HEALTH POLICY IN CANADA

Abdou Saouab
Political and Social Affairs Division

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HEALTH POLICY IN CANADA

ISSUE DEFINITION

Responsibility for matters related to the health of Canadians is shared between the federal and provincial governments. Health policy can be divided into two categories: (1) health care and (2) health promotion. Most improvements in the health status of Canadians in the past have been attributed to health care measures. Certain demographic trends, however, suggest that hope for still further improvements in the health of Canadians may lie in health promotion.

BACKGROUND AND ANALYSIS

A. Government Responsibility for Health

At Confederation, government involvement in health was minimal. People relied on their own resources and those of the family; hospitals were administered and financed by private charities and religious organizations. The only specific references to health matters in the Constitution Act, 1867 allocated jurisdiction over marine hospitals and quarantine to the federal government and jurisdiction over hospitals, asylums, charities and charitable institutions to the provinces. Since the provinces were assigned all matters of a local or private nature, as governments became increasingly more involved in the health field, the provision of health services was acknowledged as primarily a provincial responsibility. Federal government involvement came about largely as a result of the spending powers given to that level of government in the Constitution.

The principal federal department for health matters is Health and Welfare Canada, which pursues the objective of maintaining and improving the health of Canadians in conjunction
with other federal agencies and with provincial and local governments. The federal government is responsible for payments to provincial health insurance programs covering hospital, diagnostic, medical and extended health care services, as provided for in legislation (health care). This involves federal monitoring of provincial compliance with basic program conditions on which federal payments depend. The federal government also carries out a wide range of activities intended to protect Canadians from hazards to health. These activities include protection of food safety and nutritional quality, the safety and effectiveness of drugs and medical services and reduction and monitoring of environmental health hazards such as smoke, dangerous chemicals, radioactivity and disease (preventive health). Through the Federal Centre for AIDS, the federal government is also involved in prevention and control of the spread of HIV infection.

In the area of health promotion, the federal government, in cooperation with the provincial governments and non-government organizations, develops and delivers health education and information in areas such as nutrition, drug and alcohol use, smoking, and family, child and individual health care (see Figure 1, appended). The federal government does not contribute however, toward the costs of purchasing land, building hospitals or servicing debt, or toward debts contracted before the Medical Care Act came into force. Nor do federal contributions cover health care provided to veterans, or costs related to psychiatric institutions, homes for the elderly or nursing and care services in custodial institutions.

The federal government has special responsibilities for the health of aboriginal people, residents of the Yukon, immigrants and public servants at home and abroad. In addition, it pays 50% of the cost of various health and social services provided to persons in need under the terms of the Canada Assistance Plan. It also supports scientific research and related activities and provides for the training and maintenance of health research personnel. Finally, physical fitness is promoted, encouraged and developed through the Fitness and Amateur Sport Program of Health and Welfare Canada.

The Canadian system also offers a number of advisory services for assessing the health of certain categories of persons: Canadians posted abroad, civil aviation personnel, would-be immigrants, certain visitors making prolonged stays in Canada, foreign students, refugees, refugee claimants and seasonal workers. Figure 2 (appended) shows that medical examinations
for immigration purposes increased by over 100% between 1985 and 1989 and by almost 150% between 1985 and 1990. It should be noted, however, that the figures shown in Figure 2 include visitors on prolonged stays, refugees, seasonal workers and foreign students.

The formal structure established to facilitate federal-provincial cooperation in the health field consists of a Conference of Ministers of Health and a Conference of Deputy Ministers of Health who meet periodically. Additional bodies which deal with particular health issues are federal-provincial advisory committees on Institutional and Medical Services, Community Health, Health Human Resources, Mental Health, International Health Affairs and Environmental and Occupational Health.

B. The Health Care System

Canada provides universal health insurance coverage for its population through health insurance programs jointly financed by federal, provincial and territorial authorities. These authorities design their own health insurance programs following national standards codified in the Canada Health Act.

To qualify for full federal cash contributions, provincial plans must meet the following minimum criteria: (1) universal population coverage; (2) comprehensiveness of coverage; (3) reasonable access to service; (4) portability of benefits; and (5) administration by a public agency on a non-profit basis. These criteria are intended to ensure universal access for Canadians to pre-paid hospital and medical care.

The Canada Health Act does not specify what benefits are required in a "comprehensive" program and provinces and territories can and do include additional benefits that are not required under the national standards.

Provincial and territorial health insurance plans must cover medically necessary hospital services, physician services and certain surgical dental procedures. Provinces are not required to insure residents for the costs of eyeglasses, outpatient prescriptive drugs, general dental care and semi-private or private hospital accommodation. However, most provinces include an outpatient prescription drug benefit for the elderly and individuals who qualify for social assistance.
Coverage of long-term care is not required under the Canada Health Act but the federal government makes an equal per capita contribution to the provinces and territories in support of nursing home care, home care and ambulatory health care.

While they cannot impose user fees or extra-billing without losing federal financial support, provinces have considerable latitude in determining how their shares of health care costs are financed. They may institute insurance premiums or sales taxes, use general revenue or adopt a combination of approaches. Health insurance is the single largest program funded by provincial governments, but there is considerable variation in jurisdictions as to the amount of resources devoted to health care and the rate by which health care costs are increasing.

C. Financing the Health Care System

In addition to the power to legislate in certain areas, the Constitution Act, 1867 gave the federal government the power to spend moneys from the consolidated revenue fund on any activity, providing that the legislation authorizing the expenditure did not fall within provincial powers. This spending power enabled the federal government to make payments to the provinces and persons in the health field, for example, to hospital and medical care insurance programs, health grant programs, health resources and fitness and amateur sport. It also enabled the federal government to provide consultation and information services and to undertake research.

This national health insurance system was initially achieved through two pieces of legislation: the Hospital Insurance and Diagnostic Services Act, 1957 and the Medical Care Act, 1966. Federal financing in relation to both Acts was extended to provincial plans through a 50-50 cost-sharing plan. This arrangement presented problems for both federal and provincial governments. The federal government found the agreement too open-ended and the provinces complained about its inflexibility in relation to the allocation of resources. A new "block-funding" program was introduced with the passage of the Federal-Provincial Fiscal Arrangements and Established Programs Financing Act (EPF) in 1977.

"Block funding" gave each province a set amount of federal money, based on its population. The amount of the block fund for each province was to increase at the rate of
growth in population and the growth in gross national product (GNP). Part of the federal contribution to the provinces was given in cash and part in tax points. When block funding started, the federal government cut personal income taxes by slightly over 9% and the provinces raised their taxes by the same amount and therefore taxpayers noticed no difference. Combined with earlier federal tax transfers, this gave the provinces 13.5% points of personal income tax and 1% of corporate income tax. The balance of the federal contribution under the block-funding formula was paid in cash.

In the EPF arrangements, federal payments are calculated independently of provincial expenditures: the provinces are required to spend the federal contribution in the health field but not necessarily to make matching expenditures. With the expiry of controls on incomes and prices in 1978, the latter part of that year and 1979 saw large increases in the number of doctors extra-billing, more militancy among nurses and other unionized hospital groups, and charges that, as a result of the EPF, the provinces were diverting federal "health contributions" to non-health purposes. The federal government established a commission of inquiry (the Health Services Review '79) to investigate these issues. The Commission reported that the provinces were not diverting federal health contributions but that extra-billing and user charges would clearly destroy the program "creating in that downward path a two-tier system incompatible with the societal level which Canadians have attained." The Commission further recommended binding arbitration as a solution to the problem of fee negotiations between the government and physicians. Manitoba, Nova Scotia, Saskatchewan and Alberta accepted the concept of binding arbitration with their medical communities in the mid-1980s. The Manitoba government cancelled the arrangement in 1988, however, when the doctors received awards which the government considered were too generous. In August 1990, binding arbitration with doctors in Manitoba was reinstated after a 47-hour strike.

In 1980, a House of Commons Task Force was appointed to examine federal-provincial fiscal relations, including the impact of EPF, and to consider whether a sufficient proportion of national resources were being committed to meet essential health care needs. In its report, Fiscal Federalism in Canada, the Task Force concluded that federal funding for health care services was generally adequate although specific areas, such as preventive health, might require expansion. The Task Force reinforced the recommendations
of the Health Services Review with respect to extra-billing and user fees, going further with recommendations for financial penalties against provinces that permitted such practices. The Health Services Review and the House of Commons Task Force paved the way for the *Canada Health Act*.

In 1984, the provisions of the two previous insurance acts were consolidated in the *Canada Health Act* reaffirming the program conditions and providing financial penalties for provinces permitting extra-billing and hospital user fees, practices which, from the federal point of view, violated minimum standards required for federal financial support. The federal government laid out its position in a White Paper, *Preserving Universal Medicare*, in 1983. The proposals in this paper were heatedly and widely debated by governments and affected interest groups. Nevertheless, the *Canada Health Act* was proclaimed law 17 April 1984, its automatic sanctions to become effective 1 July 1984. For every $1 the provinces received in extra-billing and hospital user fees, $1 of the federal cash contribution for health under EPF arrangements was withheld. Those provinces ending the unapproved practices within three years could and did recover the lost grants in 1987. After significant federal-provincial conflict on these issues, all provinces complied with the *Canada Health Act* by the 1 April 1987 deadline.

A number of times since 1977, the federal government has limited the overall growth in the block fund. In 1986, it was reduced from the rate of GNP growth to GNP growth minus two per cent. Bill C-69, in early 1991, froze federal transfers for two years (1990/1991 and 1991-1992) and, after that, reduced growth to GNP minus three percent. The February 1991 federal budget extended the freeze on EPF payments through 1994-1995. Since the money raised by the tax points continues to grow, all the reductions in the growth of the block fund come out of the federal cash transfers. This means that the cash portion of federal block funding shrinks over time and some observers fear that the federal government will be unable to enforce the standards of the *Canada Health Act*. The federal government could lose its leverage to withhold cash transfers to the provinces in the event that the provinces allow user fees or extra billing. It is similarly argued that financial pressures on the provinces to limit services will be very strong.
D. Challenges Facing the Health Care System

In 1985, the overall cost of health in Canada, including expenditures by the private sector and all levels of government, was 18 times that in 1960. Health care now accounts for a large portion of provincial government budgets; e.g., approximately one quarter in New Brunswick and one third in British Columbia and Ontario. The budget allocated for medical care in Quebec went up by 19% between 1988-89 and 1990-91, while in Ontario it went up by 24% between 1989-90 and 1991-92. Health care expenditures represent 34.6% of Ontario's total budget, 24.4% of Quebec's, 33.2% of Alberta's and 23.3% of Newfoundland's.

As much as 85% of this health expenditure is for doctors and hospitals and they are being pressured by governments to help contain health care costs. Some suggest that doctors, on whom Canada's medical system hinges, may be responsible for a large share of the financial problems the system is facing. In Ontario, although doctors receive only 20-25% of the total spent on health care, they can nevertheless influence the system's other costs, for example by increasing the number of services they offer their patients even if these services are not always necessary.

People over 65 years of age are heavy users of the health care system and there is concern that the aging population which is expected to double within the next 50 years, will overburden the system and further increase health care costs. Most seniors are not sick, however: a small group of "frail elderly," over 85 years, are the heavy users of health care. Most research suggests that it is elderly people's heavy and often inappropriate use of health care, not their numbers, which is the problem that must be addressed. Canada can draw on the experience of European countries, who have had for the past 20 years the same percentage of elderly people as Canada expects to have by 2031.

At the same time, governments are emphasizing alternatives to the sickness care system and a redirection of funds toward home care services and community-based health clinics and toward fighting the causes of disease and disability, such as drinking, smoking and pollution. Community organizations are urging governments to intervene to reduce poverty, which they view as an important precursor of poor health and disability. Research finds that, while the disparity in life expectancy between rich and poor is diminishing, the size of the gap remains
large. Similarly, while infant mortality has been cut nearly in half since 1971, the rate among the poor remains almost double that among the rich.

Traditionally, the health care system has been based on a medical model of health and has consequently focused on treatment and prevention of illness and premature death. The burden of ill-health has been enormously relieved since Confederation. Original improvements came with socio-economic developments and public health measures associated with the development of medical science. The passage of the *Food and Drugs Act* in 1920, for example, led to the protection of the food and drug supply. Other pieces of legislation, including the *Meat Inspection Act*, the *Fish Inspection Act* and the *Consumer Packaging and Labelling Act*, were important legislative tools in maintaining and improving the nutritional value of food. These serve as examples of the numerous cases where health policy requires cooperation among several government departments, e.g., Agriculture Canada, Fisheries and Oceans and Consumer and Corporate Affairs. There were decreases in morbidity and mortality rates and, after the middle of this century, major changes in disease patterns. Many once prevalent infectious diseases, such as smallpox and diphtheria, for example, were virtually eliminated. Gradually, nationwide health insurance, which would provide greater access to better health care services for the population in general, began to be considered.

Proposals for a national health insurance plan including both hospital and medical care, were part of the *Green Book Proposals* for postwar reconstruction in 1945. While these proposals did not become a reality at that time, national health insurance did become a matter of public concern and debate. Saskatchewan started its hospital insurance plan in 1947, well before federal assistance was available, and the *Hospital Insurance and Diagnostic Services Act* brought a national program of hospital insurance in 1957. The *Royal Commission on Health Services* (the Hall Commission) reported in 1964 that "the fruits of health sciences" were still not accessible to all Canadians and recommended a universal health services program for all Canadians as the "most effective use of the nation's health resources to attain the highest possible levels of physical and mental well-being." In 1966, the *Medical Care Insurance Act* provided for public medical insurance. The 1984 *Canada Health Act* consolidated the two previous Acts and made the abolition of extra-billing and hospital user fees a condition of federal funding.
Since the advent of medicare the fee-for-service system and discretionary decision-making powers of physicians have come under increasing pressure. With the end of extra-billing, individual physicians ceded to provincial governments discretion over the price of their services. Controversy continues around administrative charges, the definition of insured services and overall increases in the fee schedule. Some research suggests that, faced with fee constraints, physicians may increase the number of patient visits and the number of services provided. For instance, the Ontario government estimated in its 1988 budget that during the 1980s the cost of the province’s health insurance plan had increased by 15%, of which 8% was actually attributable to higher costs and 7% to an increased (and by implication incited) demand for services. According to this view, there must ultimately be controls on "utilization." An alternative strategy, now being tried by some provincial governments, particularly Quebec and Ontario, is to establish group practices and clinics funded on a per capita or global budget basis (similar to Health Maintenance Organizations in the United States) under contract to a government insurance plan. Ontario is the first province to consider a bill to license, regulate and finance independent health clinics.

Some experts still argue that, due to rising health care costs, the Canada Health Act may have to be amended to allow charging patients for "non-essential" medical and hospital services and thus keep down the demand for such services, which they see as fuelling rising health care costs. This is precisely the path on which the provinces have gradually embarked. Quebec, for instance, no longer pays for certain types of dental care and cosmetic surgery and has begun imposing fees of $2 per prescription on elderly persons who receive health care outside hospitals. In Ontario, individuals with an annual income of more than $20,000 and families whose income exceeds $40,000 per year will soon be required to pay a health insurance premium of up to $300 annually. These measures are arousing great concern among the elderly, but the provincial government is defending itself against claims that it is rejecting them, maintaining that official 1991 statistics show that 71% of those older than 65 who are living on their own have an annual income of under $20,000 and will therefore not be affected by the planned measures. In British Columbia, the elderly who receive health care services outside hospitals pay 75% of their prescription costs, and those under the age of 65 pay the first $325. The Alberta government has
attempted to de-insure tubal ligations and vasectomies. the British Columbia government wanted to refuse medicare coverage for abortions and the New Brunswick government proposed charging cancer patients a fee for out-patient beds in hospitals.

On 17 June 1992, the provincial and federal ministers responsible for finance and health met in Ottawa to determine what could be done about the soaring cost of health care in Canada. The provinces took advantage of the opportunity to ask the federal government for funding to help cover the transitional period while they were formulating and implementing strategies for cutting costs in their health care programs. Some of the provinces (Quebec, New Brunswick, Saskatchewan and British Columbia) called for a federal policy permitting them to charge user fees for certain health care services, so that the shortfall caused by reduced federal transfers could be met.

It should be noted that Quebec’s health care system has changed profoundly since the province joined the federal health insurance program in 1970. Not only does the Quebec system incorporate the physical, mental, and the socio-cultural aspects of health care, it also encourages preventive medicine, participation by the population in the decision-making process and diversification of health care, which is provided by establishments that are interdependent both vertically and horizontally.

In 1981, Quebec passed Bill 27, under which responsibility for evaluation of medical practices, utilization of resources and quality control of services was shifted to the chairmen of clinics based in public hospitals. In July 1992, Quebec’s Ministry of Health and Social Services stated that reform of the health care system would focus on sickness prevention and health promotion. According to the Minister, the Hon. Marc-Yvon Côté, universal access to health care has not produced the anticipated results, and from now on the main aim of the government’s health care policy will be to improve the socio-economic situation of poor people by improving their employability, investing more money in educational programs and persuading young people to stay in school. Placed in this comprehensive context, health and well-being depend on joint action by a number of players.

In its wish to impose user fees and a special tax on middle- and upper-level income earners who use certain health services. Quebec is only trying, like some of the other provinces, to cope with reduced federal contributions. While the federal government contributed
45.7% of funding for Quebec's health care system in 1977-78, federal funding accounted for only 37.3% in 1990-91, and is expected to drop to less than 30% in 1994-95.

It appears that the Quebec population is becoming aware of the issue of high health care costs: Quebec residents indicate that they are prepared to assume their share of responsibility. According to a survey conducted by SOM-Les Affaire among 992 Quebec adults, 80% of respondents would agree to pay $5 per visit to a doctor, and 59% were prepared to pay twice that amount. However, it must be pointed out that 57% of those who favoured a fee of $10 per visit earned between $35,000 and $45,000 a year. Among those who had an individual annual income of $55,000 and over, the percentage was 78%. Nevertheless, 80% of respondents stated that they were opposed to any budget cuts in old-age pensions, and 74% were opposed to cuts in health care.

Nurses and other health care workers have also resisted some strategies to reduce health costs which they view as contrary to their interests. Strikes by nurses in British Columbia, Saskatchewan, Alberta and Quebec are symptomatic of this trend.

Some lobby groups, including the Canadian Medical Association, consider Canada's health care system an intrinsic part of Canada's identity. Others, such as unions and community organizations, as well as a considerable proportion of people working in this field, continue to insist that the disappearance of universal health care will also mean the disappearance of other elements that form the foundation of social welfare for Canadians, particularly those most disadvantaged.

The controversy concerning the funding of the "health care system" continues. Meanwhile, provincial governments must deliver the health care services which the public has come to expect. British Columbia is the first province to enter into a formal agreement to send patients to the United States for heart by-pass surgery to help clear a backlog for such surgery. Media reports suggest that the Ontario Health Insurance Plan paid out as much as $30 million to addiction treatment centres in the United States in 1990. Critics fear that these arrangements will increase the pressure on health care funding. Additional demands on funding can be expected to be made as a result of such factors as the increasing number of elderly people, the AIDS epidemic and the striking down by the Supreme Court of Canada of the abortion law. The situation faced by the provinces is further complicated by the high costs of expanding medical...
technology, an impending surplus of physicians, fee demands, wage and salary negotiations with professionals and workers in the field and a lack of incentives for hospital efficiency.

Many provinces, including Quebec, Ontario, Alberta, Nova Scotia, New Brunswick and Saskatchewan, have undertaken major studies of their health care systems and the provincial premiers announced, in August 1988, that they would be studying the funding of health care in the future in three national symposiums the following year. There is concern generally about the cost of continuing to provide health services based on the traditional medical model.

There is now a growing interest in community health services across the country. Many pilot projects are being established in some provinces to determine the benefits of alternative approaches to health care. A clinic in Ferryland, Newfoundland, for example, is an experimental project sponsored by the World Health Organization to measure the extent to which nurses can improve health care and reduce costs. The project relies on common sense and emphasizes illness prevention, health promotion and community participation. Other provinces are taking similar initiatives. The Ontario Ministry of Health, for example, has recently launched a $10-million pilot project in five communities aimed at reducing hospital stays and improving the quality of home health care. In March 1993, Quebec's Council of Ministers approved midwifery, thereby opening another door to reducing the costs related to hospital stays and at the same time allowing the public to select the obstetrical practices best suited to their needs. Midwifery has, however, been subject to the stringent rules of a government order, which contains a long list of obstetrical and neonatal risks that require a physician's presence and intervention.

Although it is still too early to evaluate their real impact, available data indicate that communities increasingly favour these approaches and that a substantial reduction in health care costs has been achieved by various pilot projects across Canada.

A national centre to co-ordinate the assessment of new health technology was announced in December 1989 by the federal and provincial health ministries. The centre will act as a clearing-house to share information on new health technology.

Many health care professionals argue that the health of Canadians is being seriously jeopardized by underfunding of the health care delivery system. The June 1990 report
of the Standing Senate Committee on Social Affairs, Science and Technology, *Accessibility to Hospital Services - Is There a Crisis?*, concludes that, unless action is taken without delay, Canada does in fact face a national crisis in accessibility to health services. The federal government and health policy analysts tend to argue that putting more money into the existing system will not necessarily improve the present health status of the population. They claim that improved health and controlled costs, will be best achieved through an emphasis on health promotion and prevention of illness. Dr. Robin Walker, Vice-President of the Canadian Council on Children and Youth, told the House of Commons Standing Committee on Health and Welfare, on 2 May 1988, that the savings from reducing the low birth weight rate, even by 1%, would be millions of dollars a year. The cost of caring for each of Canada's surviving underweight babies is about $100,000 annually. The incidence of low-birth weight babies is highest in populations characterized by young mothers with poor overall health care and lifestyles. Clearly, preventive measures and health promotion programs aimed at modifying practices and conditions that are detrimental to health (e.g., obesity, poor diet, inactivity, substance abuse) would improve the health status of many Canadians and relieve some of the pressure on health care funding in the longer term. In the meantime, many observers see the need for new and innovative approaches to managing delivery of health care services in order to make good quality care more accessible and cost-efficient.

There has been much conjecture and controversy concerning the possible effects of the Canada-U.S. Free Trade Agreement (CUSFTA) on this country's health care system. There is considerable agreement among experts in the field that the CUSFTA will lead to more private management of Canadian health care institutions and programs but there is no corresponding consensus on whether this trend poses a threat to medicare. Proponents of privatization argue that governments can no longer afford the rising costs of health care and that in the interests of efficiency, effectiveness and responsiveness they must increasingly encourage involvement by the private sector. The United States has the foremost and largest firms in this field and has shown a long-time interest in expanding these services in Canada. According to critics, profit-motivated health care corporations will undermine the health care system by creaming off the profitable areas. The result will be a two-tiered system of health care, with one standard of service for those who can afford private health services and another but lower
standard for those who cannot afford them. As an example of such a system, these critics single out the United States, where those who can afford it enjoy a very high standard of health care while approximately 35 million citizens have no health insurance coverage at all. In addition, in the United States, health care accounts for 10.6% of GNP as compared to only 8.6% of GNP in Canada.

E. Health Promotion

In the early 1970s and 1980s, demographic and disease trends indicated that hope for further improvements in the health status of Canadians lay in the area of health promotion. Trends such as the aging of the population and the high incidence of certain diseases and disabling conditions related to lifestyle, e.g., cardiovascular disease, cancer, accidents and mental illness, led to a new emphasis on the reduction of risk to health, early detection of health problems and improvements in rehabilitation and coping strategies. In 1974, A New Perspective on the Health of Canadians: A Working Document, published by Marc Lalonde, Minister of National Health and Welfare, spelled out guidelines for a health planning approach.

Health promotion, though similar to the preventive measures associated with the "old public health" concept is a "holistic" approach that focuses on the total population in the physical and social environment. It is related to matters such as environmental pollution, family violence, highway accidents, stress and workplace hazards which, strictly speaking, are outside the realm of health policy. Health promotion, therefore, entails the coordination of health policy with other policies. This "new public health" is also holistic in the sense that it focuses on whole individuals in their total day-to-day environment. Health in this view is considered as a state for which people strive and not as merely the outcome of curing, treating or preventing illness and injury. Within the health field itself, health promotion implies the sharing of responsibility and resources by governments and health professionals with individuals planning their personal health strategies, and with community and other support groups not previously regarded as part of the health care team. Health promotion includes research funding programs and a national AIDS program under which 12 post-graduate bursaries and 17 career awards are given out. A child sexual abuse and spousal violence awareness program has also been funded.
In 1977, Canada endorsed the health planning program and policy initiative of the World Health Organization (WHO), *Health For All by the Year 2000*. Influenced by the Lalonde Report, Health and Welfare Canada and Statistics Canada conducted a health survey in 1978-79 which, unlike previous health surveys, was based on a health promotion approach. This *Canada Health Survey* collected information not only on disease and disability but also on demographic correlates of lifestyle and preventive health practices. In 1985, the *National Health Promotion Survey* updated the information in the previous survey and provided comprehensive information on people’s knowledge of and attitudes toward their behaviour. A key finding of this second survey was that knowledge about health matters and belief in their importance do not necessarily lead to better health or changed behaviour. In other words, providing information alone is not an adequate preventive health strategy. On the other hand, a more recent study (1989) indicates that campaigns to make Canadians aware of health problems and of their own attitudes and behaviours have encouraged more than half of the country’s young people to stop using drugs and alcohol. The data in the national study carried out in 1989-90 by Statistics Canada at the request of the Health Services and Promotion Branch show that Canadians are more conscious than they used to be of the impact on society of alcohol and drugs and take steps, for example, to avoid driving when impaired.

In November 1986, Mr. Epp, Minister of National Health and Welfare, presented a plan for health promotion in a paper at the International Conference on Health Promotion in Ottawa. In this paper, *Achieving Health For All: A Framework For Health Promotion*, three challenges to the Canadian health system identified in the Health Promotion Survey were discussed:

1. the low health status of low-income groups, children, women, the elderly, natives and immigrants;

2. the need to prevent harmful lifestyles and behaviours such as drinking, smoking and consumption of high fat diets which contribute to high incidence diseases such as lung cancer, liver disease, cardiovascular disease and accidents;

3. the need for individuals, families and communities to develop coping mechanisms to deal with chronic health problems associated with aging, mental illness and other socially and physically disabling conditions.
The best mechanisms for addressing these challenges, the paper suggests, are: **self-care**, where people take an interest in and make decisions about their own health; **mutual aid**, where people help each other to cope; and **healthy environments**, conditions and surroundings conducive to health. Three strategies suggested in the paper for establishing these mechanisms were: (1) fostering public participation; (2) strengthening community health services; and (3) coordinating public health policy.

There have been some accomplishments in health promotion: greater public awareness of the benefits of fitness and proper nutrition; government anti-smoking campaigns; legislation making the use of seat belts compulsory; and allocation by the federal government of $30 million annually to improve the quality of life of the elderly through self-care projects and education. Health promotion policy is only just beginning to touch the sickness care system itself. Alternatives to long-term hospitalization of the elderly and rehabilitative services for them after release from hospital are being developed and inexpensive preventive and self-help programs are being established to make more rational use of health personnel and resources.

Increasingly greater numbers of health professionals and experts agree that there are long-term savings and benefits in pursuing the goals of health promotion and disease prevention rather than treating sickness after it occurs. Recent health promotion initiatives include a federal program to fight alcohol and drug abuse in elementary and high schools. The federal and Manitoba governments announced a new research centre in Winnipeg to design and market special health care products and services which will help elderly people and the disabled live safely in their own homes. Some health observers suggest that reorienting the health system will probably not come about until it is demanded by a public which sees such reorientation as superior to the scientific and technological approach of the existing system.

Some health experts see employment trends as very relevant to public health. The trend away from secure full-time jobs toward part-time minimum wage positions, they fear, will contribute to poverty and poorer health in Canada. People living in poverty tend to have poor nutrition and a sense of hopelessness that may lead them to have less caution in adopting a lifestyle which might contribute to potential health problems. Such employment trends could reverse the gains made to date in promoting healthy lifestyles.
The health status of native people and the level and appropriateness of native health services are demanding more attention. A federal inquiry into native health services began in September 1988 following a hunger strike by four Cree protesting about the services at Sioux Lookout Zone hospital in Ontario.

PARLIAMENTARY ACTION

The Constitution Act, 1867 made few direct references to government responsibility for health because governments had only minimal involvement in the field at that time.

The Hospital Insurance and Diagnostic Services Act, 1957 introduced a national hospital insurance program.

The Medical Care Act, 1966 introduced a national medical insurance program.

The Federal-Provincial Fiscal Arrangements and Established Programs Financing Act, 1977 changed the cost-shared funding arrangements for health insurance between the federal and provincial governments to block funding.

The Canada Health Act, 1984 (Bill C-3) consolidated the provisions of the two previous insurance acts and reaffirmed and strengthened the federal government's commitment to universal prepaid national health insurance.

The Act to Amend the Federal-Provincial Fiscal Arrangements 1977 (Bill C-96) 1986 reduced the growth of the block grant from the rate of GNP to GNP growth minus 2%.

The Government Expenditures Restraint Act (Bill C-69) 1991 froze the block grant for two years (1990-91 and 1991-92) and after that reduced growth to GNP minus 3%. The 1991 budget extended the freeze to 1994-95.

CHRONOLOGY

1867 - The only references to health in the Constitution Act allocated responsibility for marine hospitals and quarantine to the federal government and jurisdiction over hospitals, asylums, charities and charitable institutions to the provinces.
1957 - The *Green Book Proposals* on postwar-reconstruction contained recommendations for a national health insurance program.

1957 - The *Hospital Insurance and Diagnostic Services Act* introduced national hospital insurance.

1964 - The report of the Royal Commission on Health Services (the Hall Commission) advocated a national medical insurance program.

1966 - The *Medical Care Act* provided for a national medical insurance program.


1977 - The *Federal-Provincial Fiscal Arrangements and Established Programs Financing Act* made it a condition of federal payments that a province must show that its plan satisfied the federal medicare criteria.

1980 - The *Health Services Review '79* reported that extra-billing by physicians and hospital user fees were endangering the principle of reasonable access to health care.

1980 - The House of Commons Task Force, while reinforcing the Health Services Review recommendations for financial penalties for provinces continuing to permit extra-billing and user fees, concluded that federal funding for the health care system was adequate.

1981 - The *Health of Canadians: Report of the Canada Health Survey* was released offering information not just on disease and disability but also on lifestyle, environment and socio-economic factors influencing health.

1984 - The *Canada Health Act* consolidated the two previous Acts and reaffirmed and strengthened the federal commitment to universal prepaid public health insurance.
The Act to Amend the Federal-Provincial Fiscal Arrangements 1977 restricted the growth in federal transfers to the provinces to growth in GNP minus 2%.


The main findings of the 1985 National Health Promotion Survey were published in the Active Health Report. For the first time, information on knowledge about and attitudes toward certain lifestyle behaviours and preventive health practices were gathered as a basis for an informed health promotion strategy.

The House of Commons Standing Committee on National Health and Welfare, in its Interim Report on the Canadian Health Care System: Facts and Issues, identified institutional care, health manpower, medical technology, health promotion, accessibility and financing as issues which need to be addressed if the health care system is to continue to provide high quality care at a cost that Canadian society can afford.

The report concluded that action must be taken immediately to avoid a crisis of access to acute care. It is possible, according to this report, to curtail health care costs and still provide excellent health care.

The Government Expenditures Restraint Act froze transfers to the provinces for two years (1990-91 to 1991-92) and after that reduced its growth to GNP minus 3%.

The House of Commons Standing Committee on Health and Welfare, Social Affairs, Seniors and the Status of Women tabled its report. The Health Care System in Canada and its Funding: No Easy Solutions. The report concludes that the health care system does face a variety of challenges, many of which cannot be solved by simply increasing spending on
the system as it currently exists. It emphasizes the need for more cost-effective and appropriate distribution of resources in a system that recognizes that health goes well beyond hospital and medical care.

SELECTED REFERENCES


Crichton, Anne, Ph. D., and David Hsu, M.D. with the assistance of Stella Tsang. *Canada's Health Care System: Its Funding and Organization*. Canadian Hospital Association Press, Ottawa, 1990.


APPENDIX
### Figure 1: Health Promotion Grants and Contributions Program

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>General Health Promotion</td>
<td>3,540</td>
<td>5,131</td>
<td>6,475</td>
<td>6,991</td>
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<tr>
<td>AIDS</td>
<td>10,804</td>
<td>9,999</td>
<td>5,000</td>
<td>2,785</td>
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<tr>
<td>Drugs</td>
<td>4,300</td>
<td>6,317</td>
<td>4,300</td>
<td>2,153</td>
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<tr>
<td>Child Sexual Abuse</td>
<td>0</td>
<td>159</td>
<td>400</td>
<td>493</td>
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<tr>
<td>Driving While Impaired</td>
<td>1,000</td>
<td>926</td>
<td>1,500</td>
<td>971</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>19,644</strong></td>
<td><strong>22,532</strong></td>
<td><strong>17,675</strong></td>
<td><strong>13,393</strong></td>
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* Forecast

Figure 2: Medical Assessments - Immigration Medical Services

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<th>Year</th>
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<th>North America</th>
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<tr>
<td>1986</td>
<td>40,850</td>
<td>125,083</td>
<td>165,933</td>
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<td>1987</td>
<td>50,629</td>
<td>180,203</td>
<td>230,832</td>
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<td>1988</td>
<td>55,483</td>
<td>206,739</td>
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<td>1989</td>
<td>59,819</td>
<td>263,801</td>
<td>323,620</td>
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<tr>
<td>1990</td>
<td>77,172</td>
<td>258,385</td>
<td>335,507</td>
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<td>1991</td>
<td>61,608</td>
<td>187,665</td>
<td>249,273</td>
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