurance for services that are publicly insured, as discussed above.

Notably lacking from the health and social service network are physician practices. As in other provinces, most physicians continue to practice on an independent basis, either individually or in physician-controlled groups. However, also like other provinces, Quebec is moving slowly and on a pilot basis to reorganize primary care services. The same legislation that established the frameworks for local health and social service networks also provided for the establishment of "family medicine groups," as will be further discussed below.

4.2.3 Local health integration networks and community care access centres (Ontario)

Regional structures somewhat similar to those in Quebec are taking shape in Ontario. There, legislation passed in 2006 set up a phased implementation process for the establishment of a regional structure comprising 14 Local Health Integration Networks (LHINs), charged with planning for the integration of hospital and community health care services in their respective regions, and ultimately with holding and allocating budgets for those services.[14] The key difference in Ontario, unlike any other province, is that the governing boards of individual hospitals and other agencies were left in place.

As in other provinces, the regional LHINs were established as not-for-profit corporations at arm's length from the provincial government. The LHIN boards are nonetheless appointed by the provincial Minister of Health and Long-Term Care, as were the first set of CEOs. (In the future, each LHIN Board will select is own CEO.) The LHINs are intended to play a pivotal role in the overall system of planning and accountability for publicly-funded health care in Ontario, analogous to the role of Regional Health Agencies in Quebec. Within the strategic plan developed by the Ministry for the province as a whole, each LHIN will develop a plan for its own region. Once the LHINs have assumed OMCC authority (to occur in 2007), they will them allocate funding to the institutions and agencies under their jurisdictions. Funding flows will be governed by contracts or "accountability on service agreements between the Ministry of Health and each individual LHIN, and in turn by "service accountability agreements" between each LHIN and its respective institutions and agencies. The LHIN also has specific authority to make "integration decisions" to reorganize the delivery of hospital and community services within its territory – for example, by transferring responsibilities for certain services from one provider to another – although it may not close an institution nor abolish an institutional board. (Those latter powers continue to rest with the Minister.) LHINs may also contract with each other for the provision of specialized services.

[14] These LHINs replaced 16 District Health Planning Councils, which had a much more limited mandate advisory to the Minister.

The financial independence of LHINs is very limited. At the outset, existing budgets and associated "accountability agreements" with individual institutions and agencies will simply be transferred from the Ministry to the relevant LHIN. These budgets are primarily historically-based, although the intention is that in the future LHIN budgets will be population-based. LHINs may not borrow money or engage in fundraising without government approval – essentially, they must live within the budgets granted by the Ministry. The effectiveness of these provisions remains to be seen – they mean that LHINs may not incur deficits, but they follow in a historical context in which hospitals have routinely incurred deficits that are eventually covered through negotiations with the Ministry, despite explicit and ultimately legislative provisions to the contrary.

Unlike regional bodies in some other provinces, LHINs may not contract with private providers of specialized services. The Ministry itself, however, does fund the provision of publicly-insured diagnostic services (including provide most imaging and pulmonary function tests) and certain day-surgery and chronic care services (such as cataract and retinal laser surgery, abortion, chronic-care haemodialysis, plastic surgery, laser dermatologic surgery, and gynaecologic surgery) in "Independent Health Facilities" (IHFs) licenced under provincial legislation. As of 2005 950 diagnostic IHFs and 22 ambulatory care IHFs were licensed and funded in Ontario. Physicians practicing in IHFs are remunerated under the provincial schedule of benefits, while the IHFs themselves receive "facility fees." No direct charges may be made to patients. IHFs must be accredited by the provincial medical licencing authority, the College of Physicians and Surgeons of Ontario, in order to qualify for licensure by the province. In addition, three proprietary private specialty hospitals were "grandparented" shortly after the full establishment of public physician and hospital insurance in the 1970s, and are regulated under legislation that specifically precludes the licensing of any other private hospitals. The provincial government as also constrained the expansion of the range of services that may be performed in these hospitals: for example, the Minister of Health and Long-Term Care has rejected a proposal from one to provide hip and knee replacements in addition to knee arthoscopy that it currently provides.

Arrangements for funding home care in Ontario also differ from those in other provinces. Like Quebec, but unlike other provinces, the Ontario structure includes an intermediate body between the regional funding authority and home care delivery agencies, but unlike Quebec's local health and social services networks that have taken over the management of home care agencies, Ontario has established Community Care Access Centres (CCACs) on a regional basis. CCACs pre-date the LHINs, having been established in the mid-1990s as contracting bodies for publicly-funded home care services. With the advent of the LHINs, the CCACs were restructured and reduced in number from 42 to 14, to coincide with the LHIN regional boundaries. Like other delivery agencies, the CCACs will receive funding through the LHINs under service accountability agreements (this transition to be completed by 2009/10). Unlike the hospital sector, the home care sector is fairly densely populated with competing for-profit as well as not-for-profit providers, and CCACs write contracts with both types under a request-for-proposal process. In awarding contracts to competing providers, the CCACs sit, with Alberta RHAs, at the most highly elaborated end of the OMCC spectrum for regional bodies in Canada.

4.2.4 Primary health care groups

As pointed out earlier, regional restructuring in all provinces has been concerned with hospital and community services, and has excluded physician services and prescription drugs from the purview of regional bodies. Such restructuring as has occurred with respect to physician service has involved group-based funding arrangements for certain specialists in certain hospitals (beginning with teaching hospitals), and primary care reform. With respect to the latter, all provinces have moved tentatively to establish a variety of new models for the provision of primary care through community clinics, group practices, networks and teams including family physicians and nurses. Most but not all of these models require patients to enroll with the providing practice, clinic or network, funded on a composite basis taking account of population served and other factors, which undertakes to provide 24/7 access to a comprehensive range of primary care services. Ontario, for example, has established "Family Health Groups" (group practices of family physicians), "Family Health Teams" (interdisciplinary practices comprising non-physician as well as physician members) and overarching "Family Health Networks" drawing multiple practices under a common agreement. In Quebec, Family Medicine Groups are being established under the planning auspices (but not the financial purview) of the Regional Health Agencies. In both Ontario and Quebec, the contracts and agreements under which the groups, teams and networks are established show considerable variety – for example, with regard to the terms for remunerating physicians and the mechanisms for integrating service provision. All of these initiatives are being undertaken gradually, and were still in their infancy in the mid-2000s. And notably, in none of them do family practitioners play a purchasing role for services beyond primary care (unlike Primary Care Trusts in the UK).

These moves have involved intensive negotiations with provincial medical associations and have proceeded on a voluntary basis, in contrast to the horizontal and vertical restructuring of hospital and community care. There is by no means unanimity within the medical profession on this (or any other) issue; and a substantial proportion of the profession, including those in family practice, remains entrenched in fee-for-service practice. In Ontario, for example, in 2005 49 percent of registered family physicians were paid solely on a fee-for-service basis, with the remainder funded through one of the primary care initiatives or through alternative funding plans in academic health science centres (Government of Ontario 2006). Nonetheless, experience in other jurisdictions suggests that a voluntary approach structured with appropriate incentives (including substantial financial inducements) can gain sufficient acceptance to be universalized – as in the case of GP Fundholding leading to Primary Care Trusts in Britain and GP Budgetholding leading to Primary Health Organizations in New Zealand (Mays 2004). If and as they do take root, these primary care groups and networks have the potential to provide a key OMCC function in holding budgets and allocating funding to their constituent practitioners, and possibly in purchasing other services as well. The terms under which they receive their budgets from provincial governments will be crucial in determining the discretion they have to play this role, and the nature of the performance for which they will be held to account.

4.2.5 Provincial drug plans

Expenditures on pharmaceuticals constitute the fastest-growing component of public (and total) health expenditures in Canada, and in 2000 surpassed physician services as a share of total health spending. By 2006, spending on drugs amounted to 17% of total health spending – greater than the 13% share devoted to physician services. Because the public purse pays for 99 percent of physician services but only about 38% of drug costs, the drug and physician shares of *public* health spending were 9% and 18% respectively. Although the advent of a few new and very expensive drugs (principally cancer drugs) has galvanized media attention as governments wrestle with whether and how to cover these drugs, it remains the case, as Morgan reports, that a "surprising majority of drug spending in Canada is for common, relatively cheap treatments for cholesterol, hypertension, heartburn & ulcers, and depression" (Morgan 2006:5).

Historically, third-party payers, both public and private, played passive roles in underwriting the costs of pharmaceuticals. Employer plans typically included coverage for pharmaceuticals as a component of their health benefits, and provincial governments introduced programs of pharmaceutical coverage out of a concern for those who were perceived to be the most vulnerable members of the population: the elderly and the indigent. Because most drugs were for common conditions and carried modest per-unit costs, there was little concern with "value for money" or other types of utilization management considerations and mechanisms (Morgan, Bassett, and Mintzes 2004).

Complicating greatly the exercise of the OMCC role for pharmaceuticals in Canada is the highly fragmented and decentralized organization of responsibility in this arena. The federal government regulates the safety of new prescription drugs by requiring all new drugs to obtain approval from the Therapeutic Products Directorate of the federal ministry of health (Health Canada). Prices of patented medications, which constitute about 65% of the market, are regulated by the federal Patented Medicines Prices Review Board. (Prices of generic medications and drugs whose patents have expired after the 20-year patent period are not regulated). Regulated prices are set relative to other prices for similar drugs: they may not exceed the highest Canadian price for other drugs with the same therapeutic application, and if no other such drugs exist they are set at the average price for the same drug in seven comparator jurisdictions (France, Germany, Italy, Sweden, Switzerland, the UK and the USA). This price regulation, introduced in 1987, has been relatively successful: in 1987, average prices for patented drug in Canada were 23% above the world median, and by the early 2000s they were 5 to 10 percent below world prices. In contrast prices of unregulated drugs were 24 to 40 percent above world prices in the early 2000s (Barry 2003).

Beyond price regulation for patented drugs, however, purchasing decisions for prescription drugs are made in a very diverse context. As late as the early 1990s, the use of formularies or other utilization management strategies by hospitals and governments was very limited (Morgan 2006:8). By the end of the decade, however, such formularies were ubiquitous. Each provincial government maintains its own formulary for out-of-hospital pharmaceuticals, as do individual hospitals for those provided in-hospital. With very few exceptions (the most notable being the Winnipeg Regional Health Authority in Manitoba), formularies continue to be developed and administered on an individual hospital basis even where regional authorities have taken over the management of

hospitals. This highly decentralized process means that those who perform OMCC functions cannot take advantage of either the economies of scale in assessing drugs for purchase nor the volume purchasing power that would come from a more centralized process. The inter-provincial Common Drug Review process established in 2003 under what is now the Canadian Agency for Drugs and Technologies in Health promises to go some distance toward filling the first of these gaps, but it plays an advisory role that still requires the continuation of province-by-province decision-making mechanisms.

For the most part, cost-effectiveness and value-for-money considerations still play a relatively limited role in these provincial mechanisms. A notable exception is the province of British Columbia, which has adopted a system of "reference pricing" for drugs to be listed on its formulary. Under this system, drugs are first grouped into categories that have equivalent effectiveness in treating given conditions. A "reference price" for each category is then established – either the lowest or the average price of the drugs in the category. The public benefit is then set at the reference price; patients who wish to choose a more expensive drug in the category must pay the difference. Such evidence as exists suggests that this system has been effective in constraining drug costs in BC without negative effects on health outcomes (Schneeweiss et al. 2002; Grootendorst et al. 2001). Other provinces have gone some distance in this direction by using the price of generic drugs as their reference prices, but this approach is limited in tow respects: first, it necessarily applied only to those categories of drugs that include generic equivalents; and second, because only the price of patented drugs is regulated in Canada, the price of generics tends to be relatively high by international standards. Other forms of utilization management, such as disease management protocols, are limited and confined to pilot projects.

5. Conclusion: An Emerging Paradigm?

5.1 Canada on Chernichovsky's map

Notwithstanding the fact that it has had a "purchaser-provider split" in the structure of its public health insurance plan since its inception in the 1950s and 1960s, the Canadian system remains at some distance from the end-point "P" on Chernichovsky's map describing the Emerging Paradigm, and rather ranges along a diagonal axis between points A and Z (Figure 3). For physician and hospital services, funding is almost entirely centralized in provincial governments. The "OMCC" function, however, while also technically centralized in provincial governments has historically been very weak, as a result of a central accommodation or "grand bargain" between providers of hospital and physician services on the one hand and provincial governments on the other. The initially passive role of government payers evolved to a focus on setting broad budget limits, including global budgets for individual hospitals and individual caps on payments to physicians. But within these "budgets," decisions about the provision of care to patients were made by individual hospitals and physicians themselves. On Chernichovsky's map, this would seem to have placed hospitals and physicians *formally* close to point Z, although the formal OMCC role of the central authority was only weakly realized.

If there is a more recent movement toward point P, it is more visible in the hospital services sector, in which budget-holding and allocation has been devolved in large part to intermediary regional bodies, who are expected to play a more active OMCC role. These bodies do not compete with each other, and competition amongst providers of service is very limited. In three provinces, specialized clinics compete with public hospitals for public funding in a few niche areas, but for the most part regional bodies have taken over the budget-holding and allocation function from provincial governments without requiring hospital providers to compete for contracts. Historically-based hospital global budgets are nonetheless gradually being adjusted to reflect a greater emphasis on service volumes, performance measurement and accountability; and funding to regional authorities is over time being adjusted to reflect population health needs. The pace and extent of each of these developments varies considerably across provinces.

Furthermore, there is some possibility that public purchasing of certain services from private clinics may provide those clinics with a financial base from which to engage in private markets for other services, or even, in Quebec, to compete with the public sector in private markets by offering certain services faster than they can be accessed on a publicly-financed basis. These developments are far for clear as of 2007, but the hospital arrow is shown as slightly leftward-bending to allow for that possibility.

Funding for physician services remains highly centralized in provincial governments, and is allocated under agreements negotiated with the provincial medical association. The development of intermediate bodies with OMCC functions is much less developed than in the hospital sector, although sole practices are slowly being replaced by drawing physicians into groups of practitioners. Modes of remuneration other than fee-for-service, some involving performance-based components such as volume targets for particular services, are gaining acceptance. However, more than half the practicing profession continues to bill provincial plans on a fee-for-service basis; and the provincial fee schedule remains the touchstone for the negotiation of alternative arrangements. Whatever the mode of remuneration, the great majority of physicians function as independent practitioners. Competition for patients is limited to non-existent given the supply of physicians, which is limited compared to most other developed nations. However, if private markets for some currently hospital-based services develop as noted above, physicians will be involved in those markets; hence another slightly leftward bending arrow is shown for physician services as well.

Beyond physician and hospital services (which together account for about 43% of total health spending), the Canadian pattern is shifting within the lower half of Chernichovsky's map. Home care and long-term care services are provided by competitive suppliers through a mix of public and private funding that varies across provinces, although except in the Atlantic provinces funding is largely from provincial general revenues.[15] The majority of funding for prescription drugs outside hospitals is private (with private insurance playing a large role), and public funding

[15] As a rough estimate, about three-quarters of the funding for each of these sectors comes from public sources. The public share of home care funding has been estimated at about 78% (Canadian Institute for Health Information 2007); and funding for "other [.i.e. non-hospital] institutions," a category largely populated by long-term care facilities, was about 72% public in 2006, as noted in Table 1 above.

is typically limited to coverage for those 65 years of age or more and recipients of social assistance. This is an area of fairly dynamic change, however: three provinces have moved from age-based to income-based public coverage for prescription drugs across the population, and all except the Atlantic provinces have instituted coverage for drug costs that exceed given proportions of household income. Finally, dental care, vision care and a variety of other allied health services occupy a territory well within Chernichovsky's lower-left quadrant near point A, in private markets supplemented only by public programs providing access to some services as social assistance benefits.

What is the likelihood that the Canadian pattern will converge somewhere closer to Chernichovsky's point P? Certainly the issues of more explicit contracting for hospital services, not only from publicly-funded hospitals but potentially from private clinics, and of expansion of public "pharmacare" to ensure universal coverage of out-of-hospital prescription drugs, are live issues of public debate in Canada. The first of these options would increase competition among providers of hospital and related services for public funds; the second would increase public funding for competing pharmaceutical products. There are several factors that operate to constrain these developments, and a few potential catalysts of change.

5.2 Constraining factors

Some of the constraining factors are at least in part technical; others are firmly embedded in the policy economy of health care in Canada.

i) Information: Principal among the quasi-technical constraint is the lack of information, and information systems, necessary to perform a sophisticated purchasing function, including the specification of contracts and monitoring of compliance. The decentralized (albeit non-competitive) nature of health care delivery means that hundreds of individual hospitals and thousands of physicians and other providers in private practice have maintained their own information systems. Although these systems may have worked well for the particular administrative purposes for which they were designed, they do not allow for planning and monitoring population needs and patient flows on a system-side basis at regional, provincial and national levels. Work is proceeding at an agonizingly slow pace on the development of a common format for an electronic medical record (EMR), or more broadly an electronic health record (EHR).

In 2001, with an infusion of C$500 million in funding from the federal government, the federal, provincial and territorial governments jointly launched Canada Infoway, an arm's-length, not-for-profit corporation whose members comprise the 14 federal, provincial and territorial deputy ministers of health. Over the next three years, another $700 million in federal funding was provided, bringing the total investment capital of Canada Infoway to $1.2 billion. By June 2006, Canada Infoway had invested $702 million in a variety of projects including cross-provider information systems for drugs and for diagnostic imaging. The impact of these investments, however, is slow to be felt; and the goal of having 50% of Canadian covered by an EHR by 2009 appears very ambitious. (In June 2005, the CEO of Canada Infoway estimated that the current proportion was about 4%) (Canadian

Healthcare Manager 2005). At that time, a panel of experts active in the health information field assembled by *Canadian Healthcare Manager* magazine gave progress toward implementing the EHR a mixed appraisal – a B+ for developing a common architectural blueprint for an integrated system of EHRs, but only a C for progress toward actually implementing the architecture in information systems for drugs, laboratory services and diagnostic imaging (idem).

Barriers to progress in the development of EHRs are many. As noted, many hospitals and laboratories have invested in information systems that work well for their own purposes. Without mandatory regulatory requirements or other incentives such as exist in the USA, these providers are loath to incur the transaction costs and up-front investments of adopting new systems. As in other budget-constrained systems, expenditures for information technology tend to be viewed as costs to be incurred rather than investments with returns (Tuohy 1999:250-54). Moreover, the traditional budgeting methods that still prevail present disincentives and barriers to change (McKillop 2002). These and other factors feed a vicious cycle: limited demand means that there is a limited market of suppliers of information systems tailored to the Canadian context, and thus requires those who do adopt new technology to bear the costs of customizing systems developed elsewhere, typically in the USA (Pooley 2006).

Nonetheless, progress is being made in some regions. Alberta, with the most fully-fledged regional system, is leading in this regard. In 2004, the Capital Health Region in Edmonton introduced the first regional EHR system in the country in the form of a web-based portal for physicians (idem); and the system began to be implemented on a province-wide basis, extending to pharmacies, in 2006.

ii) Equity Concerns and Regulatory Issues: Canada's publicly-financed health care system is based on a principle of equal access – specifically, according to the *Canada Health Act,* access on "uniform terms and conditions" such that patients do not face any financial barriers to service. The principal effect of this provision is to ban any direct charges to patients for publicly-insured physician and hospital services. The fact that this principle is set in federal legislation means that any province permitting such charges will have its federal transfer reduced by the estimated total amount of the charges; and several provinces have incurred modest penalties over the years as a result of private charges made by clinics for services for which they also received public funds. But beyond its status as a legislative provision, the principle of equal access has been embedded in Canadian attitudes toward what is without dispute Canada's most popular social program, with almost iconic status.

In the mid-2000s, however, for reasons discussed in s.4.3 above, the issue of the intersection between public and private finance for health care in Canada is a matter of very live debate. In this context, Chernichovsky's Emerging Paradigm presents public policy-makers with some important trade-offs, and potentially with some complex regulatory challenges, regarding the extent to which providers competing for public funds should also compete in markets for privately-financed services. Should public funds be used to subsidize private markets, by giving providers a publicly-financed base from which to compete? Does this amount, effectively, to subsidizing unequal access?

One way in which this might occur is through the "bundling" of publicly- and privately-financed services. If, for example, providers receiving public funding for the provision of a service

(such as a hip replacement or a cataract operation) also require that patients pay an additional fee for a particular type of prosthesis or lens *as a condition of receiving the service*, they violate the prohibition of direct charges to patients. A similar problem occurs if private clinics bundle services such as nutritional counselling or other ancillary services with publicly-funded services and offer access only to the full "bundle." This is the type of strategy that has been much at issue in Alberta, British Columbia and Quebec, where the provincial governments have adopted various regulatory measures and enforcement strategies in attempts to constrain such behaviour, as they have moved to allow public authorities to contract with private clinics. Such skirmishes, and the regulatory complexity of dealing with them, have made provincial governments cautious about expanding the universe of those who may compete for public funds.

Even apart from equity concerns is the potential for negative feed-back on the public sector if providers receiving public funds may also compete in private markets, which may occur if providers withdraw from providing publicly-funded services in favour of operating on a more lucrative privately-financed basis. Some providers may "cream-skim" the demand for services such as hip and knee replacements by selecting relatively less complicated cases (patients without significant co-morbidity, for example) to be performed in private clinics, without the immediate back-up provided in a comprehensive hospital. By so doing, they can offer quicker access for higher fees, and/or they can perform more procedures in a given period of time than they would be able to do with an entirely publicly-financed case-load. By moving some supply as well as demand to the realm of private finance, then, the provision of a private alternative will simply shift the locus of services to a segment of patients from the public to the private sector. This will not reduce waiting times for publicly-financed services, and raises equity problems in a system based on solidaristic principles. However, if providers who move to the private sector also generate additional demand for their services on a private basis (serving, for example, patients who would not qualify for access to publicly-funded services on the basis of medical need), they would draw supply but not commensurate demand out of the public sector, reducing supply relative to demand in the public sector and thereby increasing waiting times. There is some limited evidence that just such effects have occurred in the UK and elsewhere (Tuohy, Flood and Stabile 2004).

As described above in s.3.1, most provinces have sought either to discourage providers from practising on both a publicly- and a privately-financed basis though measures such as banning private insurance, regulating fees and in some cases requiring that physicians opt fully in to or out of the public system precisely to minimize such negative feed-back effects. These measures have served to constrain dramatically the emergence of a privately-financed sector. But as at least some public authorities seek to purchase services from providers who also compete in private markets, they will need to find ways to integrate public and private finance without incurring negative effects on the public sector. Cautious experimentation along these lines is taking place.

iii) Provider accommodations and networks: Chernichovsky's Emerging Paradigm chafes against a number of features of the provider-state accommodations and the provider networks that lie at the heart of the Canadian system (s.5). The autonomy and clinical discretion of individual institutions and practitioners, within broad budget parameters established by the state, are central to those accommodations. Networks have operated through professional connections and norms, not through explicit contracts for exchange. These are features of health care systems in all advanced nations; but for historical reasons the Canadian system stands out internationally as one in which

these distinctive accommodations and networks have proved to be particularly strong and resilient (Tuohy 1999). Hence the shape of the emerging paradigm in Canada, and the pace at which it emerges, will be mediated by these features of the system.

We observe these influences in a number of ways. As noted above, the strength of provider networks and the high value placed on autonomy have constrained and channelled the development of information systems. As well, the extent to which professional autonomy has been symbolically tied to fee-for-service remuneration has slowed the adoption of other modes of remuneration. (A more concrete and tangible example of the braking effect of attachment to the fee-for-service mode on the adoption of organizational and financial arrangement has occurred in Ontario. There, an unanticipated consequence of the imposition of a global cap on the fee-for-service physician budget in the mid-1990s was that an annually-adjusted fee-for-service "pot" came to be viewed by the professional association as an entitlement in negotiations, limiting the ability of the provincial government to negotiate an expansion of alternative modes of payment.)[16]

iv) Macro-political and fiscal considerations: Health care is unquestionably a flash-point in Canadian politics. The model established in the mid-20th century, by the generous public underwriting of the costs of a traditional system of delivery to which both patients and providers were accustomed, proved popular beyond anything its founders could have foreseen. For the ensuing half-century attachment to this system has formed a key element of the Canadian identity and political psyche (Tuohy 1999:102-3). Politicians of all partisan stripes approach changes to the organizational and financial structure of the systems with great caution. This caution has at least two implications for the emergence of a new paradigm. First, it makes governments unwilling to give up such levers of control as they do exercise. Although it might be argued that the establishment of intermediary OMCC organizations can buffer politicians against political risk, experience across nations suggests that in health care the government of the day cannot escape political responsibility for what is done with public funds. If governments must inevitably "own" these results in a politically charged arena, they are understandably reluctant to give up control. The long history of tension between centralization and decentralization in the British NHS provides a non-Canadian case in point.

Second, the popularity of "the Canadian model" in Canada makes politicians very reluctant to be seen to endorse any move toward the "privatization" of the system. It is a matter of some frustration to policy-makers that contracting between public authorities and private clinics is presented in the media as "privatization," even when no private charges or finance is involved.

As important as these political considerations are the fiscal implications of change. Although the emergence of a new paradigm with a more effective OMCC function may allow public authorities to "spend smarter" and may possibility reduce the rate of escalation of health care costs in the future, experience in Canada and elsewhere suggests that substantial up-front investment is needed to inaugurate such changes. This is even more the case if the scope of coverage is to be increased at the same time, as Quebec found with the introduction of universal pharmacare in the late 1990s

[16] Personal communication, Mark Geiger, March 2007.

and early 2000s. In a context in which health costs are already creating an alarming fiscal squeeze (s.4.2), governments find themselves between a rock and a hard place in deciding whether to make such investments.

5.3 Catalysts of change

Those very fiscal pressures, however, are concentrating the attention of governments across Canada. These governments are also facing the impending demographic pressure of a massive generation beginning to form post-60 age cohort. Although most analysts recognize that aging *per se* will not place catastrophic pressure upon the health care system, the prospect of the aging of the "baby boomers" (the products of the baby boom after the Second World War) has great political salience, and may be creating a context of greater openness toward change in the organization and financing of health care.

Providers may come to be more open to these models, in part as the result of generational and demographic change within the medical profession. With recent increases in enrolments in medical schools and loosening of restrictions on the licensing of more foreign-trained physicians, large cohorts of new entrants (younger, more female, and more likely to have had experience with other systems) are entering practice, with different expectations about terms of employment. Furthermore, by introducing changes in primary care on a voluntary basis, governments are allowing the potential for these new structures to be developed and demonstrated by those who are most positively disposed to having them succeed – a strategy which appears to have borne results in the UK and New Zealand.

Public reaction to these changes remains a great unknown. Opinion polls are notoriously unreliable in this are: reported attitudes toward various organizational and financial options appear to be very susceptible to the phrasing and sequencing of questions; and polls commissioned by sponsors with different stakes in the outcome have had dramatically different results. But public opinion has not driven significant change in Canadian health care policy in the past - rather, it has tended to follow in its wake (Tuohy 1999:113-15).

As in other nations, the Canadian health care system is in a state of flux. The Canadian model is being shaped, as it has been in the past, by the interplay between policy initiatives and the accommodations and networks that form the core system. Its distinctive features are a heavy weight for provider networks as the nexus of decision-making about health care delivery, especially in the physician services and hospital sectors, and a wariness of public finance in those sectors. As a result, Canada's purchaser-provider split is likely to be aligned more closely to a "commissioning" model with a growing emphasis on the monitoring of performance against professionally-determined standards, than to a "contracting" model based on competition among providers. If this model succeeds in meeting demand for health care while satisfying the solidaristic principles on which health policy has been based, it will blunt the emergence of the private alternatives that are increasingly visible on the horizon. That very success, however, will likely require a more comprehensive approach, regulatory as well as fiscal, to the integration of public

and private finance than Canada has been prepared to countenance in the past. In this regard, as in other instances in the past, policy experimentation is occurring in several provinces. The different approaches in the "laboratory" afforded by Canadian federalism bear close watching in the future.

Annex

Table 1
Public Shares of Health Care Finance, by Sector, and Sectoral Shares of Total and Public Health Care Expenditure, 2006 (percentage)

	Public Finance as Share of Sector	Sector Share of Total Expenditure	Sector Share of Public Expenditure
Hospitals	91	30	39
Other Institutions	72	9	10
Physicians	99	13	18
Other Professionals	9	11	1
Drugs	38	17	9
Capital	82	4	5
Public Health	100	6	8
Administration	49	4	3
Other	79	6	7
Total	70	100	100

Source: Estimated 2006 expenditure data, Canadian Institute for Health Information, available at www.cihi.ca.

Table 2
History of Regionalized Structures for Health Care, Canadian Provinces and Territories

Province/ Territory	Current Number of Regional Health Authorities	Basis of Membership of Boards	Date of Establishment	Date and Nature of Re-structuring
British Columbia	5 regional health authorities, 16 health service delivery areas, 1 provincial health service authority	Appointed by Minister	1997	2001: 11 regional health boards, 34 community health councils, and 7 community health service societies replaced with current structure
Alberta	9	Appointed by Minister	1994	2001: moved from fully appointed boards to a system of 2/3 elected and 1/3 appointed boards. 2003: number of regions reduced from 17 to 9; returned to fully appointed boards
Saskatchewan	12 regional health authorities, 1 northern health authority	Appointed by Minister through public nomination process	1992	2001/02: replaced 32 district boards with 12 RHAs; moved from elected to appointed boards
Manitoba	11	Appointed by Minister		2002: 12 RHAs became 11 with the amalgamation of 2 boards

Table 2 (continued)

Province/ Territory	Current Number of Regional Health Authorities	Basis of Membership of Boards	Date of Establishment	Date and Nature of Re-structuring
Ontario	Regionalized budget allocation, not management (14 Local Health Integration Networks)	Appointed by Minister	2006	
Quebec	18 régies régionales de la santé et services sociaux (RRSSSs)	Appointed by provincial government from lists provided by various categories of stakeholder organizations	1989-1992	2001: replaced election with system of government appointments 2003: Regional authorities became planning and allocation bodies; management devolved to 95 new health and social service centres with own governing boards
Nova Scotia	9 district health authorities	Appointed by Minister: 2/3 from lists submitted by community health boards; 1/3 through public nomination process	1996	2001: 4 regional health boards replaced with current structure of 9 district boards
New Brunswick	8 regional health authorities (6 regions have 1 authorities each; 1 region has 2 authorities)	As of May 2004, a combination of election and appointment (8 members of each board elected, 7 appointed)	1993, 1994	2004: shift from fully appointed boards to mix of elected/appointed members

Table 2 (continued)

Province/ Territory	Current Number of Regional Health Authorities	Basis of Membership of Boards	Date of Establishment	Date and Nature of Re-structuring
Prince Edward Island	4 regional health authorities; 1 provincial health services authority	Each board has a majority of members elected by electoral zone, with the balance appointed by the provincial government	1993, 1994	1999: move from fully appointed to elected/appointed boards 2002-03: amalgamation of 2 RHAs; establishment of Provincial Health Services Authority for specialized services
Newfoundland and Labrador	6 institutional health boards; 4 health and community services boards; 2 integrated boards	Appointed by Minister	1994	
Nunavut	Not regionalized			
Northwest Territories	8 health and social services authorities (5 regional, 2 community, 1 territorial)	Appointed by Minister from community-nominated list	1988-1997	2003: 1 of the then 7 boards was split into 2
Yukon	Not regionalized			

Source: Canadian Centre for Regionalization and Health, www.regionalization.org; Canadian Institute for Health Information 2003: 12.

Table 3
Alberta Regional Health Authorities –
Planning and Reporting Functions

Assessment of Regional health needs

- assess, on an ongoing basis, the health needs of the region
- determine priorities in providing health services in the region, and allocate resources accordingly
- ensure that reasonable access to quality health services is provided in and throughout the region
- promote health services in a way that responds to the needs of individuals and communities and supports the integration of services and facilities in the region. Health authorities are required to meet provincial public health targets.

Report on performance

- prepare and submit to the Minister of Health and Wellness a proposal for a health plan for the region; the health plan must contain statements addressing how the regional health authority proposes to carry out its responsibilities, and how it will measure its performance in carrying out those responsibilities
- provide for the establishment of one or more community health councils in each health region
- provide an annual report – including audited financial statements – to the Minister of Health and Wellness, in accordance with the regulations

Accountability

Health authorities are required by law to develop health plans, business plans, capital plans and annual reports. These plans and reports are made available to the public, to ensure health authorities are accountable to Albertans.

The purpose of the Health Plan is to:

- Provide health authorities with a mechanism to set out the long-term direction for effective governance of it's health region
- Communicate with the minister how a health authority has laid out plans that align with the ministry business plan
- Indicate what achievements are planned to meet both the regional health authority's and government's expectations and
- Promote accountability through compliance with legislated requirements.

The purpose of the Business Plan is to:

- Communicate how the health authority expects to achieve the next year's expected results of the 3-year Health Plan, including measures and targets.
- Describe planned tactical and operational approaches and implementations, and
- Indicate how available financial and other resources are to be deployed.

Table 3 (continued)

The purpose of the Capital Plan is to:

- Improve the overall planning and management of the health infrastructure.
- Communicate future capital expenditures needed to effectively maintain or modify the asset base to support service delivery strategies.
- Provide a context for assessing provincial capital project priorities as the basis for annual decision on project approvals.
- Provide a preliminary estimate of the operating cost implications of proposed capital investment.

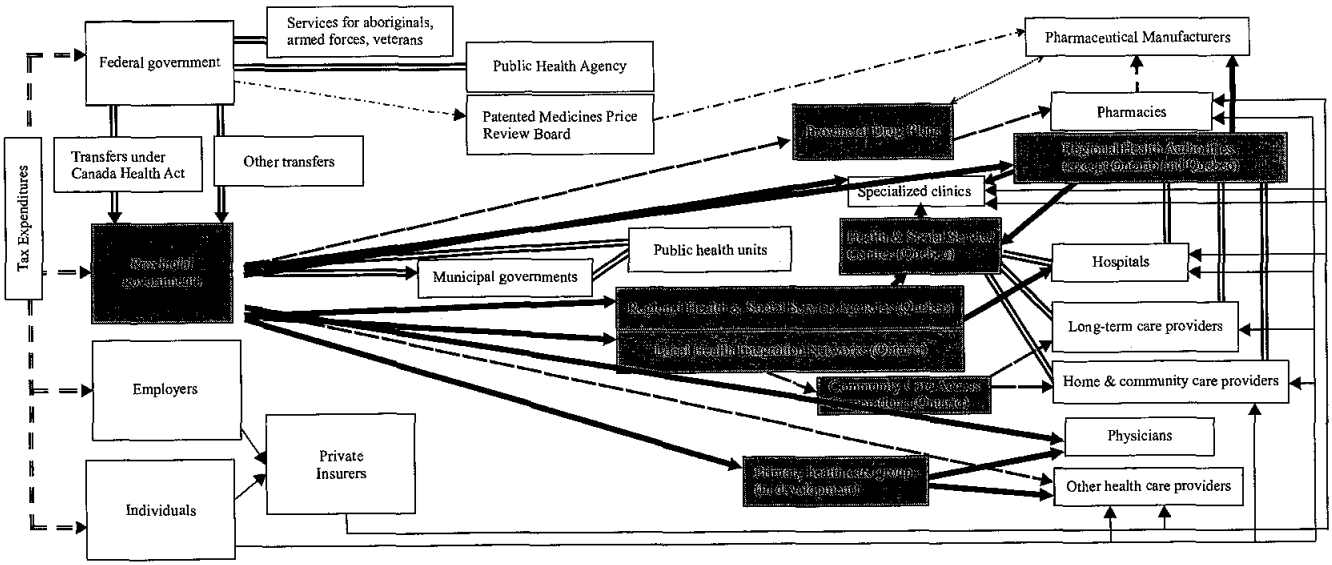
The purpose of the Annual Report is to:

- Be a key public accountability document for reporting how the health authority has discharged its legislated responsibilities and any other responsibilities delegated by the Minister,
- Provide a means for highlighting the health authority's accomplishments, progress and results achieved over the year, including explanation for any significant variation between actual results and those expectations planned in the 3-year Health Plan, and to
- Be a vehicle for communication to residents of the region and people of Alberta.

Health and business plans state a health authority's responsibilities, the results to be achieved and how progress will be measured. Progress is reported in quarterly reports and in the annual report.

Source: Alberta Health and Wellness.

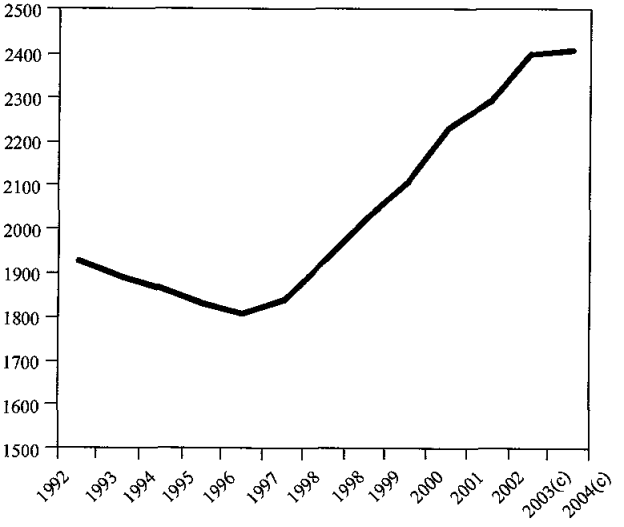
Figure 1
Health Care in Canada: Organization and Finance



LEGEND

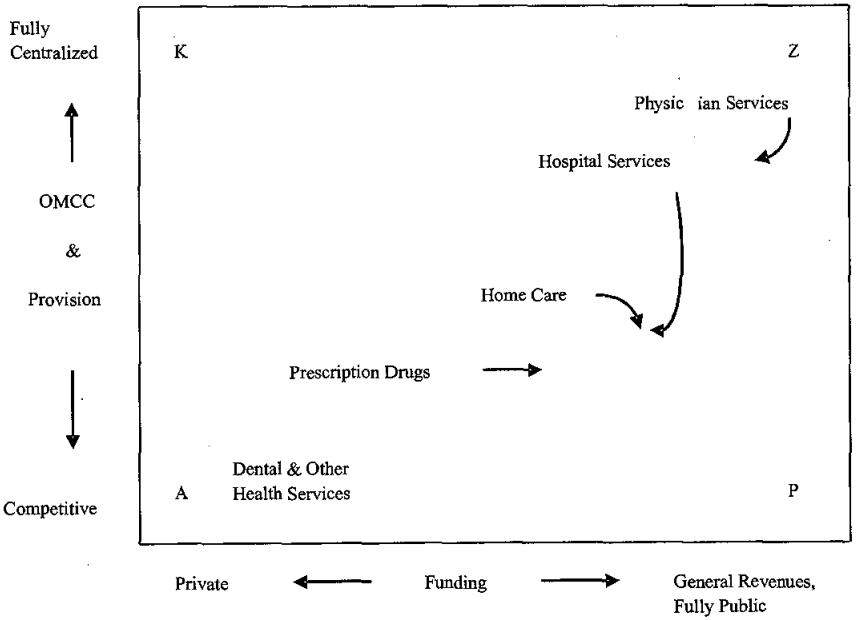
Intergovernmental transfers	Budget allocation & payment-single payer programs
Direct Provision	Budget allocation & payment-non-single payer programs
Price Regulation	Private expenditure
Tax expenditure	Negotiation

Figure 2
Per Capita Public Health Care Spending, Canada
1992-2004, (Constant 1997$)



Source: Calculated from Canadian Institute for Health Information, National Health Expenditures 1975-2004, adjusted by CPI.

Figure 3
Canada's Position on Chernichovsky's EP Map



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