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## Canada and U.S. Approaches to Health Care - Canadian Speaker

Jon R. Johnson

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## CANADIAN SPEAKER

*Jon R. Johnson<sup>†</sup>*

Dan, thank you very much. Doctor King, I'd like to thank you for inviting me to speak on this particular topic. It is a very important topic. I think the particular interest in this topic is because the approaches in Canada and the U.S. to health care are really so different. So anyway, thank you very much for having me.

I am going to break my talk into three parts. In the first part, I will spend some time talking about similarities and differences in the Canadian-U.S. political, regulatory, and legal systems, insofar as they relate to health care.

In the second part I will explain as best I can how the Canadian health care system works. I will conclude by talking about positive aspects of the Canadian system, and some of its problems.

I think there are more differences than similarities insofar as health care is concerned. The one similarity is that both countries are federal systems.

But I think there are significant differences in our constitutional approach, certain aspects of our legal system, certainly in our politics, and in our approach to the value of equality, which lies at the heart of the Canadian health care system.

Both Canada and the United States have a federal system, and the result of that is there is a bifurcated responsibility for health care. However, in Canada, we have one province, Quebec, that aspires, at least in some quarters, to be independent and acts, in many respects, like it is independent. We

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<sup>†</sup> Jon Johnson has been a partner at Goodmans since 1982. He focuses on trade and international trade law. In 1989, he assisted in the \$300 million sale of assets of Catelli Inc. by John Labatt Limited to Borden, General Foods and Campbell Soup. Jon has been counsel to the Canadian government on a variety of matters, including border issues, rules of origin, expropriation and dumping issues under NAFTA. He continues to advise the government, various industry associations and clients in both the public and private sectors on matters involving international trade arising under NAFTA and the Agreement Establishing the World Trade Organization (WTO). Since the replacement of the GATT by the WTO, Jon's work has increasingly involved advising clients on WTO and NAFTA requirements. He was first appointed Vice-Consul of Iceland in Toronto in 1971 and since 1983, he has served as the Consul of Iceland in Toronto. His work has appeared in the C.D. Howe Institute Commentary, in publications of the Fraser Institute in Vancouver and the committee on Canadian law of the International Law and Practice Section of the American Bar Association. He has a both a B.A. in Political Science and Economics and an LL.B. from the University of Toronto, and an LL.M. from Osgoode Hall.

have another province, Ontario, which has a third of the population of Canada. That would be like having a single state with 100 million people in it. We have a third province, Alberta that has 90% of our oil and gas resources, and has no debt, and basically has a financial clout to do pretty much what it likes. Then we have British Columbia sitting off there on the west coast, separated by a range of mountains, that thinks of itself as being more allied with Oregon, Washington, and California, in many respects, than it does with the rest of Canada. So there are differences in the make up of federal systems between Canada and the United States.

Now, in the federal system in Canada, under our constitution, we have listed powers for both the federal and the provincial governments<sup>1</sup>. Hospitals and other such institutions and asylums are clearly under exclusive provincial control<sup>2</sup>. The federal government has responsibility for certain specific aspects of health care, but the main involvement of the federal government is through its power to spend. The way that the spending power works is that the federal government can say to a province that if the province establishes a program that fulfills certain criteria, the federal government will pay for a portion of the program costs.<sup>3</sup> That is called the "spending power," and that has been regarded as being a legitimate use of federal power, although objected to strongly by provinces from time to time. So what you have is, in terms of the split in jurisdiction between the provinces and the federal government, is that provinces have the direct and immediate responsibility for health care, and the federal government provides funding (not all the funding by any means) and sets criteria upon which the provision of funding is conditional.

Now, there are certain constitutional differences between Canada and the United States that affect the approach to health care. The U.S. Constitution has specific provisions that protect due process and property rights<sup>4</sup>. Those aspects of the U.S. Constitution have restrained U.S. Government from making sweeping intrusions into areas where the private sector is active. In Can-

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<sup>1</sup> See Constitution Act, 1867, 30 & 31 Vict. Ch. 3 (U.K.), as reprinted in R.S.C., (1985), §§ 91-92 (listing the powers of the Parliament and the provincial governments, respectively).

<sup>2</sup> See *id.* § 92(7) (saying that the provincial governments have exclusive power to make laws in relation to: "The Establishment, Maintenance, and Management of Hospitals, Asylums, Charities, and Eleemosynary Institutions in and for the Province, other than Marine Hospitals"); see also: Roy J. Romanow, Q.C., Building on Values: The Future of Health Care in Canada - Final Report 3-4 (Commission on the Future of Health Care in Canada 2002) [hereinafter the "Romanow Report"] (discussing the constitutional responsibility for health care. On page 3, the author states: "it is now well accepted that the provinces have primary jurisdiction over the organization and delivery of health care services in Canada. In contrast, Yukon, Nunavut and the Northwest territories do not have formal constitutional responsibilities over health care, although they have assumed these responsibilities in recent years").

<sup>3</sup> See Romanow Report, *supra* note 2, at 4 (discussing federal spending power).

<sup>4</sup> U.S. Const., amends. V, XIV, § 1.

ada, at the time the health care system as we know it now was created, we did not have any constitutionally entrenched rights at all. The federal government and the provinces really had no difficulty in making a massive expansion into an area that was serviced at that time by private insurers. The situation, constitutionally, is still that way in Canada. We now have entrenched various individual rights,<sup>5</sup> but we still do not have entrenched property rights. That is one significant constitutional difference between Canada and the United States that impacts on the organization of the health care systems in each country.

As far as the Canadian and U.S. legal systems are concerned, one big difference that does impact health care is that there are massive tort awards in the U.S. for malpractice. We do not have those in Canada. We have, of course, malpractice actions, and we have awards, but massive awards are not part of the legal landscape and are not a cost driver in Canada anywhere near to the extent that you have in the United States. Private insurance for doctors for malpractice costs a fraction in Canada of what it does in the United States. And I think that that does impact on the systems. If we had massive tort awards like in the United States, the Canadian public sector might be a little less enthusiastic about being so involved in the system.

Now, the next area is political. I think, as we all know, the political center in Canada is far to the left of the United States, and left wing parties – and I am referring specifically to the New Democratic Party, or NDP, and its predecessor, the Commonwealth Cooperative Federation, or CCF– have had substantial success at the provincial level. One might consider the NDP, and its predecessor, the CCF, as the “natural governing party” in the Province of Saskatchewan. Manitoba has an NDP Government at present and has had at least two other NDP governments in the past. British Columbia had NDP governments in the 1970s and also in the 1990s. Even Ontario had an NDP Government from 1990 to 1995. So the organized political left, to which there is no U.S. equivalent, has had substantial success at the provincial level. Regardless of political affiliation, most Canadians take massive government involvement in health care for granted.

Equality is obviously a value in both Canadian and U.S. political life, but it manifests itself in different ways. The U.S. is said to emphasize equality of opportunity, while Canadians place more emphasis on equality of outcome. In Canada, we have all kinds of inequality like you do in the United States, but in Canada there are some aspects of Canadian life where equality becomes a value that eclipses all others (such as liberty, freedom of choice), and this is no more evident than with health care. The Canadian health care system is driven by an ideology of equality.

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<sup>5</sup> See Charter of Human Rights and Freedoms, Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 ch. 11 (U.K.), as reprinted in R.S.Q., ch. C-12 §§ 1-34.

Now I am going to speak briefly about how the Canadian system works. Health care, both as a service or a product, has economics that are different from other services or products. The need for health care is based largely on fortuitous events such as disease or accident. Demand is often infrequent and unexpected. One may go for years without having a health care need, and then one might have massive need. So health care lends itself to coverage by insurance. Under insurance principles, the greater the risk, the higher the premium, so health insurance becomes least affordable to those most at risk. There are real equity problems with pure insurance principles.

There are probably any number of different types of health care systems, but I will identify three for purposes of this speech. There are what might be called “social, welfare-based systems;” “social, insurance-based systems;” and “private insurance systems.”<sup>6</sup> With “social, welfare-based systems,” access to health care is viewed as a right, and financed through the tax system. Benefits received are not based on payments made by people, like premiums. The Canadian health care system is such a system, as are the systems in the United Kingdom, Sweden, and Australia.<sup>7</sup>

Under “social, insurance-based systems,” access to health care is based on payment of insurance premiums. In these systems, insurance is, by one means or another, compulsory, and the insurers are both profit and nonprofit, private sector, and public. And there are quite a few examples of these types of systems: Germany, France and Belgium,<sup>8</sup> as well as Switzerland.<sup>9</sup>

Now, in the third type of system, the “private insurance systems,” insurance is provided through employers, or self-purchased. The insurance is not compulsory, so people can be covered to the extent they see fit. Such systems provide for public coverage of certain groups like elderly or indigent, and that roughly describes the U.S. system.<sup>10</sup>

Now, in terms of public versus private spending, the following table lists a number of countries with each type of system that I have just described.

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<sup>6</sup> PHILIPPE CYRENE, *PRIVATE HEALTH CARE IN THE OECD: A CANADIAN PERSPECTIVE*, 10 (University of Toronto Press 2002).

<sup>7</sup> *See id.*

<sup>8</sup> *See id.*

<sup>9</sup> *See* Kelly Grimes et al., *Challenging Health Care System Sustainability: Understanding Health System Performance in Leading Countries 11-24* (Conference Board of Canada 2004) [hereinafter *Conference Board Study*] (describing the Swiss system; while Philippe Cyrene does not identify the Swiss system as a social insurance-based system, Cyrene believes that is the best description for it. The private sector component in the Swiss system is larger than in other social insurance-based systems, but all Swiss residents are guaranteed basic health insurance coverage (CYRENE, *supra* note 6)).

<sup>10</sup> *See* Michael J.L. Kirby, *The Health of Canadians – The Federal Role, Interim Report. Volume Three: Health Care Systems in Other Countries 45-51* (The Standing Senate Committee on Social Affairs, Science and Technology 2002) [hereinafter the “Kirby Report”].

PUBLIC VERSUS PRIVATE<sup>11</sup>

	Public	Private
Canada	71%	29%
U.K.	84%	16%
Sweden	85%	15%
Australia	70%	30%
Switzerland	43%	57%
Germany	75%	25%
France	76%	24%
United States	45%	55%

The first four countries *listed*, namely Canada, U.K., Sweden, and Australia, have “social, welfare-based systems.” The level of private spending in Canada is certainly not the highest, and is in line with Australia. The next three countries on the slide are Switzerland, Germany, and France, which have “social, insurance-based systems.” The public component for Switzerland, at 43%, is below Canada’s, but the public component for each of Germany and France is substantially higher than Canada. The seventh country, the United States, has a “private insurance system.” With 45% of U.S. health care expenditures being public, there is certainly a great deal of public spending in the U.S. system. So, all of the systems have a large public sector component.

Up until the late 1940s, the Canadian health care system was based on private medicine and private insurance, and access to health care was based on the ability to pay. In 1947, the Government of Saskatchewan introduced a public universal plan for hospital services. This deserves a little elaboration. Saskatchewan had a CCF Government at the time under one Tommy Douglas, who became premier in 1944. Tommy Douglas was recently chosen as Canada’s greatest Canadian by the Canadian Broadcasting Corporation, and he is often said to be the father of Medicare in Canada. Just to give you a flavour of what sort of person Tommy Douglas was, I would like to read a speech of his, called “Mouseland,”<sup>12</sup> that was a very successful speech for getting votes in rural Saskatchewan, which he needed to become premier.<sup>13</sup>

<sup>11</sup> See generally Conference Board Study, *supra* note 9, at 3 (reporting in Table 1 that Canada is 70% public); see also Romanow Report, *supra* note 2, at 24 (giving the 71% figure for Canada in Figure 1.17); see also Kirby Report, *supra* note 10, at Appendix B (giving the U.S. figures).

<sup>12</sup> New Democrats, *The Story of Mouseland*, <http://www.saskndp.com/history/mouseland.html> (last visited Nov. 12, 2005).

<sup>13</sup> It is interesting he would say “Mouseland” in view of elephant and mice metaphors in reference to our trading relationship with the United States.

“It’s the story of a place called ‘Mouseland.’ Mouseland was a place where all little mice lived and played, were born and died. And they lived much the same as you and I. They even had a Parliament. And every four years they had an election. They used to walk to the polls and cast their ballots. Some of them even got a ride to the polls. And got a ride for the next four years too. Just like you and me. And every time on election day all the little mice used to go to the ballot box, and they used to elect a government. A government made up of big, fat, black cats.

Now, if you think it strange that mice should elect a government made up of cats, you just look at the history of Canada for the last 90 years, and maybe you’ll see they weren’t any stupider than we are.

Now, I’m not saying anything against the cats. They were nice fellows. They conducted their government with dignity. They passed good laws – that is, laws that were good for cats. But the laws that were good for cats weren’t very good for mice. One of the laws said that mouseholes had to be big enough so a cat could get his paw in. Another law said that mice could only travel at certain speeds – so that a cat could get his breakfast without too much effort.

All the laws were good laws. For cats, but, oh, they were hard on the mice. And life was getting harder and harder. And when the mice couldn’t put up with it any more, they decided something had to be done about it. So they went en masse to the polls. They voted the black cats out. And they put in the white cats.

Now, the white cats had put up a terrific campaign. They said: ‘All that Mouseland needs is more vision.’ They said: ‘The trouble with Mouseland is those round mouseholes we’ve got. If you put us in, we will establish square mouseholes.’ And they did. And the square mouseholes were twice as big as the round mouseholes, and now the cat could get both his paws in. And life was tougher than ever.

And when they couldn’t take that any more, they voted the white cats out and put the black ones back in again. And then they went back to the white cats. And then to the black cats. And they even tried half black and half white cats. And they called that a coalition. They even got one government made up of cats with spots on them: they were the cats that tried to make a noise like a mouse but ate like a cat.

You see, my friends, the trouble wasn’t with the colour of the cat. The trouble was that they were cats. And because they were cats, they naturally looked after cats instead of mice.

Presently, there came along one little mouse who had an idea. My friends, watch out for the little fellow with the idea. And he said to the other mice, 'Look, fellows, why do we keep electing a government made up of cats? Why don't we elect a government made up of mice?' 'Oh,' they said, 'He's a Bolshevik. Lock him up.' So they put him in jail.

But I want to remind you, that you can lock up a mouse or a man, but you can't lock up an idea."

Well, Tommy Douglas had an idea, and that idea was Medicare. In 1957, the federal government followed suit through a shared-cost program and provided funding for provincially administered hospital insurance.<sup>14</sup> In 1962, Saskatchewan, leading the way again, extended public health insurance to cover physician services. The doctors resisted initially, but ultimately the doctors caved in, so Saskatchewan was the first province with Medicare.

In 1966, federal government enacted the Medicare Act,<sup>15</sup> under which the federal government would cover one half of the cost of eligible provincial plans covering physician services.<sup>16</sup> By 1972, all provinces, some quite reluctantly, like Ontario, had adopted such plans.<sup>17</sup> In 1984, the federal government passed the Canada Health Act,<sup>18</sup> and the Canada Health Act is the existing model template within which the Canadian health care system operates.

The Canada Health Act establishes the template, but the plans are administered by the ten provinces, and also by three territories.<sup>19</sup> The result is thirteen different systems based on the same model. The provincial incentive to comply with the template mandated by the Canada Health Act is a potential federal loss of funding for failing to comply.

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<sup>14</sup> Romanow Report, *supra* note 2, at 4 (referring to the Hospital Insurance and Diagnostic Services Act, S.C., ch. 28 (1957)). Shared cost programs have been quite common in Canada, with the federal government promising to share the costs of a program that the federal government does not have the authority to implement, provided that certain criteria are satisfied. Shared cost programs have been a constant source of friction between the federal and provincial governments.

<sup>15</sup> *Id.*

<sup>16</sup> *Id.* at 22.

<sup>17</sup> *Id.* at 4; see also STEVE PAIKIN, PUBLIC TRIUMPH AND PRIVATE TRAGEDY: THE DOUBLE LIFE OF JOHN ROBARTS 82-86 (Penguin Group 2005) (regarding Ontario, John Robarts was the Progressive Conservative Premier of Ontario from 1961 to 1971. Robarts opposed Medicare for a number of reasons, not the least of which was he considered that the federal government was usurping an effective provincial plan. He ultimately gave in because the federal sharing of 50% of the costs could not be passed up. Robarts was also concerned about costs. As Paikin states on page 85, Robarts ominously told Ontario legislators, "This is the end of controlling the costs of health care in Canada.' (Three and a half decades later, his prescience is all too apparent)").

<sup>18</sup> Canada Health Act, R.S., ch. C-6 (1985); see also Romanow Report, *supra* note 2, at 4.

<sup>19</sup> The three territories are Nunavut, the Northwest Territories, and the Yukon.



When we are talking about compliance, we are really talking about eligibility to get funding. The provincial plan must do two things: It must cover "insured services,"<sup>20</sup> and the coverage for the "insured services" must comply with the five principles of the Canada Health Act.<sup>21</sup> Otherwise federal funding will not be provided.

Now, the "insured services," the services that must be covered, include hospital services, which are medically necessary services provided by a hospital both to inpatients and to outpatients, and include hospital facilities and drugs used in the hospitals. The "insured services" must also include "physician services." These are medically required services rendered by medical practitioners. The third category of "insured services" that must be covered is "surgical-dental services." These are medically dentally required services that are performed in a hospital. While "insured services" cover many medical procedures, there are clearly a lot of medical services that are not covered.

There are a number of services that are not included in the Canada Health Act and that do not have to be included in the provincial plans. Dentistry outside of hospitals, which is a big item, does not have to be covered. Drugs outside hospitals are not covered. A third category that is not covered is home care. A fourth category that is not covered is cosmetic surgery and various other procedures that aren't medically necessary.

There is a lot of wiggle room in "medically necessary," and what is considered "medically necessary" varies from province to province. Some procedures that one might think are medically necessary are not treated as such. Tests for Prostate-Specific Antigen (PSA) in Ontario, are not covered, and are paid for directly by the patient. That's the test for prostate cancer. So there is a fair bit of variation within those parameters, but essentially what the insured services cover are what might be called "core medical benefits."

We have the concept under the Canada Health Act of "insured services." Now, in providing "insured services" under the plan, each province must comply with the five principles mandated by the Canada Health Act.<sup>22</sup> These are: (1) public administration, which means that the plan has to be administered on a nonprofit basis by a public authority;<sup>23</sup> (2) portability, which means that one is able to move from one province to another and still be covered, subject to a short waiting period;<sup>24</sup> (3) universality, which means that

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<sup>20</sup> Canada Health Act, *supra*, note 18, § 2 (defining "insured services," "hospital services," "physician services," and "surgical-dental services," each of which is described below.).

<sup>21</sup> *Id.* at §§ 7-12. The five principles of the Canada Health Act are set out in Section 7 and elaborated upon in Sections 8 through 12.

<sup>22</sup> Canada Health Act, *supra*, note 18, § 7.

<sup>23</sup> *Id.* § 8.

<sup>24</sup> *Id.* § 9.

100% of the residents of a province have to be covered;<sup>25</sup> (4) comprehensiveness, which means that the plan has to cover the legislatively mandated “insured services,”<sup>26</sup> which are not in fact “comprehensive” but are fairly extensive; and (5) accessibility, which means that the services covered by the plan must be free, and payment for them to providers comes from the plan in accordance with the tariff to providers.<sup>27</sup>

Canada is not unique in having a social welfare-based system. Certainly, other countries do, but there are two aspects of the Canadian health care system that are unique. The first is a result of the first principle of public administration. The result of the application of this principal is a single-payer system in each province. Private insurers are wholly excluded from being able to provide insurance coverage for “insured services” as defined in the Canada Health Act.<sup>28</sup> This aspect of the Canadian system is unique because all the other systems have some role for the private insurers on a broad range of services.<sup>29</sup>

Now, the second unique aspect of the Canadian system flows from the principle of accessibility, which has been interpreted as requiring that “insured services” must be provided free of charge. Doctors are not allowed to extra bill, and co-payments and user fees are prohibited.<sup>30</sup> Co-payments exist in virtually all the other systems. Sweden, for example, has a co-payment. It is not very high and there is a cap of about \$CDN 155 each year.<sup>31</sup> All the other systems have co-payments, but the Canadian system does not.<sup>32</sup> A patient is prohibited from going directly to a doctor and paying for an “insured service” privately outside the system.

Now, let us turn to services not covered by the Canada Health Act that do not have to be covered by provincial plans. There are a variety of approaches.

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<sup>25</sup> *Id.* § 10.

<sup>26</sup> *Id.* § 11.

<sup>27</sup> *Id.* § 12.

<sup>28</sup> The legislation in some of the provinces, such as Alberta and Ontario, expressly exclude private insurers. In the other provinces, private insurers are effectively excluded.

<sup>29</sup> See the review of the systems in other countries in: The Conference Board Study, *supra* note 9 (Switzerland, Sweden, Spain, France, Australia and new Zealand); the Kirby Report, *supra* note 10 (Australia, Germany, The Netherlands, Sweden, United Kingdom and the United States); and CYRENE, *supra* note 6 (United Kingdom, France, Germany, Belgium, Sweden and Australia).

<sup>30</sup> Canada Health Act, *supra*, note 18, §§ 18 (extra-billing), 19 (user charges). Extra billing is the practice of doctors billing patients amounts for procedures over and above what the provincial plan will pay for or reimburse. The Romanow Report, *supra* note 2, at 28, supports the ban on user fees and co-payments as the “right decision”.

<sup>31</sup> Conference Board Study, *supra* note 9, at 27. There is some variation in this figure, depending on the report that one reads, due mainly to the exchange rate that is used.

<sup>32</sup> See the reviews of the various systems referred to above in footnote 29.

Dental services performed outside hospitals are not insured and are not a covered service.<sup>33</sup> Ninety-four percent of the cost of dental services is paid by private insurance and direct payment.<sup>34</sup> There are no current recommendations to expand that system.<sup>35</sup> So dental services are out of the public system.

With vision, 91% is paid for by private insurance and direct payment,<sup>36</sup> and there are no current recommendations to expand the public coverage.<sup>37</sup> With eye exams, the public system in Ontario paid for an eye exam every two years, but ceased doing this a few years ago. I get an eye exam every year because my father and my grandfather both had glaucoma. My doctor takes great delight in telling me that if I do not have glaucoma, I pay \$75, but if I have glaucoma, the eye exam is for free.

Drugs outside hospitals are not covered by the Canada Health Act.<sup>38</sup> There is a whole range of provincial plans that vary from province to province, so payment for drugs outside hospitals is a mix of public funding and private insurance plans, as well as direct payment.<sup>39</sup> In 1999, the breakdown was: direct payment (cash for drugs over the counter) 22%; private insurance plans 34%; and public insurance plans 44%.<sup>40</sup> So there is a large public component in the payment for non-hospital drugs, and the public insurance plans are established by the provinces. There is a current recommendation by the Commission on the Future of Health Care in Canada (known as the Romanow Commission, after the Commissioner, Mr. Romanow, who was the former premier of Saskatchewan) to expand the Canada Health Act to cover catastrophic drugs.<sup>41</sup> Drug prices are controlled in Canada.<sup>42</sup> However, I will not be dealing with that because you will deal with that in a later session with trade and pharmaceutical products.

So far as home care and other noncovered services are concerned, there is a variety of provincial programs, some private insurance, and some direct payment. For example, with home care, the private sector is responsible for paying 23% of costs, the provincial government 76%, and the federal gov-

<sup>33</sup> Canada Health Act, *supra*, note 18, § 2.

<sup>34</sup> Romanow Report, *supra* note 2, at Table 1.2.

<sup>35</sup> By "current recommendations," I mean the recommendations set out in the Romanow Report, *supra* note 2 and the Kirby Report, *supra* note 10.

<sup>36</sup> Romanow Report, *supra* note 2, at Table 1.2.

<sup>37</sup> The "current recommendations" to which I am referring are those in the Romanow Report, *supra* note 2 and the Kirby Report, *supra* note 10.

<sup>38</sup> See Canada Health Act, *supra*, note 18, § 2. The definition of "hospital services" included in the definition of "insured services" includes only "drugs, biologicals and related preparations when administered in a hospital".

<sup>39</sup> Romanow Report, *supra* note 2, at 195.

<sup>40</sup> *Id.*

<sup>41</sup> Romanow Report, *supra* note 2, at 197, 252. See Recommendation 36. Mr. Romanow's party was the NDP party, the successor party to the party of Tommy Douglas.

<sup>42</sup> Through the Patented Medicines Prices Review Board.

ernment 1%,<sup>43</sup> and there is a current recommendation to bring certain aspects of home care in under the Canada Health Act as insured services.<sup>44</sup>

Okay. How is all this financed? There are two approaches to funding a public system. One way is through compulsory insurance premiums or subsidized insurance, and the other is through general taxation. Being a social welfare type system, Canada funds through general taxation.<sup>45</sup> Most of the funding is through general tax revenues. Some provinces, like Ontario, have targeted health taxes. These are not a premiums, but rather taxes targeted to a specific purpose attached to it. These payments are not premiums because the health services that a person receives are not linked to that person paying the health tax.

The breakdown for funding of health care costs in Canada is set out in the following table:

TOTAL HEALTH CARE EXPENDITURES BY SOURCE (1999)<sup>46</sup>

Source	Amount	Percentage
Taxation	\$63.4 billion	71%
Out-of-pocket	\$14.2 billion	16%
Private Insurance	\$9.8 billion	11%
Other (donations, hospital investment and other income)	\$2.1 billion	2%

I was a little surprised the private insurance was lower than the out-of-pocket.<sup>47</sup> This leaves about 2%, which comes from donations to hospitals, hospital investment, and other income (such as from hospitals running ancillary services like cafeterias, shops, that sort of thing).

Now, let us turn to the federal-provincial split. Again, the provinces administer the plans, and the plans are financed through provincial taxation (income tax, or share of income tax and sales taxes, various other taxes), and

<sup>43</sup> Romanow Report, *supra* note 2, at 174 fig.8.

<sup>44</sup> See recommendation 34 of the Romanow Report. *Id.* at 176.

<sup>45</sup> CYRENE, *supra* note 6, at 10.

<sup>46</sup> Romanow Report, *supra* note 2, at 24 fig.1.17.

<sup>47</sup> *Id.* The Romanow Report observes that only Japan and Australia have higher levels of out-of-pocket expenditures than Canada. The Report observes that Canadians pay relatively high co-payments and deductibles for services outside the Canada Health Act, which results in Canada having a higher percentage of out-of-pocket payments than other countries. *Id.* at 26.

from transfers from the federal government.<sup>48</sup> Now, as far as federal transfers are concerned, when the Medicare system was originally established, the federal government paid about 50% of the actual cost of the services.<sup>49</sup> The federal government, over time, found that this approach was administratively difficult, and also, they had no control over the amount of spending there would be. As a result, the federal government switched over to various block-funding systems, where basically the payments would not be linked directly with the expenditures made by the provinces. Rather, the federal government would give a block of money to the province, and there were various formulae over the years for calculating the block grants. From 1977 to 1995, the block funding transfer from the federal government to each province covered post-secondary education as well as hospital and medical services.<sup>50</sup> From 1995 to 2004, there was another format referred to as the Canada Health and Social Transfer, where the block covered a larger set of items, namely health care, post secondary education, and social assistance.<sup>51</sup> This has been changed as a result of the recommendations of the Romanow Commission. There is now a transfer for health called the Canada Health Transfer, which is targeted for health.<sup>52</sup> There is a further Health Reform Transfer which is to provide additional funding for primary care, home care, and catastrophic drug coverage.<sup>53</sup> There is a goal under the Romanow Commission for recommendations to make the federal share 25%,<sup>54</sup> and the social transfer has been separated out.<sup>55</sup>

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<sup>48</sup> *Id.* at 35-40 (discussing the various forms that federal transfers have taken).

<sup>49</sup> *See id.* at 35-36.

<sup>50</sup> These were called Established Programs Financing (EPF). *See generally id.* at 37-38 (describing the EPF regime).

<sup>51</sup> *See generally id.* at 38-39 for a description of the Canada Health and Social Transfer (CHST) regime.

<sup>52</sup> *See* recommendation 6 of the Romanow Report that is now in effect. *Id.* at 65 ("To provide adequate funding, a new dedicated cash-only Canada Health Transfer should be established by the federal government. To provide long-term stability and predictability, the Canada Health Transfer should include an escalator that is set in advance for five year period.").

<sup>53</sup> *See* recommendation 7 of the Romanow Report, which recommended a new Rural and Remote Access Fund, a new Diagnostic Services Fund, a Primary Health Care Transfer, a Home Care Transfer and a Catastrophic Drug Transfer. *Id.*; *see also id.* at 71-72 (describing the reforms recommended).

<sup>54</sup> *Id.* at 67.

<sup>55</sup> The Canada Health and Social Transfer (CHST) was a block transfer that could be used for a variety of social purposes. *See supra* text accompanying note 52. As a result of the implementation of the recommendations of the Romanow Commission, there is now (since 2004) a Canada Health Transfer and a Health Reform Transfer, and a separate block transfer called the Canada Social Transfer that is to be used for post-secondary education and social assistance. *See* Canadian Social Research Links, <http://www.canadiansocialresearch.net/cap.htm> (last visited Nov. 11, 2005).

Federal transfers can take the form of the federal government writing a cheque to each province. They can also take the form of the transfer of “tax points.” Both the federal government and the provincial governments have the power to collect income tax. Some of the provinces let the federal government collect the income tax and then take a portion. Other provinces, like Quebec, collect their own income tax. Providing funding through tax points simply means that the federal government lowers its tax rates so that the provinces can move in and receive a larger portion, or, for those that collect their own income tax, raise their rates.

Now, the federal share, if you take cash transfers only, has gone from about 47% in the late ‘70s, to hit a low of below 15% in ‘98-99.<sup>56</sup> It has come up somewhat since then, and there is the Romanow goal of 25%. And then if you take cash and tax points together, the percentages are higher, but the provinces take issue with those percentages.<sup>57</sup> There are also equalization payments, which I will not get into.<sup>58</sup>

There is a real ideological component with the role of the private sector in the Canadian health care system, which is basically rooted in the principle of equality. The specter of a two-tier health care is a real political issue in Canada. Two-tier health care means that rich people go to a private well-funded system that is better, and then everybody else goes to an inferior system that isn’t well funded and is worse.

As far as the private sector involvement is concerned, private insurers, they are wholly excluded from the insured services sector, but for non-covered services, they are fairly active.<sup>59</sup> Most hospitals are not government owned, but most are not for profit, and most are publicly funded.<sup>60</sup>

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<sup>56</sup> Romanow Report, *supra* note 2, at 66. The figures quoted are a high of “close to 47%” in 1976/77 to a “low of 14.6% in 1998/99.” *Id.*

<sup>57</sup> Transfers through tax points is simply a transfer of funds from the federal government to the provincial governments through the federal government taking a smaller share of the income tax pie and the provinces taking a larger share. The larger share taken by the provinces need not go to health care but, rather, can be spent on any provincial program. Hence, it is debatable whether the federal government increases its percentage of health funding through the transfer of tax points. *See id.* at 37-38.

<sup>58</sup> Equalization payments grew out of the concept developed after the Second World War that each province should have the financial wherewithal to provide a minimum standard of services. As the economic condition of the provinces varies considerably, some provinces are in a much better position than others to raise revenues for services. The concept developed that there are “have” provinces and “have-not” provinces. Equalization payments are effected by the federal government so that money is transferred from “have” to “have-not” provinces so that “have-not” provinces can adequately fund services. *See generally* Murray G. Brown; *Rationing Health Care in Canada*, 2 ANNALS HEALTH L. 101, 102-05 (1993) (discussing equalization payments and how they “augment provincial general revenues”). Needless to say, equalization payments have from time to time been the source of great political tension.

<sup>59</sup> Private insurers provide dental plans, supplemental coverage plans (that include coverage not included in the public system such as semi-private or private hospital rooms) and drug

As far as delivery of services is concerned, most physicians are independent contractors operating on a fee-for-service basis. Fees are fixed by negotiations of tariffs with medical associations and provincial governments, and there is no extra billing.<sup>61</sup> There is a real concern as far as private clinics are concerned. There is no inconsistency between the concept of a for profit clinic and the principles of the Canada Health Act,<sup>62</sup> but there is considerable resistance to expansion of for profit clinics, certainly in some provinces like Ontario, although they are becoming more common in provinces like Quebec.<sup>63</sup> The private sector is active in delivering diagnostic services, and the private sector is somewhat active here.

The Canadian health care system is briefly summarized in the following table:

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plans. See Raisa B. Deber, *Canadian Medicare: Can it Work in the United States? Will it Survive in Canada?*, 19 AM. J.L. & MED. 75, 79 (1993).

<sup>60</sup> Many hospitals are "owned" by charitable organizations. However, practically all the funding comes from the provincial government. A small portion comes from donations and also from profit centres in hospitals such as cafeterias and shops. See Christopher P. Manfredi & Antonia Maioni, *Courts and Health Policy: Judicial Policy Making and Publicly Funded Health Care in Canada*, 27 J. HEALTH POL. POL'Y & L. 213, 223-24 (2002).

<sup>61</sup> As noted earlier, extra billing is billing the patient over and above the amount fixed by the tariff, which is the amount paid for by the provincial government. See Michael Roth, *Universal Health Care: Concerns for American Physicians, Using the Canadian Experience as a Model*, 4 IND. INT'L & COMP. L. REV. 415, 426-27 (1994). Extra billing is prohibited by Section 18 of the Canada Health Act. Canada Health Act, *supra*, note 18, § 18. If a province permits extra-billing, the conditions prescribed by the Canada Health Act will be breached, with effects on funding. See Roth, *supra*, at 427-28.

<sup>62</sup> What I mean by this is that the emphasis of the Canada Health Act is on access to medical services and the fact that all medically necessary services be paid for out of public funds. The Act does not contain any requirements as to how or by whom the services are delivered. A province may contract with a for-profit clinic to provide "insured services" to patients. The Canada Health Act is not violated so long as the patients do not have to pay for those services. However, if patients are free to contract with the clinic and pay the clinic directly or through private insurance plans for "insured services," the Canada Health Act is violated.

<sup>63</sup> Private payment for health care services is now a major issue by reason of a Supreme Court of Canada decision, released after this speech was given, arising from a constitutional challenge in Quebec. The prohibition of private contracting for and payment for medically necessary services that is at the core of the Canadian health care system as presently structured was successfully challenged in the case of *Chaoulli v. Quebec (Attorney General)*. *Chaoulli v. Québec (Procureur général)*, [2005] S.C.J. No. 33. In that case, the plaintiff challenged the constitutionality of Quebec legislation that, consistent with the Canada Health Act, prevented him from privately obtaining a hip replacement. Quebec has a charter that resembles the Canadian Charter of Rights and Freedoms and contains a provision protecting the security of the person. Four out of the seven Supreme Court judges decided that the Quebec law violated the Quebec charter guaranteeing security of the person, and three of those four judges also found that the Quebec statute violated the Canadian Charter of Rights and Freedoms.

## SUMMARY OF CANADIAN SYSTEM

	<b>CHA Insured Services</b>	<b>Non-Covered Services</b>
Financing	All taxation, federal and provincial	Provincial programs, private insurance, direct payment
Private Insurers	Excluded	Significant component
Private Delivery	Primarily non-profit except physicians fee-for-service	For-profit much more significant

To wrap up, I have some numbers about how well Canada does. We are about the middle of the pack as far as outcomes are concerned.<sup>64</sup> We are not the top; we are not the bottom.

The following table from the Kirby Report compares health care spending in Canada with other countries as a percentage of GDP and in terms of dollars per capita.

SENATE COMMITTEE – HEALTH CARE SPENDING<sup>65</sup>

	<b>As % of GDP</b>	<b>Dollars per capita</b>
Canada	9.5%	\$2,312
U.S.	13.6%	\$4,178
Australia	8.5%	\$2,043
Germany	10.6%	\$2,424
Sweden	8.4%	\$1,746
U.K.	6.7%	\$1,461

The Kirby Report compares Canadian performance with some other countries in terms of life expectancy and infant mortality:

<sup>64</sup> See the following tables.

<sup>65</sup> These figures are taken from the table entitled "Health Care Spending, Health Care Resources and Health Status: Comparative Data, 1998." Kirby Report, *supra* note 10, at 77.



SENATE COMMITTEE – HEALTH STATUS INDICATORS<sup>66</sup>

	<b>Life Expectancy at Birth (males and females)</b>	<b>Infant Mortality per 1000 live births</b>
Canada	79.1	5.5
U.S.	76.8	7.2
Australia	78.3	5.0
Germany	77.3	4.7
Sweden	78.7	3.6
U.K.	77.3	5.7

The following table was prepared by the Conference Board of Canada:

CONFERENCE BOARD – RANKINGS AMONG OECD COUNTRIES<sup>67</sup>

	<b>Health Status</b>	<b>Health Outcomes</b>
Canada	5th	20th
Switzerland	1st	3rd
Sweden	5th	6th
Spain	2nd	3rd
France	11th	6th
Australia	10th	6th

I think the great benefit of the Canadian system is that there is a very strong principle to everybody having access. Nobody gets left out. Nobody is going to go broke because they can't afford health care or health insurance.

The biggest single detraction of the system is that it basically is locked into an ideological template that is very, very difficult to break out of. This makes consideration of market solutions very difficult to discuss and very difficult to bring up. The other great problem with the Canadian health sys-

<sup>66</sup> *Id.*

<sup>67</sup> See Conference Board Study, *supra* note 9, at 3-4 tbl.1. "Health Status" means "infant mortality, life expectancy, disability-free life expectancy, self-reported health status, etc." *Id.* At 5<sup>th</sup>, Canada does quite well. "Health outcomes" means "lung cancer, acute myocardial mortality rates, stroke mortality rates, etc." *Id.* Canada ranks quite poorly in 20<sup>th</sup> place. As the Conference Board observes on page 2, "Countries with a greater commitment to addressing non-medical factors, such as obesity, road traffic accidents and immunization, have better health outcomes." *Id.* at 2. There are 24 OECD countries altogether. *Id.* at 1. In terms of overall ranking on this table, the results were as follows: Canada 13<sup>th</sup>, Switzerland 1<sup>st</sup>, Sweden 2<sup>nd</sup>, Spain 3<sup>rd</sup>, France 3<sup>rd</sup> and Australia 8<sup>th</sup>, which puts Canada in the middle of the pack. *Id.* at 3-4 tbl.1.

tem is that the whole subject of health care is very politicized, and it is almost impossible to have an intelligent public discourse about it. So that's my wrap-up.

(Applause.)

