CALEDON
INSTITUTE OF
SOCIAL POLICY

A Review of the Alberta Private Hospital Proposal

by

Michael L. Rachlis, MD, MSc, FRCPC

March 2000

ISBN 1-894159-92-6

The Caledon Institute of Social Policy occasionally publishes reports and commentaries written by outside experts. The views expressed in this paper are those of the author.

Executive Summary

Alberta Premier Ralph Klein intends to introduce legislation shortly to allow regional health authorities to contract with for-profit companies for inpatient medical and surgical procedures. The Premier claims that his intention is to reduce waiting lists and protect the public system. He has vowed that the new bill will be consistent with the Canada Health Act (CHA). Federal Health Minister Allan Rock has expressed his concerns about the plan, but Mr. Klein has promised to proceed.

Mr. Klein's government previously introduced several bills to expand for-profit health care. However, political pressure forced the Premier to back down. In its first term in office, the Chrétien government penalized Alberta under the Canada Health Act for allowing private outpatient surgical clinics to charge patients directly for services. In May 1996, Ottawa signed an agreement with Alberta whereby the province would pay the overhead fees (through Regional Health Authorities). However, the agreement allowed clinics to charge for "…voluntary service enhancements and non-medical costs."

The political pressure to allow Regional Health Authorities to contract out medical and surgical procedures requiring overnight stays has been driven by several key interests, nurtured by an ideology that espouses privatization of public services and facilitated by loopholes in the Canada Health Act and Ottawa's failure to rigorously enforce the Act.

The Klein proposal would be bad for Alberta's health care system, almost certainly raising costs and potentially diminishing quality. While the proposal might not be immediately contrary to the letter of the Canada Health Act, it builds into hospital care the concept that patients can be charged privately for non-insured clinical services while they are receiving an insured service. This situation inevitably will lead to interference with reasonable access. The proposal also might activate provisions under the North American Free Trade Agreement (NAFTA). NAFTA would, first, bind succeeding Alberta governments to deal with for-profit hospitals. Second, the proposed Alberta legislation would allow foreign companies to claim to an international arbitration tribunal that they should be allowed into all provinces because the Alberta law has the effect of changing federal legislation.

The federal government should act immediately to protect other provinces' health care systems from the activation of NAFTA provisions by the proposed Alberta legislation. As soon as the legislation is proclaimed, there will be no recourse.

After the federal government has moved to protect other provinces from the activation of NAFTA provisions, it should commission a review of Canada's medicare system with terms of reference similar to that given to Justice Emmett Hall in 1979 in his own important reassessment. Preferably, the review would be launched cooperatively with the other provinces. However, the federal government should act independently, if it must.

Introduction

On November 16, 1999, Alberta Premier Ralph Klein announced his government would introduce legislation in the spring 2000 session to allow regional health authorities to contract out medical and surgical procedures requiring an overnight stay to private, for-profit companies. The Premier claimed that his intention was to "find new ways to reduce waiting lists and alleviate suffering." The Premier stressed that his government was taking these steps to "protect the public system…" and vowed that "(T)he new bill would enshrine, in law, our commitment to the principles of the Canada Health Act."

Federal Health Minister Allan Rock responded with a letter to Alberta Health Minister Halvar Jonson on November 26, 1999, evincing concern for the new initiative, asking a series of questions about the proposal's likely impact on costs and access, and requesting that Alberta delay the implementation of its proposal. Mr. Jonson answered Mr. Rock's letter on December 9th, stating that his government would proceed with the initiative. The most recent reports from Alberta indicate that the government is proceeding full pace with its intentions.

Background

Mr. Klein's government has introduced two previous pieces of legislation during the past four years to permit the operation of private hospitals in the province. Other pieces of legislation also have been tabled to permit more for-profit delivery of health care. The Alberta government has withdrawn these bills after strong political opposition, which included the provincial Liberals and NDP as well as broad-based citizen action led by such groups as the Alberta Friends of Medicare.

In its first term in office, the Chrétien government penalized Alberta under the Canada Health Act (CHA) for allowing private outpatient surgical clinics to charge patients directly for services. The clinic doctors were billing Alberta medicare for the physicians' services but were charging the patient directly for the clinic overhead, the so-called 'facility fee.' Eventually, this dispute led to a settlement with the federal government whereby Alberta agreed that its Regional Health Authorities (RHA) would contract with these private clinics and the RHAs would pay the facility fee. However, the agreement included approval of Alberta's decision to contract with for-profit clinics and allow the clinics to charge for "…voluntary service enhancements and non-medical costs, just as hospitals may charge for such services" (wording from May 30, 1996 Alberta Ministry of Health press release). The federal government's settlement with Alberta in 1996 appears to have sowed some of the seeds of the present controversy.

On two occasions (1997 and 1999), the provincial government also has asked the College of Physicians and Surgeons to develop standards for commercial operators providing procedures that require overnight stays. Both times, the College's Council refused to develop such standards, saying it was premature to do so without enabling provincial legislation and effectively sending the issue back to the Alberta government.

The political pressure to allow overnight stays has been driven by several major interests, nurtured by an ideology that espouses privatization of public services and facilitated by loopholes in the Canada Health Act and the federal government's failure to rigorously enforce the Act. Many of the key individuals involved in for-profit health care in Calgary have been strong supporters of Premier Klein throughout his

political career. Moreover, the Calgary Regional Health Authority recently has appointed to prominent positions a former provincial Treasurer and a former cabinet secretary, establishing it as a formidable political player in this dispute.

A loophole in the Canada Health Act could help the Health Resource Group get a foothold in the market for inpatient services. The Canada Health Act does not govern the workers' compensation system, which already contracts with the Health Resource Group for outpatient services. The Alberta Workers' Compensation Board (and potentially other compensation boards in Western Canada) could be a source of patients for overnight procedures offered by the Health Resource Group.

Federal Health Minister Rock has strongly voiced his concerns about the Alberta proposal, but his government does not seem to be protecting adequately the Canada Health Act. On November 30, 1999, the federal Auditor General, Denis Desautels, was very critical of Health Canada's performance in monitoring the Canada Health Act. Mr. Desautels noted that Health Canada believes several provinces are violating the Canada Health Act but is doing nothing to punish them. The Auditor General claims that Ottawa has adopted a passive approach to monitoring compliance with the Act and has insufficient personnel to monitor and enforce the legislation. Citizen complaints have resulted in polite letters to provincial officials and little, if any, action.

Analysis

Is the proposal good health policy?

The development of private hospitals in Alberta would result in increased costs and, probably, reduced access for certain groups. There already is information on the performance of for-profit health care in Alberta from a Consumers' Association of Alberta survey of outpatient cataract surgery in the province. In Calgary, all cataract surgery is done in commercial clinics and 80 percent of Calgary cataract patients pay an average of $400 for the procedure. For this expense, they get a lens implant (which may or may not be higher quality than the lens implant supplied under medicare) and a variety of other services, which can include a video of the procedure. In Lethbridge, where all cataract surgery is done in public hospitals, the higher-cost implant costs the hospital "substantially less than $100" and is provided to patients for free. The Calgary Regional Health Authority does not have to reveal its contracts, so there is no official knowledge of the costs of cataract surgery. However, the Consumers' Association of Alberta estimates the cost of a private operation is 50-100 percent higher than a public, nonprofit one.

It would be easy for the provincial government to pay too much for hospital care. If the regional authority paid a fee for a procedure based upon an average level of risk and difficulty, but the commercial operators preferentially took easier cases, then the public purse would be overpaying. This has been a continuing problem in the United States and other countries, which have attempted to 'carve out' patients from the general population. The whole point of public health insurance is to create a large, balanced risk pool. The basic idea of for-profit insurance and delivery is to identify and serve the low- risk population.

In fact, it might seem quite reasonable for smaller, freestanding, public health care facilities to do less complicated cases, such as a hip replacement for a 55-year-old ex-athlete. As

long as the public sector does all the cases, there is no need to worry about risk adjustment factors and assessing an appropriate fee for the small number of patients who inevitably will need acute care for complications.

What does the research say?

There are about 20 studies that have compared for-profit with not-for-profit acute care. Some of the early studies in 1970s and 1980s were inconclusive, although most showed higher costs with for-profit care. However, four recent studies, which are methodologically very strong, all favour not-for-profit delivery. Three of these studies have used data from the entire United States:

- In a 1997 article in the *New England Journal of Medicine*, Harvard physicians Woolhandler and Himmelstein analyzed 1994 data from all 5,201 acute care hospitals in the US. They found that for-profit hospitals were 25 percent more expensive per case than public facilities. Private not-for-profit hospitals were in the middle. Fifty-three percent of the difference in cost between public and for-profit hospital care was due to higher administrative charges in commercial facilities. The researchers also found that administrative costs were increasing much faster in for-profit facilities.

- Some Canadians claim that opening the health care market for competition would lead to more efficiency. However, a 1999 study by Dartmouth University researchers, published in the *New England Journal of Medicine*, concluded that introducing for-profit hospitals increased community health care costs. Using data from the entire American Medicare program, which insures people 65 years and older, Silverman et al. found that health spending was higher and increased faster in communities where all beds were for-profit compared with communities where all beds were not-for-profit. Spending grew fastest in those communities that had converted all their beds to for-profit care during the study period.

- Some observers might maintain that these increased costs are worth the price because they result in better quality health care. However, the available research on quality of care also seems to support a not-for-profit approach. Drs. Himmelstein and Woolhandler concluded in a 1999 article in the *Journal of the American Medical Association* that for-profit US health maintenance organizations (HMOs) rated lower than not-for-profit HMOs on all 14 quality indicators measured by the National Committee for Quality Assurance. Their study covered 329 HMOs representing 56 percent of all United States HMO enrolees. The authors estimated that there would be an extra 5,925 breast cancer deaths annually in the United States if all HMOs were for-profit.

- Another 1999 *New England Journal of Medicine* report, by Johns Hopkins researchers, investigated all dialysis centres in the United States. It concluded that patients receiving care at for-profit facilities had 20 percent higher death rates and were 26 percent less likely to be placed on a waiting list for renal transplantation than those attending not-for-profit centres.

Will the proposal create problems under NAFTA?

Canada's health care system is increasingly under pressure from various trade agreements. The United States has been aggressively pursuing a liberalized trade agenda. The Americans very much view health care as a market good and have been trying to get other countries to treat health care in a similar fashion to other tradable goods and services.

Canada's federal government did attempt to shelter health care by taking a reservation under the North American Free Trade Agreement (NAFTA), but this action did not fully protect health care. Health care is protected only to the extent that it is considered a social service carried out for public purposes. Further, NAFTA protects only policies "maintained in force" after January 1, 1994. A jurisdiction can change its laws only to make them more consistent with NAFTA, because the essence of free trade agreements is to liberalize trade. That means that if the Klein government allows for-profit hospitals, the law will bind every succeeding Alberta government. Despite Premier Klein's assertions that this policy can be tried out like a new suit, a future Alberta government that wished to terminate the experiment with for-profit care would be faced with a major problem. While the legislature still could pass any law it wished, any company (either one which did not have its contract renewed or one which was not even part of the original market) could sue the Alberta government for expropriation of its assets.

There are two private for-profit hospitals in Ontario, one of which is the Shouldice Clinic hernia hospital just north of Toronto. These facilities are regulated under the Ontario Private Hospitals Act. However, this Act simply 'grandfathered' some small facilities that existed prior to medicare and does not allow other for-profit hospitals to be licensed after October 29, 1973. It is unlikely that this precedent alone could be used to open up the rest of the Canadian market to for-profit hospitals.

NAFTA does recognize subnational governments, so a change in Alberta would not automatically open up other provinces' health care systems to for-profit hospitals. However, practically speaking, there could well be implications for the rest of the country. First, any new trade agreement (e.g., the proposed Multilateral Agreement on Investment which failed last year or the failed negotiations with the World Trade Organization in Seattle in November 1999) would not recognize subnational governments. Therefore, the presence of for-profit hospitals in one province at the time of a new trade treaty would put all provinces at risk.

Second, even under NAFTA, a foreign for-profit health care company could charge that the Alberta law had an impact on federal law (notably the Canada Health Act) and, therefore, the whole country was now open to for-profit hospitals. That would allow a foreign company to sue another province if it tried to block that enterprise from entering its marketplace. Again, NAFTA does not forbid governments from enacting legislation, but it does open them to suits alleging expropriation if they are forbidden from conducting business. A Canadian government or court would not make the decision about whether there was an impact on federal legislation. Rather, an international arbitration tribunal would make the decision and its decision would not be open to appeal.

Therefore, it appears that the Klein government's proposal would have the immediate effect of binding all its successors in Alberta and could have an impact on other provinces.

Is the proposal contrary to the Canada Health Act?

Strictly speaking, the proposal may not be contrary to the letter of the Canada Health Act. However, it does appear to be contrary to the spirit of the Act. The Canada Health Act section 12 (1) (a) says that, in order to satisfy the condition respecting accessibility, a province's health insurance plan "must provide for insured services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons."

Technically, the charging of fees for uninsured services contemporaneously with an insured service might not compromise access. Theoretically, the uninsured service would not be medically necessary and, therefore, there would no interference with access by limiting its provision to those who could afford the extra charge.

However, practically, at least some patients will feel that they cannot have the basic service without paying more. There will be others who will feel that they do not want to upset their surgeon by refusing the (presumably better) recommended extra service. Furthermore, the rules of medicare billing agencies and the professional regulatory bodies appear not to be strong enough to prevent excessive charges, or even charges for services that are somewhat dubious. Some Calgary cataract surgery patients currently pay hundreds of dollars above the true cost of their lens implant. There would be even more opportunities to charge for non-medicare services in hospitals than in outpatient facilities.

Is the proposal contrary to the Social Union Framework?

One of the Social Union Framework Agreement's principles is to "(E)nsure adequate, affordable, stable and sustainable funding for social programs." However, as mentioned previously, evidence from the United States and Alberta demonstrates that for-profit care costs more than not-for-profit care. Therefore, more for-profit care would lead to a less affordable and sustainable health care system. The Social Union Framework Agreement also refers to ensuring access "…to essential social programs and services of reasonably comparable quality." Again, however, the American experience indicates that for-profit acute care is, in general, of poorer quality than not-for-profit care.

Echoes of 1979: Parallels with the Hall Review of Medicare

There are many parallels with the situation that pertained in 1979 when Health Minister David Crombie asked Justice Emmett Hall to review the medicare program. There were concerns that some provincial governments were infringing upon the existing legislation as well as about the lack of federal enforcement. At that time, it was legal for doctors to extra-bill patients above the medicare fee schedule; the proportion of Ontario doctors who engaged in the practice increased from less than 10 percent to 20 percent in only a few months. Extra-billing also was a concern in other provinces, notably Alberta. British Columbia had imposed user charges for people admitted to hospitals.

Justice Hall met with officials from the federal, provincial and territorial ministries of health; representatives of health professionals, health institutions and health associations; and with users of health care services. His review served as a forum for debate and commissioned research papers that enriched the public discourse. Notwithstanding the legality of extra-billing and the fact that this practice had been part of the so-called Saskatoon Agreement which settled the 1962 Saskatchewan doctors' strike, Justice Hall concluded that "if extra-billing is permitted as a right and practiced by physicians in their sole discretion, it will, over the years destroy the program, creating in that downward path, the two-tier system incompatible with the societal level which Canadians have attained."

Justice Hall's report became the rallying point for the advocates of medicare and led directly to the Canada Health Act, which was passed in May 1984. (Of course, there also was some deft political work accomplished by Health Minister Monique Bégin and others to ensure that the legislation did, in fact, see the light of day.)

Today, as in 1979, the enemies of medicare are portraying their proposals as compatible with existing medicare legislation. As in 1979, the present situation already appears to breach the spirit, though not the letter, of medicare. Even more so than in 1979, some key newspapers are critical of medicare. The *Globe and Mail*'s editorial policy is ambivalent about medicare, and the *National Post* and other Hollinger papers consistently take editorial stands in favour of Klein's proposal. Partly as a result, important information is not reaching many Canadians. For example, the media outside of Alberta has scarcely reported the evidence on the existing Alberta for-profit outpatient surgery clinics. As in 1979, there is an opportunity to balance the debate with a public review of medicare.

Options for Action

The federal government has a variety of options. The first decision is whether it should be passive or active initially.

Passive

The federal government could wait until the Alberta government introduces the promised legislation in the spring 2000 session of the legislature. If the legislation is tabled, the federal Minister of Health then could remain passive or could move into one of the active options.

Advantages

- avoids immediate conflict with Alberta
- may avoid any conflict if the Alberta government decides not to introduce the legislation because of internal political opposition.

Disadvantages

- continues to give the Alberta government the initiative
- it appears that Klein is proceeding with full speed
- as soon as Alberta passes its legislation, the NAFTA provisions are activated. It would be too late to roll them back.

Active

The federal government could:

a. implement legislation or regulation to protect other provinces from the potential damage from NAFTA

b. commission an independent review

c. call for a review under the Social Union Framework Agreement

d. cooperate with the Senate review of medicare.

The need for immediate action to protect other provinces

As mentioned earlier, the Alberta legislation would bind the province to a policy of for-profit hospitals forever. A case could be made that Ottawa has a responsibility to protect Albertans from their own government's actions. An even stronger case can be made that Ottawa should protect other provinces from Alberta's actions.

The federal government or another province could claim that Alberta is, in fact, legislating on matters that concern international trade. Then the federal government could claim that the Alberta law was *ultra vires* because it concerns trade issues. But, if Ottawa waited to challenge the law after it was passed, it might be too late. The federal government cannot be sure how a trade tribunal would rule on the Alberta legislation's impact on federal law. Ottawa has been proven wrong before in its interpretation of NAFTA rules. There is a high degree of risk for the whole country if a tribunal declared that the other provinces must open their borders to for-profit hospitals.

The federal government also could consider passing legislation clarifying that any provincial legislation on for-profit hospitals was limited to that province and did not affect matters pertaining to international trade.

However, these are weighty issues that deserve an impartial judicial and administrative review – which does not characterize the current state of decision-making. In other words, there should be a truce among Alberta, the federal government and the other provinces, so that all Canadians can weigh the issues in a democratic fashion.

Advantages of rapid action under NAFTA

- immediately derails Alberta's proposals
- protects other provinces from potential damage.

Disadvantages

- none apparent.

The various options for review of the Alberta proposal would not replace the need for federal protection of other provinces from NAFTA provisions. These options have their own advantages and disadvantages:

Advantages of calling for an immediate federal review of medicare

- moves initiative away from Alberta and proponents of privatization
- brings some immediate balance to the public debate

- provides more opportunity to introduce other issues of concern besides Alberta's proposal – e.g., illegal extra-billing by Ontario doctors, queue-jumping for MRI (Magnetic Resonance Imaging) scans

- might force Alberta to hold up legislation until the review is completed and might prevent the introduction completely

- if citizen groups, non-governmental organizations (NGOs) and other provinces push for an immediate review, they are more likely to be able to shape the review than if they wait for the federal and Alberta governments to act. It does appear likely that Ottawa will act at some point, but might negotiate behind closed doors and aggravate the issue, as appears to have happened in the case of the Alberta settlement of 1996. That settlement gave federal government approval for private clinics charging patients at the same time as they are receiving insured services through medicare, and paved the way for the current crisis.

Disadvantages

- might not be necessary to derail Alberta proposal if internal opposition alone could prevent it from being introduced.

Independent Federal Review

As in 1979, the federal Minister of Health could request a third party to review the Alberta situation or any aspect of the medicare program. In 1979, Health Minister David Crombie initially suggested the creation of a neutral third party, a Canadian Institute for Health, to review medicare. The provinces (especially Quebec and Ontario) balked at this suggestion, so Mr. Crombie proposed he appoint the reviewer and the provinces acceded. However, the federal government may feel that if it proposes any review, it should use the provisions of the Social Union Framework Agreement negotiated between Ottawa and the provinces.

Advantages

- pro-medicare groups could focus on one government (the federal government) to ensure that the review was open, would conduct hearings and would travel across the country

- a review would be less likely to suffer from encumbrances raised by 14 different governments

- a review could deal with all issues affecting medicare instead of just the Alberta proposal (e.g., illegal extra-billing by Ontario doctors, queue-jumping for MRI scans).

Disadvantages

- Alberta (and other provinces) might question the legitimacy of a federal review and might not cooperate. Alberta has not agreed to delay its legislation in response to Mr. Rock's original letter and is unlikely to delay in the face of a federal review

- others may question the legitimacy of a federal review because of the Auditor General's criticism of Health Canada's enforcement of the Canada Health Act. This problem would be particularly acute if the review were confined to the Alberta situation and did not investigate other problems with medicare

- would not prevent Alberta from passing its legislation and triggering NAFTA and other trade-related concerns.

Review under the Social Union Framework Agreement

The Social Union Framework agreed to on February 4, 1999 outlines a mechanism to deal with disputes between governments. It is likely that, if nothing is done earlier, the Alberta situation ultimately will be referred for resolution to the mechanism described in the Framework Agreement. One of the key principles of the Framework is citizen participation – "…ensure appropriate opportunities for Canadians to have meaningful input into social policies and programs." Another section refers to ensuring "… effective mechanisms for Canadians to participate in developing social priorities and reviewing outcomes."

However, Section 6 of the Agreement, which deals with dispute avoidance and resolution under the Canada Health Act, does not refer specifically to public participation. It states that any government can make public reports of fact-finders or mediators and that governments will report publicly annually on the nature of intergovernmental disputes and their resolution. There are no details about who would conduct a review and what process they would use. There is no specific mention of public participation through hearings or travelling forums.

Advantages

- it might be difficult for Alberta to refuse such a review because the province has called repeatedly for such a mechanism to resolve medicare disputes. The review could prevent Alberta from proceeding with its proposed legislation before the review was completed
- if citizens and non-governmental organizations called early for the Social Union review, they would be more likely able to shape the form of that review. As mentioned, the dispute resolution mechanism described in the Framework Agreement does not refer specifically to public participation and public hearings.

Disadvantages

- if, as expected, the federal government and the provinces stick to the strict letter of the Social Union Framework Agreement, citizens would be shut out of the review. The subsequent backroom deliberations might result in a similar unfortunate settlement as that signed by the federal government and Alberta in 1996
- the federal government is unlikely to invoke the dispute resolution mechanism until after Alberta has passed its legislation, when it would be too late to avoid the problems under NAFTA
- it is unlikely that a review under the Social Union Framework Agreement could cover all aspects of the current situation for medicare, including abuses in other provinces and the Auditor General's criticisms that Health Canada has been negligent in monitoring and enforcing the Canada Health Act.

Senate review of medicare

The Senate will be conducting a study of Canada's health care system, including a review of the principles of the Canada Health Act.

Advantages of a Senate review

- can be mounted quickly
- a Senate review would be freer than an independent federal review and might well examine the current problems in Alberta and other provinces, as well as investigating problems with Health Canada's monitoring and enforcement of the Canada Health Act.

Disadvantages of a Senate review

- the Senate has low credibility with many Canadians, particularly in Alberta
- the Senate review would not replace any other review that might be launched. If no other review is commissioned, it is likely that the federal government ultimately would have to refer the matter to the Social Union Framework Agreement for resolution
- the Senate review would not prevent Alberta from passing its legislation and triggering NAFTA and other trade-related concerns.

Conclusion

The Klein proposal would be bad for Alberta's health care system, almost certainly raising costs and potentially diminishing quality. The proposal might not be immediately contrary to the letter of the Canada Health Act. However, it builds into hospital care the concept that patients can be charged privately for non-insured services while they are receiving insured services. This situation appears always to lead to interference with reasonable access.

The proposal also might activate provisions under the North American Free Trade Agreement. NAFTA, first, would bind all succeeding Alberta governments to dealing with for-profit hospitals. Second, the proposed Alberta legislation would allow foreign companies to make a case to an international administrative tribunal that they should be allowed into all provinces because the Alberta law has the effect of changing the interpretation of the federal legislation.

Recommendations

The federal government should act immediately to protect other provinces' health care systems from the activation of NAFTA provisions by the proposed Alberta legislation. As soon as that legislation is proclaimed, there will be no recourse.

After the federal government has acted to protect other provinces from the activation of NAFTA provisions, it should commission a review of Canada's medicare system with terms of reference similar to that given to Justice Emmett Hall in 1979. Preferably, the review would be launched cooperatively with other provinces. However, the federal government should act independently, if it must.

The Terms of Reference for Justice Emmett Hall's 1979-80 Review of Medicare

The Health Charter for Canadians reads:

"The achievement of the highest possible health standards for all our people must become a primary objective of national policy and a cohesive factor contributing to national unity, involving individual and community responsibilities and actions. This objective can best be achieved through a comprehensive, universal Health Services Program for the Canadian people.

Implemented in accordance with Canada's evolving constitutional arrangements;

Based upon freedom of choice, and upon free and self-governing professions;

Financed through prepayment arrangements;

Accomplished through the full cooperation of the general public, the health professions, voluntary agencies, all political parties and governments, federal, provincial and municipal;

Directed towards the most effective use of the nation's health resources to attain the highest possible levels of physical and mental well-being."

1. The federal Hospital Insurance and Diagnostic Services Act has been in existence for 21 years and the Medical Care Act has been in existence for 11 years.

2. The social and economic climate within which publicly financed health insurance programs operate has changed significantly over that period.

3. Health care priorities and technology have been under constant development.

4. Health insurance programs themselves have evolved over the period in question and the federal and provincial finance arrangements related to these programs have changed.

5. Various groups and individuals have expressed concern with some aspects of the health care delivery system.

6. Provincial ministers have pledged their 'full support in any activities aimed at clarification and re-evaluation of health care programs.'

The Commissioner is charged to:

1. Consider the extent to which the goals of the Charter of Health for Canadians have been met;

2. Examine the extent to which the principles of portability, reasonable access, universal coverage, comprehensive coverage, public administration, reasonable compensation and uniform terms and conditions are being achieved;

3. Consider whether there should be other basic principles underlying health insurance delivery;

4. Consider the nature and extent of necessary revisions to the Hospital Insurance and Diagnostic Services Act and the Medical Care Act and related legislation;

5. Consider other means by which public authorities may best comply with the principles referred to above.

ISBN 1-894159-92-6

Published by:

The Caledon Institute of Social Policy
1600 Scott Street, Suite 620
Ottawa, Ontario, Canada
K1Y 4N7
Phone: (613) 729-3340
Fax: (613) 729-3896
E-mail: caledon@caledoninst.org
Website: www.caledoninst.org

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