

European Forum

Market Incentives and
Health Reform in Canada

ANTONIA MAIONI

EUF No. 99/12

EUI WORKING PAPERS



EUROPEAN UNIVERSITY INSTITUTE

European University Institute



3 0001 0037 8603 7



EUI Working Paper EUF No. 99/12

Maioni: *Market Incentives and Health Reform in Canada*

**WP 309
EUR**



This Working Paper has been written in the context of the 1998-1999 European Forum programme on **Recasting the European Welfare State: Options, Constraints, Actors**, directed by Professors Maurizio Ferrera (Universities of Pavia and Bocconi, Milano) and Martin Rhodes (Robert Schuman Centre).

Adopting a broad, long-term and comparative perspective, the Forum will aim to:

- scrutinize the complex web of social, economic and political challenges to contemporary European welfare states;
- identify the various options for, and constraints on institutional reform;
- discuss the role of the various actors in promoting or hindering this reform at the national, sub-national and supra-national level;
- and, more generally, outline the broad trajectories and scenarios of change.

EUROPEAN UNIVERSITY INSTITUTE, FLORENCE

EUROPEAN FORUM

EUI Working Paper EUF No. 99/12

Market Incentives and Health Reform in Canada

ANTONIA MAIONI

McGill University, Montreal

BADIA FIESOLANA, SAN DOMENICO (FI)

**All rights reserved.
No part of this paper may be reproduced in any form
without permission of the author.**

**© 1999 Antonia Maioni
Printed in Italy in September 1999
European University Institute
Badia Fiesolana
I – 50016 San Domenico (FI)
Italy**

INTRODUCTION¹

Like most European countries, the past decade has been one of continuity and change in the Canadian health care sector. On the one hand, the delivery and financing of health care in Canada remains constant: independently-administered hospitals and fee-for-service medical care delivered within publicly-funded provincial health care systems. On the other hand, momentous changes have occurred in which public funding has been reduced, health care services have been curtailed, and health providers are increasingly regulated. This has led to a situation in which, while there remains a political commitment to and public consensus for "medicare" in Canada, severe cracks are beginning to show. Public opinion data, which measured overwhelming support for the health care system just ten short years ago, now reflect growing uneasiness about the functioning and future of health care in Canada. Discussions of privatization and market incentives, once taboo in Canadian political discourse, are becoming more frequent, particularly among politicians of the right, medical associations, and influential think tanks.

This paper examines some of the recent changes in the Canadian health care system and describes some of the market incentives in the health care sector. In contrast to European health care systems in transition, the extent and potential for market incentives is still very limited in the Canadian context. While there is evidence of some "marketlike mechanisms" (Evans 1997) used as management tools within the public sector within the public sector, the introduction of "quasi-markets" in which services are funded through the private sector, has not been as widespread in Canada as in other countries.

The first part of the paper explains why market incentives remain limited in Canada by tracing some of the institutional process of health policy development and change. The second part of the paper reviews some of the recent reforms in provincial health care systems, focussing on "supply-side" instruments (to regulate the quantity of health services) and "demand-side" incentives (limits to demand in the public sector and attempt to respond to excess demand through the private sector). Third, the paper reviews some of the proposals for parallel private markets and internal markets that are being discussed in Canada. The conclusions reflect upon the fact that there are two ways of observing the present situation in health reform in Canada: on the one hand, financial pressures from reduced public budgets, political forces in the guise of right-wing governments and organized medicine, and the rise in public

¹ This paper was prepared for the European Forum conference, "Beyond the Health Care State: Institutional Innovations and New Priorities in Access Coverage and Provisions of Health Services", European University Institute, San Domenico di Fiesole, Italy, 26-27 February 1999.

dissatisfaction may all provide windows of opportunity for the introduction of private market alternatives in Canadian health care; on the other hand, the existing structure of the health care system and the institutional contours of health policy place limits on the extent of market incentives in Canada.

PART ONE: INSTITUTIONS AND THE HEALTH POLICY PROCESS

The Development of Public Health Care in Canada

Comparative research has shown the processes by which institutions have an impact on policy outcomes in industrialized countries. For example, Immergut (1992) has shown how the types of "veto points" in political institutions can constrain interest group strategies in European health policy debates. Another such process is the way in which formal institutions condition the role of political parties. In Canada, the design of Canadian federalism and the patterns of partisan politics shaped the development of public health care in Canada (Maioni 1997). Although intergovernmental conflict delayed the process of health policy development, decentralization also encouraged provincial experimentation and led to the innovations that became the basis of public health insurance throughout Canada (Tuohy 1989; Gray 1991). A left-wing provincial party, the CCF-NDP in Saskatchewan, inaugurated the first government-sponsored hospital insurance (in 1947) and medical insurance (in 1962) systems in North America. The success of these innovations, combined with the political pressure exerted by the CCF-NDP's federal counterpart, was pivotal in convincing the national Liberal government to pass landmark legislation to share the costs of provincial programs in hospital insurance (under the Hospital and Insurance and Diagnostic Services Act, 1957) and medical care (under the Medical Care Insurance Act, 1966). Part of the federal government's rationale for engaging in such cost sharing was to avoid the development of a "crazy-quilt" of provincial health insurance programs by making federal money contingent upon the provinces' upholding certain principles of universality, comprehensiveness, portability and public funding. The goal was to ensure that Canadian taxpayers' money would be used to help finance publicly accountable health insurance systems that ensured the same basic social rights among Canadian citizens, regardless of their province of residence.

By 1971, public hospital and medical insurance plans were in operation in all the provinces. The development of a publicly-financed system with negotiated physician fee schedules and government-financed hospital budgets allowed for some measure of cost control but the retention of fee-for-service reimbursement and the open-ended nature of the cost-sharing arrangements increased overall health expenditures. In 1977, the Established Programs

Financing Act (EPF) replaced cost sharing with block funding (partly cash, partly tax points) based on population and tied to the rate of increase in GNP (Soderstrom 1978). In so doing, the federal government effectively devolved the responsibility to exercise restraint and control health care expenditures to the provinces, making them "100 percent at risk for cost increases." (Tuohy 1986).

Many of the practices the provinces allowed, including increased use of extra-billing and user fees, were seen as undermining national standards in health care. The Canada Health Act of 1984, which consolidated hospital and medical insurance under a single statute, finally enforced a federal ban on these measures by imposing an additional condition on the provinces, equal access to health services with dollar-for-dollar financial penalties (Bégin, 1987). Although this sparked considerable controversy about federal interference in provincial jurisdiction and resistance from provider groups (including a doctor's strike in Ontario), by April 1987, all of the provinces had banned user-fees and extra-billing (except in Québec, where such bans were already in effect).

When the Conservative government came to power in the mid-1980s, it implemented significant reductions in cash transfers to the provinces, leading critics to suggest that the federal government was "off-loading" its deficit problems onto the provinces (Boothe and Johnson 1992). The most important reductions, however, occurred with a new Liberal government: the 1995 federal budget announced that funding for provincial health systems would now be amalgamated into a "super-grant", the Canada Health and Social Transfer (CHST), which would substantially reduce the cash portion of federal transfers while at the same time still obliging the provinces to heed the conditions of the Canada Health Act (Smith 1995). Under increasing pressure from provincial governments and public opinion, the federal government finally announced increases in health care transfers. The 1999 federal budget, unveiled on February 16, announced the injection of C\$11.5 billion over five years to health transfers to the provinces and, although there has been virulent opposition to the new funding formula in Québec, the budget confirms the federal government's renewed commitment to providing predictable funding for public health care in Canada.

The Impact of Recent Changes in the Health Care Sector

The fiscal and political repercussions of the events of the past decade are four-fold. First, reductions in public funding available for health care have led to significant changes in the delivery of services (discussed in the following section) and on the public-private mix of money in the health care system. The most significant of these is the increase in private spending, whether out-of-pocket by patients or through their private insurance coverage. In 1996, Canada

spent C\$75.3 billion or 9.2% of GDP on health care. In terms of spending-to-GDP ratio, which has declined every year since 1993, Canada ranks fourth among OECD countries (9.2% of GDP in 1996; preliminary figures for 1998 estimate spending will total C\$80 billion or 9.1% of GDP) (OECD 1998).

More importantly, the ratio of private to public expenditure has also declined. In 1996, private expenditures accounted for 29.7% of total spending while estimates for 1998 project still further increases in private funding, to 30.3% of the health care total. Although these figures are not out of the average range for OECD countries, Canada nevertheless fall in the lower tier of these countries in terms of private to public expenditure ratio, with higher amounts spent in the private sector than many countries with more developed private health care markets. As explained in the next section, this increase in private financing is related to decreased public funding; it is also partly accounted for by changes in the types of services delivered. For example, drug expenditures, which made up only 8.5% of health care spending in 1976 and 10% in 1986, accounted for 13.6% in 1996 and is estimated to increase to 14% in 1998 (Government of Canada, 1996; Canadian Institute for Health Information, 1998).

Table 1: Health Expenditures in Canada

	1986	1996
Total as % GDP	8.5%	9.2%
Private as % total	27%	29.7%
Drug spending as % total	10%	13.6%

Source: Canadian Institute for Health Information, 1998.

Second, in terms of inter-governmental relations, provincial governments have signalled dissatisfaction with federal government decisions that changed the fiscal rules of the health policy game. They also initiated discussions on how to best preserve health and social programs in the face of federal disengagement through a "social union" between the provinces. Federal transfer cuts have also empowered Conservative leaders in some provinces to question the legitimacy of the imposition of federal standards while in Québec, such unilateral federal government actions increased ammunition for the sovereigntist movement.

Third, these developments offered a political opportunity for proponents of private market alternatives to question the legitimacy of the Canada Health Act and to suggest the introduction of market incentives in the Canadian health care sector. Most influential have been provincial medical associations, particularly in Ontario and British Columbia and the national Canadian Medical Association (CMA) itself. In the past few years, CMA general meetings have been open forums of debate over the desirability of private medicine and market incentives in Canada. While resolutions favoring this approach have been narrowly defeated at these meetings, they have gained considerable currency within the medical community. The Canadian Medical Association has advocated a public debate on private alternatives to health care and recent CMA polls suggest that 70% of Canadian doctors favour a two-tier health care system (Gray 1996)

Finally, public opinion has turned against government attempts to cut costs in the health care sector as Canadians began to express decreased confidence in the public health care system. The past decade has seen a rapid and significant shift in public opinion on health care. This is particularly evident in observing cross-national comparisons, in which Canadians went from the highest overall satisfaction in the late 1980s to a profound sense of unease about health care by the late 1990s (Blendon et al. 1990; 1995). The latest such data show that 23% of Canadians feel the health care system needs to be rebuilt while 46% agreed that recent health reforms have compromised the quality of service (Blendon et al. 1998).

Table 2: Canadian Public Opinion in Comparative Perspective

	System needs to be rebuilt		System needs minor changes	
	1988	1998	1988	1998
Canada	5%	23%	56%	20%
United States	29%	33%	10%	17%
United Kingdom	17%	14%	27%	25%
Australia	17%	30%	34%	18%

Source: Commonwealth Fund International Health Policy Survey, 1998.

While studies commissioned by the National Forum on Health in 1994 found that an overwhelming majority of Canadians support the principles of the Canada Health Act, in particular equality of access, more recent polls reveal that an increasing number seem to favour the introduction of some market incentives; for example, a recent poll found that 51% of Canadians would be willing to pay user fees for non-emergency medical services (Government of Canada, 1997).

Table 3: Public Opinion of Canadians on Health Care System

Willing to pay more for non-emergency trip to doctor?	51%
Willing to pay room and board at hospital?	31%
Federal government should set national standards?	56%

Source: Angus Reid Group, 1998.

PART TWO: HEALTH REFORM: THE CANADIAN EXPERIENCE

Since the mid-1980s, almost all industrialized countries have been engaged in the discourse and practice of health reform, mainly in terms of how to balance issues of cost containment and access to care (OECD 1994). At least two explanations can help account for these similar trends across different countries. First, is the larger experience of the end of the expansionary era of social expenditure and the politics of retrenchment across established welfare states (Pierson 1996). As public health care systems are often among the most expensive social programs, pressures for the reduction of public expenditures in general have had an impact on the funding of health care in particular. Second, is the nature of the health care services market itself. The end of the "golden age" of the welfare state coincided with the rise of the "gilded age" in the cost of health care. Breakthroughs in pharmaceutical research, the dissemination of expensive new technology and medical interventions, coupled with a more demanding and sophisticated patient clientele and an aging population, have all contributed to an upward pressure on the prices of health care services across the industrialized world.

Although the types of reforms vary across countries, virtually every OECD country has introduced some form of cost containment, through restraints in public health care expenditures, direct price controls on health care services, and/or the imposition of global budgets for health care. In many countries, competition measures have been introduced as a way to boost efficiency in the delivery and financing of health care. Canadian governments have also pursued cost containment strategies that involve global expenditure restraints in addition to specific measures targeted at providers of health care services. In both initiatives, however, incentives for market competition have been conspicuously absent.

In the past decade, every provincial government in Canada attempted some reform of the health care sector. Often presented in the context of responding to new demands and pressures in society, these reforms were generally implemented in the context of reducing public expenditures and "rationalizing" the health care system (Deber et al. 1994). With the soaring costs of medical care combined with the decrease in federal transfers, provincial governments now spend on average one-third of their total budget expenditures on health care. The increased fiscal pressure on provincial governments has led to attempts to regulate more aggressively the supply of health care, both through hospital services and imposing controls on physicians, since these costs drive health spending more than consumer demand (Evans 1984). The use of these cost-control instruments has been influenced by the objectives of health reform; that is, whether provincial reform is to involve more state intervention through regulation of the health sector, or whether cost control in the public sector opens up the possibility of less state regulation in the private market for health care.

Federal spending in the health sector initially led to a certain convergence among the provinces in terms of the adoption of public health insurance systems that involved the substitution of private for public financing of health care. In so doing, health care spending became an area of open political conflict, in which "cost control involves conflict between providers and payers" and where initiatives for reform had to do with controlling the supply and demand for health care (Evans 1989). The implementation of health insurance in the provinces involved two basic premises that were shaped by this conflict: First, under the terms of the original 1966 Medical Care Act, health insurance plans were to be publicly administered and had to cover all residents for insured services under the plan. Provincial governments through the imposition of global budgets in hospitals and the negotiation of fee schedules would regulate thus, the supply of health care, and those that produced it, with doctors. In return, administrators and physicians would retain relative autonomy in their professional spheres. The second premise, reinforced by the 1984 Canada Health Act, was that insured health care services were to be made accessible on

"uniform terms and conditions" meaning, in effect, that the demand for health care could not be restrained (through extra-billing or user fees) to thus avoid the emergence of two-tiered medicine. This gave the provinces leverage over the medical profession and many private insurance interests who hotly contested the public model.

As provincial governments attempt to control deficits through reductions in public spending, provincial health care systems have come under increasing pressure to reduce costs. Provinces have attempted to do this by controlling the supply of health care (through the closure of hospitals or hospital beds and restrictions on billing numbers or salary caps on doctors, for example) and also by controlling the direct demand from consumers (such as waiting lists for elective surgery or de-insurance of non-medically necessary services). In controlling supply, provinces have not come up against the principles of the Canada Health Act, and virtually every province has closed beds and hospitals over the past five years. Controls on demand, however, are more controversial because they raise the issue of what basket of benefits constitutes "medically necessary" services, to what extent deterrent measures can be used to avoid over-consumption of health care, and whether excess demand could be satisfied through private medicine.

The essential debate in these various attempts at reforming provincial health care systems has been between the regulation of the supply of services (and to a more limited degree, demand) in the health care sector in an effort to control total health costs, and the expansion of private sector initiatives that would offer additional supply to meet excess demand for health care.

Table 4: Principles of the Canada Health Act (1984)

Provincial health care plans must respect:

- Universality
- Comprehensiveness
- Portability
- Public funding
- Equal access

Supply-Side Incentives in the Health Care System

Hospital sector

Canadian hospitals are generally operated as non-profit institutions financed by global budgets negotiated with provincial governments. Although governments do not directly administer most hospitals, they are dependent on public funds for most of their operating costs (including personnel, medical supplies and equipment), and therefore subject to public decisions about how they operate. During the first decades of hospital insurance, provincial governments funded hospitals through "line-by-line" budget reviews and costs were then shared with the federal government. The process of global budgeting, in which hospital administrators are allotted regular payments for hospital operating costs, was accelerated after 1977 by the substitution of block funding under the EPF arrangement. Global budgets meant that hospital administrators allocated funds within the hospital at their discretion, but it also meant that they were responsible for creatively juggling resources. With the acceleration in federal cuts after 1990, hospitals reduced the availability of hospital beds, limited the use of new equipment, and reallocated services through waiting lists and outpatient care. The major fiscal objective in bed closures is to reduce labor costs, a process that has faced stiff opposition from provincial labor organizations. Another motivation, however, has been to reduce the supply of services (beds, operating room facilities) available for doctors to use in the system.

In the past decade, but most particularly since 1990, all the provinces have imposed cuts in hospital spending, which has led to the "downsizing" of the hospital system and the "consolidation" of services provided (Deber et al. 1994; Evans 1989). Bed, laboratory, operating room and entire hospital closures have been the principal methods of cost control for hospital administrators and provincial health departments. For example, the Parti québécois government in Québec encouraged the amalgamation of university teaching hospitals in Montréal and Québec City and initiated the most widespread reduction in hospital services: the closure of 7 Montréal and 5 Québec City hospitals, with funds to be reallocated to other health care priorities, such as expanding the CLSC network, long-term care and home care (Lessard 1995). In Newfoundland and New Brunswick more than 10% of hospital beds were closed, while in Saskatchewan, provincial funding was eliminated for 52 of 134 hospitals. Although the result has been longer waiting lists for elective procedures and non-emergency in-patient services, as well as overcrowding of emergency rooms and a greater reliance on outpatient care, these supply-side incentives are not considered to contravene the terms of the Canada Health Act.

In addition to downsizing, most provinces have also decentralized decision-making through the creation of regional health boards (some elected, others appointed) responsible for the allocation of funding and services. While this rationalizes budget making to some extent (by imposing fixed regional budgets) it also leads to passing the burden of accountability from provincial health ministries to local groups. In Alberta, for example, the Conservative government's 1994 Deficit Reduction Act mandated the 17 regional health boards to cut C\$3 billion from the provincial health care budget over a three year period (Cairney 1995). Changes implemented by social-democratic governments in British Columbia and Saskatchewan have stressed local decision-making and community-based care (Hurley et al. 1993). Regional health boards and community health councils will make decisions about transferring acute care to outpatient and home care in British Columbia. Saskatchewan created regional health boards with wide allocation discretion that rapidly implemented hospital closures.

Medical services

Although provincial health care plans cover most "medically necessary services provided by physicians (both in-patient and ambulatory), there is some variation in terms of defining uninsured services. Some of these may be in-patient, such as a private hospital room (as opposed to a ward), or outpatient, such as chiropractic services (covered in Ontario but not in Québec). Such extras can be covered by private insurance or paid for by patients directly but they remain relatively limited. Nevertheless, in recent years, private clinics have sprung up to offer services no longer offered by public plans, such as eye-laser surgery and in vitro fertilization, or diagnostic testing that would otherwise involve lengthy waits in the public system, such as MRIs or genetic screening. In addition, some private clinics now offer an extensive range of surgical and other interventions but they must limit their clientele to non-Canadians or to Canadians willing to pay for the entire cost of their medical care. Although private clinics, and the doctors who would like to practice there, claim that excess demand in the public system could be met by the excess capacity that exists in the private settings, provincial regulations and the Canada Health Act have so far limited the range of such alternative venues.

The willingness of Canadian doctors to contemplate alternatives to public health care stem in part from supply-side incentives that have directly targeted them in the past few years. The health care system in Canada is based on the consensus that doctors accept public funding in return for the freedom to practice on an essentially private, fee-for-service basis. Although negotiated reimbursement was designed to control cost escalation, the open-ended nature of such arrangements has allowed doctors considerable inflationary discretion of their salaries. Most observers agree that a major source of health inflation is the

supply of doctors who, in their role as gatekeepers, effectively determine the use of health services (Brown 1991).

Provinces generally pay physicians through a fee schedule negotiated with provincial medical associations. The amount of these fees, and the way they are imposed varies quite a bit, as do practices that regulate physician supply. In Québec, for example, the explicit emphasis on collective goals, primary health and community services, has led to more open confrontation and cooperation with the medical profession (Demers 1994). In addition to reimbursing physicians at a lower rate than most other provinces, Québec allows for salaried reimbursement through staffing of its CLSCs (community health and social services clinics) by salaried physicians. Québec was the first province to impose limits on billing, caps on specialist salaries, and differential fees to physicians with new billing numbers on the basis of their practice and residence within the province. Québec was also at the forefront of attempts to reduce medical school enrollments, to modify the GP-specialist ratio, and to tackle the problem of regional distribution of doctors through the imposition of financial penalties and incentives. Most provinces have implemented some or all of these measures as well, with varying degrees of success. A social-democratic government in Ontario attempted unsuccessfully to impose income caps on doctors while in British Columbia, the government's use of differential fees has come under attack in the courts (Manfredi and Maioni 1998).

The medical profession in Canada has reacted with a dual message to such initiatives. On the one hand, physicians, once among the most vocal opponents of "socialized medicine", have now become stakeholders in provincial health care systems and must lobby governments to maintain adequate funding for the public health care system. On the other hand, some provincial medical associations (in Ontario and British Columbia) have advocated the introduction of private market incentives into the health care such as user fees and two-tiered medicine as a way of soaking up excess demand and capacity (Canadian Medical Association 1993).

Attempts to regulate demand for health services

Control of the demand of health care represents an area in which provincial initiatives come into much more direct conflict with the federal government because of the conditions imposed on federal transfers. Limits on the access to publicly insured health care, through extra-billing or user fees have been much more controversial because they directly address the balance between government regulation and access .

The federal conditions established in 1966 provided for "reasonable compensation" to providers; however, there was also the stipulation that

"reasonable access" to insured services not be impeded (Taylor 1990). By 1980, the federal government had decided that access to health care was threatened by the widespread use of extra-billing, in which physicians charged their patients in excess of the provincial fee schedule and, not incidentally, pumped millions of additional dollars into overall health care spending. Extra billing had featured prominently in the strikes against public health insurance by Saskatchewan doctors in 1962 and Québec specialists in 1970. The explicit ban on extra-billing by the terms of the 1984 Canada Health Act led Saskatchewan, Nova Scotia, and Manitoba to prohibit the practice. In Alberta and Ontario, where extra-billing created the greatest barriers to access, Conservative governments initially resisted the federal government's intrusion, but the ban prevailed after a strike by Ontario doctors in 1986; economic pressures led Alberta to do the same in 1987. The persistence of extra-billing by some British Columbia doctors resulted in the withholding of \$1.75 million to the province from federal transfers in 1994 (Howard 1994). Since 1995, such practices have ended.

More conflict has centered on user fees, the direct out-of-pocket contribution of patients for their health costs (Sutherland and Fulton 1994). Although user fees are tolerated for pharmaceutical provision (e.g., deductibles for prescription drugs), health care institutions that are financed by public funds are explicitly prohibited from imposing user fees on the basis that this impedes equal access to health care. The equal access provisions of the Canada Health Act brought an end to these practices, although Québec's Liberal government flirted with the idea of a \$5 charge on hospital visits in 1991 to discourage over-consumption and curtail reliance on emergency-room care (Gouvernement du Québec 1991).

More controversial issues include the leasing of public facilities to provide privately-insured care (e.g., in Calgary the Health Resources Group refurbished the Grace Hospital to do so), the use of excess capacity in some hospitals to attract foreign patients (e.g., the case of the Institut de cardiologie in Montréal) and the imposition of facility fees by private clinics whose operating costs are not covered by public funds. Such clinics operate in many provinces, most notably British Columbia, Alberta and Ontario, and are gaining an important foothold in the health care system. In Alberta, for example, the Gimbel Eye Centre provides a range of ophthalmologist services not covered by provincial health care, and similar clinics now operate in many major Canadian cities. In some cases, these for-profit private clinics offer not only non-insured services (such as eye-laser and cosmetic surgery) but also a range of diagnostic services and medical interventions paid for directly by patients, such as the King's Health Centre in Toronto (Jones 1995).

The federal government has responded by reducing fiscal transfers to provinces that allowed such private clinics to impose facility or user fees for patients who were willing to pay to "jump the queue" for insured services (for example, cataract surgery, considered to be an insured service in the public health care system). This action was directed mainly at the Conservative government in Alberta, which has endorsed the development of private clinics. After a protracted political battle, in which Premier Ralph Klein threatened to take the federal government to court over the right to administer health care and the federal government responded by deducting hundreds of thousands of dollars from transfers to the province, the Alberta government disallowed facility fees in 1997 (Mitchell 1995).

Neither the federal government nor its provincial counterparts have banned the development of private clinics although it is not clear what role they will play in the future. Controversy over user fees in private clinics reveals a much more fundamental debate about the comprehensive and universal nature of public health insurance and the role of market mechanisms to reduce public spending. The gradual withdrawal of public funding since the early 1980s has contributed to the "silent privatization" of health care in which provinces have attempted to cut costs through shifting part of the burden to consumers of care and increasing the role of private insurers and providers in the system (Feschuck and Greenspon 1994). The replacement of surgical interventions through drug treatments, greater reliance on outpatient surgery, increases in waiting lists for non-essential services, and the de-listing of previously insured services, all open lucrative avenues for the provision and insurance of health care in the private sector.

Table 5: Provincial health reform initiatives

Supply of hospital and medical services

- hospital closures/bed closures
- waiting lists for elective surgery
- global budgets for hospitals
- salary caps on physicians
- billing limits on physicians
- control of medical school enrolments

Demand for services

- user fees (no longer allowed)
- extra billing (no longer allowed)

PART THREE: MARKET INCENTIVES IN CANADA

In comparative context, Canada remains a laggard case in the development of competition measures and the introduction of market incentives in the health care sector. As noted previously, several OECD countries, from national health systems to social insurance regimes, have turned to such initiatives in an attempt to promote at least micro-efficiency in health care delivery and financing. Australia, the Netherlands, and the UK introduced the most far-reaching competition measures, attempting to devolve responsibility for health care from governments to consumers and providers of care by encouraging contracting for services and the development of parallel private markets for health care (OECD 1998). In Italy, contracting for services has also begun, and decentralization has been the key element in health care reform, as the responsibility for health care financing, and deficits, is transferred from the central government to the regions (Maino 1999). In Sweden and Germany, the trend has been the use of internal market mechanisms, including capitation and prospective global budgeting, and some competition between providers and insurance funds (Freeman 1998).

In Canada, as was discussed previously, health reform has involved cost-containment measures by both federal and provincial governments and administrative reorganization at the provincial level. In all these initiatives, however, the introduction of market incentives or explicit competition between

providers was, in comparative perspective, notably absent. Although the Canada Health Act and provincial health care systems as they are presently designed make it difficult to envisage how such types of market mechanisms could be introduced, the Canadian health care system is far from immune to change. In some respects, the building blocks of an alternative or parallel private health care alternative are already in place: insurers, entrepreneurs and a substantial number of provider groups that would welcome some form of private health care. In addition, there already exists a certain mix of public and private medicine in Canada to the extent that medical services are offered on a fee-for-service basis (albeit publicly funded) and that in several areas health facilities built by public funds are used on a for-profit basis by private companies.

In relative terms, however, market incentives are far from widespread in Canada, and the institutional limits to the expansion of private markets are still substantial. The following section summarizes three trends in market incentives in the Canadian context: parallel markets, internal markets and the regional boards.

Private Health Care Alternatives

The introduction of a full-fledged market incentive model would essentially transform the Canadian health-care system into a two-tiered one. In this scenario, doctors could choose to practice in either the public or private system. Allowing doctors to practice in both could be an option, although judging by the NHS example, "dual allegiance" is difficult to sustain (Richmond 1996). Supporters claim that a parallel private system could act as an "escape valve" to reduce pressures on the public system, such as waiting lists for surgery, overcrowded emergency rooms, the drain of money to the US for those who can afford to pay for care, and the drain of doctors to the United States as well (McArthur et al. 1996). A variation on this model would be to redefine what "medically necessary" services should be covered by public health care, and to then allow provincial governments to "de-insure" certain procedures. In this scenario, general physician services and relatively straightforward procedures could remain under public provision, while more complicated (and expensive) treatments could be covered by private insurance (Silversides 1995; Charles et al. 1997).

Although neither of these models would necessarily involve replacing the public system, they suggest profound implications for the delivery of and access to health care in Canada. Critics claim that such initiatives would not be effective at cost-control but would instead pump much more money into the system, inflating costs for all users. In addition, despite the rhetoric of competition, the public system would potentially have greater difficulty in

sustaining high-quality providers and facilities. The co-existence of public and private delivery also raises the spectre of saddling the public system with the highest-risk, lowest-payoff patients, leading to a situation similar to that of "cherry-picking" and "dumping" in the private insurance market. Finally, if the existence of a private alternative ends up siphoning off upper and middle-class Canadians, the legitimacy of a tax-supported public system may be called into question (Evans 1993).

Besides these caveats, the immediate obstacles for the introduction of full-fledged market models remain essentially political ones: two-tiered medicine essentially contravenes the principles of the Canada Health Act, in particular the principle of equal access to medical services. In addition, such reforms would be politically difficult to introduce: despite the ambiguity of public opinion polls that reflect dissatisfaction with the present situation, it is far from clear that there is any consensus that a parallel private health care system would be popular among Canadians. Until such a consensus emerges, it remains politically risky for provincial leaders to advocate privatization and politically profitable for the federal government to portray itself as the "guardian" of the existing "Canadian model."

Reform Through Internal Markets

Advocates of reform through "internal markets" claim that competition and access are not incompatible goals in health care provision and that they can serve as tools for greater efficiency within a publicly-funded system like Canada's (Jérôme-Forget et al. 1995). The main problems of the public system are three-fold: the absence of incentives to increase hospital efficiency and the incentive for fee-for-service providers to inflate their billing practices; the moral hazard associated with consumers ignorance of the price of health care; and funding mechanisms that remain unpredictable (due to the use of general tax revenues and federal transfers) (OECD 1995). The main attempts at creating internal markets have so far focussed on the first set of problems. In the hospital system, enforced global budgets have led to substantial cost control, although the subsequent problems of over-crowding and waiting lists have yet to be fully resolved. Some hospitals are also experimenting with the introduction of DRG billing that would allow for more standardized accounting and cost comparisons. Physician incentives have focussed on reimbursement cost control, which has been less successful except where combined with salary caps and limits on physician supply. Other incentive measures attempted to create an effective "mix" of specialties and ensure a balanced regional distribution of providers. In addition, provinces have tried to create incentives for salary-based physician reimbursement, particularly in community health centres such as those in Québec.

More sophisticated internal market models suggest the solution for Canada lies in the development of “integrated” health care delivery systems through capitation and managed care to encourage sustained health care delivery (with an emphasis on disease prevention and continuity of care) at lower cost. Some suggestions include the introduction of British-style capitation for GPs in combination with incentives for rewarding highly productive physicians (Blomqvist 1995). Others suggest managed care through the creation of a network of HMO-style service providers such as a “Targeted Medical Agency” in which physicians in group practice act as agents to purchase medical procedures and diagnostic services (Jérôme-Forget and Forget 1995). So far, however, concrete attempts at introducing such practices (for example, Ontario’s “Comprehensive Health Organizations”) have had limited success because of the difficulties of recruitment and coordination (Closson and Catt 1996). Although such alternatives attempt to build on the “entrepreneurship” potential of physicians, most Canadian doctors are committed to retaining a fee-for-service payment system. In addition, freedom of choice is considered an important element of the health care system for Canadians. While integrated delivery systems may not contravene the principles of the Canada Health Act, limits on the choice of providers may be considered contrary to the “spirit” of the existing health care system.

Regional Boards and the Allocation of Health Care

In the flurry of reform proposals discussed by the provinces in the past decade, “regionalization” was a consistent theme. This was to involve devolving power from provincial health ministries to regional or local bodies that would have some level of discretion in allocating health care resources. This would permit the kind of necessary decentralization that could lead to population-based funding and other allocative efficiencies, such as ensuring the optimal level of resource mix for a particular region (Dorland and Davis 1996). Although almost all the provinces have in fact instituted such regionalization through the creation or reorganization of existing local and regional health boards, these experiments have not all been successful in establishing efficiency via internal markets. Part of the problem lies in the fact that such boards are not always empowered to make important decisions. In addition, questions have been raised as to just what kinds of decisions such boards are equipped to make, particularly if they are non-elected and hence not publicly accountable. Of particular concern is the tendency of local bodies to focus on local concerns - even at the expense of the larger provincial - or national - community.

CONCLUSION

The past decade has been one of continuity and change in the Canadian health care system. In comparison with many European countries, changes to health care have been minimal in the sense that parallel markets and even internal market incentives remain limited. Nevertheless, real change has occurred in the way in which governments have attempted to regulate providers and consumers of care in an effort to control public health care expenditures. These initiatives, while successful in exerting a measure of cost-control into the system, have been unable to change the actual institutions of health care financing and delivery. Indeed, they have exposed several fissures in the health care system: conflict between federal and provincial governments over health policy; conflict between governments and providers over levels of remuneration and regulation of the profession; and dissatisfaction within the public over the pace and extent of reform.

These fissures may grow deeper as the debate over health care reform continues in Canada. The recent injection of more public money into the system will probably not assuage the enduring financial pressures that continue to exist, nor will the federal government's budget largesse satisfy, in the long term, attempts by some provincial governments to exercise more flexibility in introducing health care reforms that include alternative models of health care financing and organization.

For the moment, the Canada Health Act exerts an institutional brake to the type of widespread market incentives being introduced in other countries. But this brake may not hold indefinitely as health care system in Canada remains under strain, both financially and politically. While public opinion and political discourse remains supportive of the system, the status quo seems untenable, leading both patients and providers to explore alternative avenues in health care.

Antonia Maioni
Associate Professor
Department of Political Science
McGill University
855 Sherbrooke Street West
Montréal, Québec H4A 2T7 Canada
Fax: 514-398-1770
Phone: 514-398-4215/4800
E-mail: maioni@leacock.lan.mcgill.ca

REFERENCES

Angus Reid Group Poll, December 3, 1998.

Bégin, Monique (1987) *L'Assurance-santé. Plaidoyer pour le modèle canadien*, Montréal, Boréal.

Blendon, Robert J. et.al. (1990) "Satisfaction with Health Systems in Ten Nations", *Health Affairs*, 11, 1, 2-10.

Blendon, Robert J. et.al. (1995) "Who Has the Best Health Care System? A Second Look", *Health Affairs*, 14, 4, 220-30.

Blendon, Robert J. et al. (1998) *Commonwealth Fund International Health Policy Survey*, Washington, DC, Commonwealth Fund.

Blomqvist, Ake (1995) "Reforming Health Care: Canada and the Second Wave" in Jérôme-Forget, Monique, Joseph White and Joshua M. Wiener (eds) *Health Care Reform Through Internal Markets: Experience and Proposals*, Montreal, Institute for Research on Public Policy.

Boothe, Paul and Barbara Johnson (1992) "Stealing the Emperor's Clothes: Deficit Offloading and National Standards in Health Care," University of Western Ontario, London, Ontario, Papers in Political Economy.

Brown, Malcolm C. (1991) *Health Economics and Policy: Problems and Prescriptions*, Toronto, McClelland and Stewart..

Cairney, Richard (1995) "Health Care Reform Comes to Alberta", *Canadian Medical Association Journal*, 156, 1861-3.

Canadian Institute for Health Information (1998) "Canada to spend more on health care in 1998", Ottawa, November 19.

Canadian Medical Association (1993) *Toward a New Consensus on Health Care Financing in Canada*, Ottawa, CMA Working Group on Health System Financing in Canada.

Charles, Cathy, Jonathan Lomas, Mita Giacomini et al. (1997) "Medical Necessity in Canadian Health Policy: Four Meanings and...a Funeral?", *Milbank Quarterly*, 75, 3, 365-94.

Closson, Thomas and Margaret Catt (1996) "Funding System Incentives and the Restructuring of Health Care", *Canadian Journal of Public Health*, 87, 2, 86-9.

Deber, Raisa B., Sharmila L. Mhatre and G. Ross Baker (1994) "A Review of Provincial Initiatives" in Blomqvist, Ake and David M. Brown (eds) *Limits to Care: Reforming Canada's Health System in an Age of Restraint*, Toronto, C.D. Howe Institute.

Demers, Louis (1994) "La profession medicale" in Lemieux, Vincent et al. (eds) *Le système de santé au Québec. Organisation, acteurs, enjeux*, Ste-Foy, Presses de l'Université Laval.

Dorland, John L. and S. Mathwin Davis (1996) *How many roads? Queen's-CMA Conference on Regionalization and Decentralization in Health Care*, Kingston, Ontario, Queen's University, School of Social Policy.

Evans, Robert G. (1997) "Going for the Gold: The Redistributive Agenda Behind Market-Based Health Care Reform", *Journal of Health Politics, Policy and Law*, 22, 2, 427-65.

Evans, Robert G. (1984) *Strained Mercy: The Economics of Canadian Health Care*, Toronto, Butterworths, 1984.

Evans Robert G. et al. (1989) "Controlling Health Expenditures. The Canadian Reality", *New England Journal of Medicine*, 320.

Evans, Robert G. (1993) "Health Care Reform: 'The Issue from Hell'," *Policy Options*, 1993, November.

Feschuck, Scott and Edward Greenspon (1994) "Canada's Hidden Health Care System", *The Globe and Mail*, May 28.

Freeman, Richard (1998) "Competition in Context: the Politics of Health Care Reform in Europe", *International Journal for Quality in Health Care*, 10,5, 395-401.

Government of Canada (1996) *National Health Expenditures in Canada, 1975-1994, Summary Report*, Ottawa, Health Canada, Policy and Consultation Branch.

Government of Canada (1997) *Canada Health Action: Building on the Legacy* Ottawa, National Forum on Health.

Gouvernement du Québec (1991) *Un financement équitable à la mesure de nos moyens*, Québec, Ministère de la santé et services sociaux.

Gray, Charlotte (1996) "Visions of our Health Care Future: Is a Parallel Private System the Answer?", *Canadian Medical Association Journal*, 154, 1084-7.

Gray, Gwendolyn (1998) "Access to Medical Care under Strain: New Pressures in Canada and Australia", *Journal of Health Politics, Policy and Law*, 23, 6, 905-47.

Gray, Gwendolyn (1991) *Federalism and Health Policy: The Development of Health Systems in Canada and Australia*, Toronto, University of Toronto Press.

Howard, Ross (1994) "Marleau to punish B.C. for Fees", *The Globe and Mail*, May 19.

Hurley, Jeremiah, Jonathan Lomas and Vhanda Bhatia (1993) "Is the Wolf Finally at the Door? Provincial Reform to Manage Health Care Resources", CHEPA Working Paper Series No. 93-12, Hamilton, McMaster University.

Immergut, Ellen (1992) *Health Politics: Interests and Institutions in Western Europe*, New York, Cambridge University Press.

Jérôme-Forget, Monique and Claude Forget (1995) "Internal Markets in the Canadian Context" in Jérôme-Forget, Monique, Joseph White and Joshua M. Wiener (eds) *Health Care Reform Through Internal Markets: Experience and Proposals*, Montreal, Institute for Research on Public Policy, 1995.

Jérôme-Forget, Monique, Joseph White and Joshua M. Wiener (1995) "Introduction" in Jérôme-Forget, Monique, Joseph White and Joshua M. Wiener (eds) *Health Care Reform Through Internal Markets: Experience and Proposals*, Montreal, Institute for Research on Public Policy.

Jones, Debroah (1995) "Surgery on Demand", *Report on Business Magazine*, November, 82-90.

Lessard, Denis (1995) "Réorganisation du réseau hospitalier", *La Presse*, February 3.

Maino, Franca (1999), *La sanità tra decentramento e concorrenza amministrata: il caso italiano in prospettiva comparata*, Ph.D. Thesis, Università degli Studi di Firenze.

Maioni, Antonia (1997) "Parting at the Crossroads: The Development of Health Insurance in Canada and the United States, 1940-1965", *Comparative Politics*, 29, 4, 411-31.

Manfredi, Christopher P. and Antonia Maioni (1998) "Courts and Health Policy: Judicial Decision Making and Publicly Funded Health Care", Paper presented at American Political Science Association, Boston, MA.

McArthur, William, Cynthia Ramsay and Michael Walker (1996) *Healthy Incentives: Canadian Health Reform in an International Context*, Vancouver, The Fraser Institute.

Mitchell, Alana (1995) "Alberta Surrenders in Clinic Battle", *The Globe and Mail*, October 12.

Organisation for Economic Co-operation and Development (1994) *The Reform of Health Care Systems: A Review of Seventeen OECD Countries*, Paris, OECD.

Organisation for Economic Co-operation and Development (1995) *Internal Markets in the Making: Health Systems in Canada, Iceland and the United Kingdom*, Health Policy Studies No. 6, Paris, OECD.

Organisation for Economic Co-operation and Development (1998) *OECD Health Data 98: A Comparative Analysis of 29 Countries*, Paris, OECD.

Pierson, Paul (1996) "The New Politics of the Welfare State", *World Politics*, 48, 443

Richmond, Caroline (1996) "NHS Waiting Lists have been a Boon for Private Medicine in the UK", *Canadian Medical Association Journal*, 154, 378-81.

Silversides, Ann (1995) "Role of Private Insurance in Public System Source of Debate", *Canadian Medical Association Journal*, 153, 827-8.

Smith, Miriam (1995) "Medicare and Canadian Federalism" in Rocher, François and Miriam Smith (eds) *New Trends in Canadian Federalism*, Peterborough, Broadview Press.

Soderstrom, Lee (1978) *The Canadian Health System*, London, Croom Helm.

Sutherland, Ralph W. and Jane Fulton (1994) *Spending Smarter and Spending Less: Policies and Partnerships for Health Care in Canada*, Ottawa, The Health Group.

Taylor, Malcolm G. (1990) *Insuring National Health Care: The Canadian Experience*, Chapel Hill, University of North Carolina Press.

Tuohy, Carolyn (1989) "Conflict and Accommodation in the Canadian Health Care System" in Evans, Robert G. and Greg L. Stoddart (eds) *Medicare at Maturity: Achievements, Lessons and Challenges*, Calgary, University of Calgary Press.

Tuohy, Carolyn, "Federalism and Canadian Health Care Policy" in Chandler, W. and C. Zollner (eds) *Challenges to Federalism: Policy-Making in Canada and the Federal Republic of Germany*, Kingston, Institute for Intergovernmental Relations.



EUI WORKING PAPERS

EUI Working Papers are published and distributed by the
European University Institute, Florence

Copies can be obtained free of charge
– depending on the availability of stocks – from:

The Publications Officer
European University Institute
Badia Fiesolana
I-50016 San Domenico di Fiesole (FI)
Italy

Please use order form overleaf

Publications of the European University Institute

To The Publications Officer
 European University Institute
 Badia Fiesolana
 I-50016 San Domenico di Fiesole (FI) – Italy
 Telefax No: +39/055/4685 636
 e-mail: publish@datacomm.iue.it
 <http://www.iue.it>

From Name

 Address

- Please send me a list of EUI Working Papers
- Please send me a list of EUI book publications
- Please send me the EUI brochure Academic Year 2000/01

Please send me the following EUI Working Paper(s):

No, Author

Title:

No, Author

Title:

No, Author

Title:

No, Author

Title:

Date

Signature



Working Papers of the European Forum

EUF No. 95/1

Diemut BUBECK
A Feminist Approach to Citizenship

EUF No. 95/2

Renaud DEHOUSSE/Thomas
CHRISTIANSEN (eds)
What Model for the Committee of the
Regions? Past Experiences and Future
Perspectives

EUF No. 95/3

Jens BONKE
The Concepts of Work and Care - An
Economic Perspective Applied to Britain
and Denmark

EUF No. 95/4

Jens BONKE
Education, Work and Gender -
An International Comparison

EUF No. 95/5

Henriette MAASSEN VAN DEN
BRINK/Wim GROOT
Household Production and Time
Allocation, the End of the Male
Chauvinist Model

EUF No. 95/6

Andrés BARRERA-GONZÁLEZ
Language, Collective Identities and
Nationalism in Catalonia, and Spain in
General

EUF No. 95/7

Diemut BUBECK
Gender, Work and Citizenship: Between
Social Realities and Utopian Visions

EUF No. 95/8

Miriam A. GLUCKSMANN
Gendered Economies of Time: Women
Workers in North-West England

* * *

EUF No. 96/1

David PURDY
Jobs, Work and Citizens' Income: Four
Strategies and a New Regime

EUF No. 96/2

Barry EICHENGREEN/Andrew
ROSE/Charles WYPLOSZ
Contagious Currency Crises

EUF No. 96/3

Yasemin SOYSAL
Boundaries and Identity: Immigrants in
Europe

EUF No. 96/4

Yasemin SOYSAL
Changing Parameters of Citizenship and
Claims-Making: Organized Islam in
European Public Spheres

EUF No. 96/5

Giovanna PROCACCI
Poor Citizens. Social Citizenship and the
Crisis of Welfare States

* * *

EUF No. 98/1

Yuri KAZEPOV
Citizenship and Poverty. The Role of
Institutions in the Structuring of Social
Exclusion

EUF No. 98/2

Massimo LA TORRE
Citizenship and Social Rights. A
European Perspective

EUF No. 98/3

Ewa MORAWSKA
Structuring Migration in a Historical
Perspective: The Case of Traveling East
Europeans

EUF No. 98/4

Virginie GUIRAUDON
International Human Rights Norms and
their Incorporation: The Protection of
Aliens in Europe



EUF No. 98/5

Patrick WEIL

The Transformation of Immigration Policies, Immigration Control and Nationality Laws in Europe: A Comparative Approach

EUF No. 98/6

Public Services and Citizenship in European Law

Mark FREEDLAND

Law, Public Services, and Citizenship - New Domains, New Regimes?

Silvana SCIARRA

Labour Law - A Bridge Between Public Services and Citizenship Rights

* * *

EUF No. 99/1

Virginie GUIRAUDON

The Marshallian Triptych Re-Ordered: The Role of Courts and Bureaucracies in Furthering Migrant Social Rights

EUF No. 99/2

Ewa MORAWSKA

The New-Old Transmigrants, their Transnational Lives, and Ethnicization: A Comparison of 19th/20th and 20th/21st C. Situations

EUF No. 99/3

Ann Shola ORLOFF

Ending the Entitlement of Poor Mothers, Expanding the Claims of Poor Employed Parents: Gender, Race, Class in Contemporary US Social Policy

EUF No. 99/4

Fiona ROSS

"Beyond Left and Right": The New *Partisan* Politics of Welfare

EUF No. 99/5

Elisabetta ADDIS

Gender in the Italian Welfare State Reforms

EUF No. 99/6

Ana M. GUILLÉN

Pension Reform in Spain (1975-1997): The Role of Organized Labour

EUF No. 99/7

Pål EITRHEIM/Stein KUHNLE

The Scandinavian Model: Trends and Perspectives

EUF No. 99/8

Luis MORENO/Ana ARRIBA

Welfare and Decentralization in Spain

EUF 99/9

Jens ALBER

The German Welfare State in the Era Kohl

EUF 99/10

Rosa MULÉ

The Politics of Income Redistribution. Factional Strife and Vote Mobilization under Thatcher

EUF 99/11

Bruno PALIER

Du salaire différé aux charges sociales, les avatars du mode de financement du système français de Sécurité sociale

EUF 99/12

Antonia MAIONI

Market Incentives and Health Reform in Canada



© The Author(s), European University Institute.

Digitised version produced by the EUI Library in 2020. Available Open Access on Cadmus, European University Institute Research Repository.

