The Political and Economic Sustainability of Health Care in Canada

Private-Sector Involvement in the Federal Provincial Health Care System

Howard A. Palley, Marie-Pascale Pomey, and Owen B. Adams

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To my grandchildren, Emma, Harry, Amelia,
Thomas, and Charlotte – Howard A. Palley
To my children, Romain, Pénélope, and Chine,
and to my mother, Danièle Pomey-Rey – Marie-Pascale Pomey

Preface

Political and Economic Sustainability: Private Sector Involvement in the Federal Provincial Health Care System

Globally, the mix of private and public sector involvement in health care delivery is a focus of political and public-policy concern. This study uses a comparative, multidimensional methodology that also is a theory with respect to the dimensions of public-policy making in order to examine the nature of expanding commercial activities within provincial health care systems. In so doing, it presents case analyses of Ontario, Quebec, and Alberta. Such factors as the provincial political culture and history related to the delivery of health care services are examined. The dynamic process between federal and provincial officials operating within the context of the Canada Health Act and Canadian fiscal federalism is also discussed, and we focus too on economic and political sustainability concerns as they relate to increased commercial activities in the health care systems of the provinces. In addition, the ideology of political leadership and the disposition to act (or to refrain from acting) are examined. These are some of the factors that shape the ways various provinces have dealt with the phenomenon of commercial activity in their provincial health care

systems. Finally, we raise the concern that in order to meet the public need for access to health care services and to quality care in this environment, a regulatory process is necessary to provide for public accountability.

Canada's complex health care delivery system is a conglomeration of more than thirteen public plans, all providing full coverage for most hospital and physician services, as well as partial coverage for many services that vary from plan to plan. This study examines the development of the public–private sector relationship in health care delivery—particularly that of the for-profit sector—both historically and in recent years, in three subnational provincial jurisdictions within a federal system, examining both similarities and differences. The case study provinces demonstrate contrasts in their political cultures and political histories vis-à-vis health care delivery. Ontario and Quebec are Canada's most populous provinces, and Alberta is a prairie state with an increasing population. Alberta has long been governed by the Progressive Conservative Party and its predecessor, the Social Credit Party. Ontario has had a more variable political history, witnessing periods of Progressive Conservative, New Democratic, and Liberal leadership, and in recent years Quebec governance has shifted between the Parti Québécois and the Liberal Party.

Provincial medical and hospital plans are constrained by the Canada Health Act of 1984. For *necessary* medical and hospital services, the provinces and territories must adhere to the five principles of the act in order to receive federal funding. For such services, first-dollar coverage is required. However, other *extended* health care and health care–related services are covered by federal contributions that are not constrained by these principles. Another factor providing some flexibility in provincial medicare plans is that necessary hospital and medical services are not enumerated in the Canada Health Act. This has allowed some "delisting" of services, a phenomenon discussed in the case studies.

The three case studies examine how the federal–provincial dynamic in the delivery of health care services has worked out in the three provinces, exploring similarities and differences regarding the involvement of the

for-profit sector both within and outside the respective medicare systems. We also examine ways the fiscal setting has affected both political and economic sustainability pressures with respect to the inclusion of private commercial initiatives in these three provincial settings. These initiatives occur both within and beyond Canadian provincial medicare systems, and there is a need to see that such initiatives are held publicly accountable for meeting equity and access goals.

This study adds to the comparative health-policy literature by applying a comparative approach to subnational provincial cases. Globally, many nations' health insurance plans comprise a mix of public and private health care delivery systems—although the mixes of for-profit and not-for-profit organizations vary with respect to the ideological, political, cultural, and historical characteristics of various nations. This book examines how such factors affect the shaping of three provincial health care delivery systems. The figures used in the discussion of Canadian federal and provincial health care expenditures as well as other health care–related expenditures are in Canadian dollars.

Acknowledgments

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and the encouragement of Howard Palley's wife, Marian Lief Palley, professor of political science and international relations at the University of Delaware.

Howard Palley gained much from committee discussions on the delivery of health services in Canada during his service on Health Canada's Science Advisory Board. Members who provided significant insights are Professor Stephen E. Bornstein, director of the Center of Applied Research at Memorial University, St. Johns, New Foundland; Professor Jacques Simard, on the faculty of medicine at Laval University; and Mamoru Watanabe, professor emeritus on the faculty of medicine and former dean of the faculty of medicine at the University of Calgary, Alberta.

Nicolas van Schendel and Elisabeth Martin, research assistants for Professor Pomey, provided invaluable help. Janice Hicks of the University of Maryland's School of Social Work provided essential and always patient support in the various technical tasks of putting the manuscript together.

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Chapter 1

Examining Provincial Variability

Canadian Fiscal Federalism, Public–Private Relationships, and Economic and Political Sustainability

The Canadian health care system is a complex conglomeration of more than thirteen public plans. Ten provincial and three territorial plans, as well as a number of federally administered plans that cover specific populations (e.g., aboriginals and veterans), all provide full coverage for most hospital and physician services and offer partial coverage for many other services that vary significantly across the plans. Those plans share a set of common principles currently embodied in a piece of federal legislation, the Canada Health Act of 1984 (CHA), and are funded through a mix of taxes, premiums, and (limited) user contributions (Forest 2010). Provinces and territories receive financial support from the federal government for operating their public health care plans, but these revenues come with conditions and constraints. In particular, it is essential that such provincial and territorial plans guarantee first-dollar coverage for all necessary hospital and medical services and that they accept responsibility for the

public oversight and management of the health care delivery system. Although the CHA principles apply only to coverage of *necessary* hospital and physician services, the act also provides federal contributions for a list of *extended* health care services that provinces and territories may choose to cover. Insurance (primarily obtained through employment) also plays an important role in funding dental care, ambulance services, pharmaceuticals, vision care, and professional services other than those provided by physicians (Evans 2009).

INTRODUCTION

This study examines the recent development of public–private sector relationships, focusing particularly on the for-profit sector, in provincial health care systems in Ontario, Quebec, and Alberta. Ontario and Quebec are Canada's two most populous provinces, and they differ widely in language, political culture, and political history with respect to health care. Alberta is a prairie state with an increasing population, unique among provinces because of its long-term governance by the Progressive Conservative Party and before that, by the Social Credit Party. Political rhetoric in Alberta has emphasized a business model as the most efficient approach to the delivery of health care services. Use of the word *delivery* in this study refers to the organization and management of health care, as well as to the physical provision of services (Deber 2002). This study also examines the factors underlying varied provincial dispositions to act regarding public–private sector initiatives (Blank and Burau 2004; Heisler and Peters 1977; Nathanson 2007).

Three factors that we touch upon in our analysis are (a) the levels of government and the nature of their involvement in public policy concerning the provincial health care delivery systems (in Canada, the provincial–federal relationship is particularly relevant), (b) the nature and characteristics of public and private sector activities developed within provincial health care delivery systems, and (c) factors influencing provin-

cial governments' political dispositions to act—that is, factors related to political leadership and political and economic sustainability issues (Heisler and Peters 1977; Nathanson 2007; also see Brown 1998; Marse and Paulus 2003; Ramsay 2004 ; Wessen 1999). The political scientists Martin O. Heisler and Guy B. Peters have also noted that existential factors—such as perceived needs, availability of resources, and the presence of a political window of opportunity—may affect policy development in the areas of health and social welfare (1977). Whereas Heisler and Peters developed a multidimensional approach to public policy decision making with respect to Canadian health care delivery decisions, our study postulates that perceived needs and perceived resource limitations are important factors affecting economic and political sustainability. Judgements regarding political and economic sustainability are important drivers leading to an increase in the number of for-profit organizations and in their participation in Canada's health care system. Heisler and Peters presented a theoretical perspective maintaining that social policies result from a multitude of variables, including governmental structure, political factors, available resources, and agency (the political disposition of political officeholders to act). A somewhat similar multifactor approach specifically focusing on health care delivery is presented in the work of Blank and Burau (2004). Recent collections by Marmor, Freeman, and Okma (2009) and Okma and Crivelli (2010) also examine the multiplicity of factors involved in national health policy reforms.

We utilize a comparative perspective because the shaping of the health care delivery system and the implementation of health care services in Canada is primarily the responsibility of provinces that are diverse in a number of respects. Further, the accumulation of national studies using a comparative framework has contributed to the comparative policy literature (See Heisler and Peters 1977; Kervasdoué, Kimberly, and Rodwin 1984; Okma and Crivelli, 2010; Dutton 2007; Marmor, Freeman, and Okma, 2009). Similarly, a comparative approach to subnational studies adds to this comparative knowledge (Altenstetter 1978; Forest and Bergeron 2005; Imbeau et al., 2001; and Tuohy 2009b).

In addition, we posit that as financial pressures increase both in the Canadian health care system and in other areas seeking federal financial assistance, over time the desire to maintain access within the health care system leads to relationships with private investors and business interests, as well as private market models within the framework of Canada's medicare system. We focus primarily on recent public–private sector developments, often of a for-profit nature (Minow 2003), in provincial health care delivery systems. Around the world, many national health insurance plans incorporate a mixed public and private health care delivery system, though such mixes of for-profit and not-for-profit service providers vary according to the ideological, political, cultural, and historical characteristics of the nations in question (Blank and Burau 2004; Forest and Bergeron 2005; Nathanson 2007; Palley, Pomey, and Forest 2011

A recent review of the comparative policy analysis and health care offers no systematic approach to such studies (Marmor, Freeman, and Okma 2009, 1–23); in this collection, Carolyn Hughes Tuohy provided a theoretical perspective for understanding change or the lack thereof regarding federal and provincial events in health policies in Canada. She designated two dimensions of the factors involved in producing change or resisting change: an institutional mix and a structural balance. Tuohy defined *institutional mix* as "the mix of *hierarchy, market and collegiality* (peer control) in the design of decision-making structures," and *structural balance* as the balance of influence across "*state actors, health care providers, and private financial interests*" (Tuohy 2009b, 62–63). Our simpler model encompasses all of Tuohy's factors. Further, in developing our analysis, we used pertinent documents (e.g., governmental reports from provincial and federal levels, judicial cases, newspaper and TV accounts), as well as semistructured interviews.