Out-of-Pocket Health Expenditures in Alberta and British Columbia: The Role of Sub-National Politics*

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Daniel Cohn, Ph.D.
Department of Political Science
Simon Fraser University
Burnaby, British Columbia
V5A 1S6

Tel. 604.291.5667
Fax. 604.291.4786
Email dcohn@sfu.ca

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Abstract

Out-of-Pocket expenditures made by families and individuals represent roughly 15 percent of health spending in Canada. These costs sometimes constitute a major barrier to accessibility. The degree to which sub-national politics impacts on these costs is assessed by comparing annual out-of-pocket health expenditures (as a percent of after-tax and transfers income) for families with varying characteristics in Alberta and British Columbia for the period 1992 - 2002. The data source used is Statistics Canada's Survey of Household Spending. Alberta and British Columbia form something of a natural experiment in that voters in the early years of the 1990s made fundamentally different choices. Those in British Columbia elected a New Democratic Party government which remained in power until 2001. In 2001 voters replaced the New Democrats with the BC Liberals who have reshaped public policy along lines typically described as neoliberal. Meanwhile, in the early 1990s, Albertans renewed the mandate of the Progressive Conservatives after the party adopted a neoliberal stance under its then new leader Ralph Klein. As a result, it is possible to compare the provinces after approximately a decade of government by parties with very different political ideologies and agendas, and also, after voters in British Columbia elected a government with an ideology and agenda similar to that which was already in place in Alberta.

INTRODUCTION

One of the fundamental questions in the study of federations is how much autonomy their sub-national governments have to act on their individual policy preferences. This paper addresses this question for Canada by considering the case of health care. Canada is seen as being among the more highly decentralized federations (Rohr 1997). Meanwhile, it is widely accepted that the provision of health care lies primarily within the constitutional jurisdiction of Canada's provinces (Romanow 2002: 3).[1] Therefore, few would be surprised that in a recent study of five federations (Australia, Belgium, Germany, the United States and Canada), Banting and Corbett (2002) found Canada to have the most decentralized health policy-making process in the group. On the other hand Siguardson (1996: 320), looking more generally at public policy, cautions that the ability of Canada's provincial governments to make use of such decentralization so as to follow their preferences is significantly limited by the federal division of powers, as well as the more commonly known practical realities of democratic politics. Bernard and Saint-Arnaud (2004) add evidence to support this view. They found only modest differences between the welfare state regimes of the four largest provinces (Ontario, Quebec, British Columbia and Alberta) and Canada's overall positioning within the universe of welfare state regimes. In other words, saying that decision-making processes are decentralized is one thing. Saying that sub-national governments, such as provinces, will be able to make use of this opportunity so as to act autonomously or that their actions will make a major difference in the daily lives of citizens are completely different matters.

The relevance of this distinction in the field of health care policy-making in Canada will be assessed by looking at the difference in out-of-pocket payments for health

care that are incurred by non-senior households (those lacking members 65 years of age or older) with different characteristics in the provinces of Alberta and British Columbia for the time period 1992-2002. Out-of-pocket expenditures for health care are any payments made by a household for health related goods, services, or insurance coverage (whether public or private), that are not reimbursed by another party. Out-of-pocket expenditures are an important component in the financing of health care throughout the OECD countries and are estimated to account for 15-16 percent of total health expenditures in Canada (Evans 2004: 139). Research shows that when public policy does not make proper allowances for ability to pay them, out-of-pocket charges are associated with unequal access to care and sometimes unequal outcomes (Newhouse 1993: 338-371; Schoen et al.: 2000; Schoen and Doty 2004; Tamblyn et al. 2001). As well, in a country with universal health insurance, changes in such costs constitute important statements by governments as to the balance that ought to be struck between state and individual provision of welfare.

The data used is from the 1992-1996 Surveys of Family Expenditure and 1997-2002 Surveys of Household Spending, which superseded the former survey (Statistics Canada 2004). Hereafter the two data sources will simply be called the Survey of Household Spending unless there is some reason to differentiate between the two surveys or the iterations from individual years. One limit to this study is that the data source used does not contain any information on the health status of household members, and as a result, this cannot be controlled for. A further limit is the relatively short time frame for which data is presented here. This essentially restricts the present paper to an exploratory study which will be followed up with a study involving a longer time-frame and more

sophisticated analytical methods. More will be said about this in the methodology section and conclusion.

Alberta and British Columbia are directly adjacent to one another, and each comprises a roughly similar portion of Canada's geographic size and population. Both are also generally seen as being among the wealthier of Canada's provinces and their populations enjoy relatively similar health status (Federal Provincial Territorial Advisory Committee on Population Health 1999).[2] Finally, during the 1990s voters in the two provinces made different choices. In 1991 British Columbia elected the New Democratic Party (NDP) -- which retained office until 2001. Although the party had factional disputes as to whether or not to adopt a "New Labour" orientation (Siguardson 1996; Fairbrother 2003), it has still been described as forming the last "real New Democratic" [sic] social democratic regime in Canada up until its last few months in power (Schmidt 2000). In 1993 the voters of Alberta re-elected the Progressive Conservative Party (PCP) after its adoption of neoliberalism under new leader Ralph Klein (Cooper 1996; Harisson and Laxer 1995; Harder 2003: 119-152).

In that social democrats and neoliberals hold differing views as to the degree to which the state and market ought to determine the welfare of individual families and the opportunities that they enjoy (Shaw 2003), the hypothesis that this study begins with is that this difference in governments will be reflected in the average out-of-pocket expenses paid by households. Re-enforcing this prediction are the periodic pronouncements made by members of the Alberta PCP, Premier Klein, and his advisors since the early 1990s, that the costs of providing health care ought to be borne more fully by individual families (Klein 2005; Boothe 2002; [PCP] MLA Task Force on Health Care

Funding and Revenue Generation 2002; Premier's Advisor Council on Health 2001; McDaniel 1997: 218; McConnell: 1992). The Alberta government has also made some high profile attempts to implement such a shifting of costs (Bhatia and Coleman 2003; McDaniel 1997: 219-220; Crockatt 1993). On the other hand, the NDP in British Columbia, in other provinces, and at the federal level, often take credit for the creation of Canada's publicly financed health care programs and have criticized proposals to shift costs from the state onto the shoulders of individual families (Begin 2002: 1-2; New Democratic Party of Canada 2004; New Democratic Party of British Columbia 2005; Ward 2004; Mandryk 2004). Second, it is predicted that out-of-pocket health spending in British Columbia will converge with those in Alberta after British Columbia replaced the NDP with the neoliberal British Columbia Liberal Party (BCLP) in the May 2001 election. Finally, in that health insurance is seen as the one policy area within Canada's welfare state where coverage is more in keeping with the social democratic ideal type rather than the liberal one (Esping Andersen 1990; Tuohy 1993), it is also predicted that average out-of-pocket costs for households British Columbia will be more similar to those in the other eight provinces than will be average out-of-pocket costs for Alberta up until 2001. However, average spending in British Columbia will trend away from the mean for the other eight provinces after the change of government experienced by British Columbia in 2001.

The results reported here generally support these hypotheses, indicating that further work is indeed warranted to both expand the data-set and increase the sophistication of the methods being employed. However, as in the study of welfare regimes in Canada done by Bernard and Saint-Arnaud (2004) overall differences are

found to be modest. Consequently, the study tends to also confirm Siguardson's claim (1996: 320) that, in spite of a highly decentralized decision making institutions and constitutional precedence in the health policy field, the autonomy of provincial governments is narrower than it first appears within the Canadian federation.

The next section reviews the structure of Canadian health care and the major policies that shape out-of-pocket charges faced by families in Alberta and British Columbia. Section three lays out the methodology used to compare out-of-pocket costs for health care in this article and section four presents the results and analysis. The fifth section forms a conclusion.

CANADIAN HEALTH CARE: PROVINCIAL SYSTEMS IN A FEDERAL FRAMEWORK

Canada's system of provincial-run single-payer, universal, health insurance plans (popularly known as medicare) enjoys widespread and stable long-term public support (Mendelsohn 2002). Included in this public judgment is the belief that the maintenance of medicare is a joint responsibility of the federal and provincial governments (Maioni, 2002: 177). Medicare is not a coherent country-wide program, nor does it represent the full extent of public involvement in the financing of health care. Rather it should be seen as the backbone of a framework within which each province has designed its own system for financing and delivering health care.

The federal framework

In order to qualify for financial support from the federal government for their health

systems, provinces must maintain health insurance programs that conform to the *Canada Health Act* (*Revised Statutes of Canada* 1985). The provinces have considerable leeway in meeting these conditions. In fact, the light hand exercised by successive federal governments in ensuring compliance with these terms has raised questions from the Auditor General of Canada (2002: Chapter 3).

Medicare was never meant to cover all health costs. Provision of items such as pharmaceuticals, non-physician care outside of hospitals, chronic and home care, are generally not covered by the terms of *The Canada Health Act*. As a result, these goods and services may be provided on any terms deemed to be appropriate by each individual province (universally or non-universally, with or without user-fees). Referred to as "extended health services," many Canadian families have private insurance to cover all or part of these costs. This insurance is often acquired as a work-place benefit (Marshall 2003). The federal tax system also offers subsidies to offset the costs of such insurance and direct out-of-pocket costs (Evans 2004: 146-147; Canada Customs and Revenue Agency 2003). In 1966 the federal government created the Canada Assistance Plan to support provincial social assistance and services for the poor, including extended health services (Cohn 1996: 170-171).

During the 1980s and 1990s successive federal governments unilaterally altered growth formulas for health and social transfers that had previously been negotiated with the provinces, ostensibly to reduce Canada's perennial budget deficits. This culminated with the 1995/96 budget. Here it was announced that effective fiscal 1996/97 the previous transfers for health postsecondary education and social programs would be rolled into a single new program, the Canada Health and Social Transfer (CHST). As

well, an absolute cap was placed on the total size of this program, eliminating the notion of a long-term escalator formula. Although the five conditions of the Canada Health Act were maintained, two key rules governing social assistance programs funded by the Canada Assistance Plan were dropped. These were the requirement that provinces aid all families in need (based on each province's own benchmark) and that provinces provide an appeal mechanism for those denied aid. As a result, provinces now have enhanced discretion in the awarding or denial of social assistance benefits, including those related to health (Cohn 1996). Both Alberta and British Columbia made use of this enhanced discretion to focus social programs more on encouraging work. However, in keeping with its ideology, Alberta's reforms, when combined with past decisions, went much further in reducing support for those lacking employment (Klein and Walshe 1999: 16). These changes in federal transfers were part of a larger reform effort aimed at better suiting the role of Canadian federal state to the present economic era of neoliberal inspired global and regional integration (Martin 1995; Drache 1995; McBride 2001).

Since the federal government returned to surplus in 1998 substantial federal "re-investments" in transfers to support provincial welfare state programs and family incomes have occurred. However, this money has been aimed at encouraging the continuation of restructuring at the provincial level, rather than restoring the previous situation (Boismenu and Graefe 2004). One such initiative is the National Child Benefit. This created a refundable federal tax credit for families with children that provinces are allowed to deduct from the support that they provide, as long as the savings are re-invested in programs and services for low-income families with children. The two provinces handled this differently. Alberta deducted the federal credit from social

assistance. British Columbia deducted it from the province's own tax credit (Human Resources Development Canada 2002). Therefore, in Alberta the full benefit of the new money went to the working poor, whereas in British Columbia both the costs and benefits were spread more evenly among working and non-working families.

British Columbia and Alberta's adaptations under the federal framework

As in Ottawa, the 1990s were an era characterized by restraint in provincial spending and by restructuring. In Alberta this restraint was aimed at better emulating a neoliberal vision of the state. In British Columbia prior to the May 2001 election, restraint was part of a strategy to salvage a progressive role for the state in an era of neoliberal hegemony (Copper 1996; Fairbrother 2003). This difference in purpose allowed the Alberta PCP government to be more single-minded. Rather than implementing reforms and harvesting savings over the long-run, it imposed upfront cuts. It then used the crises that were created so as to overwhelm resistance and to drive change in the direction preferred by the government (Schwartz 1997; Wilson 2000). After their election in May 2001, the BCLP adopted a similar strategy. The new government introducing a major tax cut on their first day in power that drove the provincial budget from a roughly balanced position into an immediate deficit. This crisis was then used to justify its subsequent reorganization of government in almost every sector of activity including health care (British Columbia Fiscal Review Panel 2001; Palmer 2001a and 2001b).[3] Since the early 1990s all of Canada's provinces adopted strategies to try and reduce the growth rate of health costs in part due to the above noted political concerns but also in part due to fears, somewhat overstated, that their present health systems were both inefficient and

unsustainable given Canada's aging population (McDaniel 1997: 214-216). Here, attention is drawn to those reforms and policies that are likely to have had significant impact (either directly or indirectly) on out-of-pocket health expenditures for non-senior families in the two provinces.

Features with a direct impact on out-of-pocket expenses

Both the Alberta Health Care Insurance Plan (AHIP) and the British Columbia Medical Services Plan (BCMSP) are supported in part by monthly premiums. By 2001 these were the only two provinces that still levied such premiums rather than supporting health care completely through general revenues.[4] In Alberta, premiums for a family of two or more rose from $39.50 per month to $68.00 per month during the 1990s and continued to rise after the millennium to $88 per month in 2002 (singles pay half this rate). Premiums in British Columbia were substantially higher than in Alberta during the early 1990s (when the NDP took power). During ten years in office they raised monthly premiums for a family of three or more by only $2.00 which still brought them to $72.00. Singles paid half this rate and couples paid $64. In 2002 the BC LP raised premiums across the board by 50 percent (Armstrong 1994; Kane 1993; Health Canada 2002: 132-147; Alberta Health and Wellness 2003: 8; British Columbia Ministry of Finance 2002).

Health insurance premiums are economically regressive. To some extent this is moderated by premium assistance programs. In 2001, assistance was available for British Columbian families with up to roughly $20,000 in net income. This benchmark rose by about $1000 at the same time the BCLP increased premiums in February 2002. In Alberta premium assistance tailed out at roughly $12,600 in net income in 2001. In 2002

Alberta raised the threshold for premium assistance substantially. For singles, full premium assistance was available for those with net incomes up to $12,450; for a couple with no children up to $21,200; and for a family with children up to $27,210. Both provinces waived premiums for those on social assistance and provided a variety of extended health services to these families as well (British Columbia Ministry of Human Resources 2002; British Columbia Medical Association 2004: 2; Alberta Health and Wellness 2001, 2002 and 2003: 5-8; Shreck 2002).[5] In that families seeking premium assistance (other than those on social assistance) must deliberately apply, both take-up rates and the amount of assistance given tend to be lower than eligibility (Warburton 2003).

Although it was responsible for a meaningful increasing the threshold for premium assistance, the NDP's refused to abolish this regressive financial measure in British Columbia. This refusal was one of the government's most significant deviations from social democratic principles in its ten year reign and one that was recognized by senior party leaders ([Vancouver] Province 1993). However, the cost of eliminating premiums -- roughly $891 million by 2001 or 10 percent of the health budget (British Columbia Ministry of Health Services 2001a: 110-111) -- would have required steeply increasing other taxes. Any government would be hesitant to take such steps, let alone one already tagged as anti-business (Schmidt 2000).

In addition to premium assistance, both provinces have also created other programs to provide extended health coverage to non-senior families not receiving social assistance. In 1999 Alberta introduced the Child Health Benefit as one of its National Child Benefit re-investments. This program provides free extended health coverage

(including dental care) to children in low income families. In 2001 the base threshold was a net income of $21,214 or less, increasing by $2,000 for each additional child (Alberta Human Resources and Employment 2001: 11).[6] Again, families must apply for coverage under this plan and take up has been lower than estimated eligibility (Alberta Human Resources and Employment 2002: 22). In mid-July 2002 the threshold for this program was increased to $22,397 (Calgary Herald 2002). Alberta also allows families lacking extended health coverage to buy into the provincially funded Blue Cross plan for seniors. The premium rate for these optional enrollees is subsidized by the province (Alberta Health and Wellness 2001: 93-94).

In British Columbia extended health coverage was also provided through several programs. Among the most important for this study are Supplemental Coverage and Pharmacare. Under the NDP British Columbia provided fully or partially funded universal access to a range of services not covered in many other provinces. This included chiropractic care and regular eye exams. In that one of the primary determinants for the cost of private extended health insurance is the scope of public insurance in each province (MacBride-King and Wassink 2004), this also likely helped to keep premiums for such coverage lower than they might otherwise have been. At the end of 2001 the BCLP government restricted coverage under this plan to those families receiving premium assistance and eliminated coverage altogether for routine eye exams for those over 19 and under 64 (British Columbia Ministry of Health Services 2001c and 2001d).

Children's dental services and optical products were also provided free under the NDP's Healthy Kids program for those families with low and modest income lacking private coverage. Under the BCLP annual benefits were restricted to $700 per year

(Creative Resistance 2002). Meanwhile, BC Pharmacare provided prescription drugs and some health products to different categories of British Columbians at different levels of cost. Two important Pharmacare programs for this study were the 100 percent coverage provided to social assistance clients (Plan C) and the universal benefit (Plan E). The latter is a catastrophic coverage plan. In 2000/2001 deductibles ranged from $600 - $800 and coverage ranged from 70 to 100 percent depending on the scale of bills and family circumstances (British Columbia Ministry of Health Services 2001b: 7). At the start of 2002 the new LP government raised the Plan E deductibles by $200 (British Columbia Ministry of Health Services 2001c). Under the NDP, British Columbia pioneered innovative methods to contain drug costs. First the province began reviewing newly licensed drugs for value before adding them to Pharmacare's formulary. Second, for some diseases, coverage was restricted to the cost of the least expensive effective treatment. These rules are waived when medically necessary. The reforms have proven to be both clinically and cost effective (Morgan et al. 2004). Still, to the extent physicians do not change their prescribing practices, these policies hold the potential to increase out-of-pocket expenses. In spite of strong pressure from pharmaceutical companies, these rules were kept in place by the new government.

Features with an indirect impact on out-of-pocket expenses

Both provinces reorganized health services, creating regional health authorities. Managers in these regional authorities were given the power to control budgets for institutions within their areas of responsibility and to purchase diagnostic, out-patient and home care services. Keeping with the Alberta PCP's strategy, this change was made

alongside of significant budget reductions so that the money needed to finance the transition had to be found immediately within each region. This magnified the problems that any organizational redesign produces and helped create some new ones. In British Columbia under the NDP restraint was introduced after changes began, shifting the purpose of reform from democratization to strengthening managerial control (Naylor 1999; Philippon and Wasylyshyn 1996; Cairney 1995; Scott Findlay et al. 2002; Davidson 1999). After taking power in 2001, one of the first major organizational reforms introduced by the BCLP was the rationalization of health authorities from over fifty down to five territorial based authorities and one province-wide authority for the provision of highly specialized care such as oncology, children and women's health services. As was the case in Alberta, the new authorities would not only have to deliver a reorganization but were required to pay for this out of existing revenue as the government cut the growth rate of their budgets to almost nil (Palmer 2001a and 2001b;). The result was a series of deficit reduction and patient care reorganization plans released to the public on 23 April 2002 (see for example Vancouver Coastal Health Authority 2002). Even the health minister was apparently caught off-guard by the severity of the cuts required and he found it difficult to answer questions put to him by reporters about the impact that the cuts would have (Palmer 2002).

It must be noted that the regional health authorities in both provinces lack authority over physicians, who operate as independent entrepreneurial professionals compensated by their provinces, predominantly on a fee-for-service basis. By rationalizing institutional capacity, regional authorities also reduced the practices of some physicians. Some of these physicians responded by creating their own private-for-profit

clinics (Jones 1997). Many clinics provide both non-medicare services (such as non-medically necessary cosmetic care, and treatments for provincial worker's compensation boards) as well as medicare services under contract to regional health authorities. Armstrong (2003), who studied ophthalmology clinics in Alberta, found that private surgical clinics have often found ways to charge patients extra for therapeutic products and services that would have been provided free of charge if their care had taken place in a public or not-for-profit facility.[7]

Another problem has been in the area of access to advanced diagnostic services, such as Magnetic Resonance Imaging (MRI). Although regional health authorities have limited budgets for MRIs, physicians have proven unwilling to curtail growth in their use. As a result queues have formed. It is beyond the ability of this article to assess whether physicians are ordering such tests inappropriately, or budgets for them are being unjustly constrained. What can be noted is that, in such circumstances, patients have the choice of either waiting for further treatment until their MRI is performed or paying privately for an ostensibly non-medically necessary "body scan" that can then be given to their physician. This problem became so rampant in Alberta at the turn of the millennium as to trigger a federal investigation of the province's adherence to the *Canada Health Act*. This was resolved when Alberta put in place plans to increase access to MRI tests and to compensate those who had paid out of pocket for them over the previous decade (Ohler 2001).

Finally, and perhaps most importantly, regionalization and the consequent rationalization of institutional care has produced an increasing reliance on non-institutional care. In neither province have non-institutional care budgets kept up with

demand, forcing patients to either go without care or pay out-of-pocket for private services. For the most part the non-acute long-term and recuperative care (whether provided in institutions or at home) is not covered by the *Canada Health Act*. As a result it can be provided at the discretion of the provinces under any terms that they set without impacting on their eligibility for federal grants. Both provinces charged user-fees (with adjustments made for income) for some in home services (Vogel et al. 2000; McDaniel 1997: 220; Parent and Anderson 2001: 24-25). Soon after taking power the BCLP government began a redesign of non-acute longer-term and recuperative care. In essence patients were re-classified so that institutional long-term care could be replaced with home care and home care (which is provided by visiting nurses) could be replaced with non-professional "assisted living" care. Experience has varied across the five regional authorities. Nevertheless, a general pattern has emerged. Less healthy patients are being seen less frequently and being provided with a more restricted rang of services by less qualified staff. In the case of home care there was an approximately 8 percent drop in the number of patients being served. This reorganization of the non-acute care fields was patterned after changes made earlier in Alberta. However, the reclassification of patients and shifting of care categories in British Columbia was done with a much more stringent timeline, seeking to accomplish in only a few years what Alberta planned to do over decades (Cohen et al. 2005).

QUANTITATIVE METHODOLOGY

The data used is from the 1992-2002 Surveys of Family Expenditures and Surveys of Household Spending (Statistics Canada 2004). These were conducted at the household

level and exclude institutionalized populations. Each iteration of the survey provides data on the income and expenditures of several thousand Canadian families. The data source used does not contain any information on the health status of household members, and as a result, health status of respondents cannot be controlled for. Health status likely has important consequences for the out-of-pocket expenditures of individual families.[8] Therefore, this represents a major limitation to the study, greatly reducing the strength of any measures of association that might be computed. However, this is unlikely to skew aggregate comparisons of out-of-pocket expenditures between Alberta and British Columbia as health status among the populations of the two provinces is roughly similar on most indicators (Federal Provincial Territorial Advisory Committee on Population Health 1999). Therefore, no attempt to measure association is made in this paper. Instead, all that is attempted is to compare the statistical significance of differences between the mean out-of-pocket expenditures for respondents. As well as comparing respondents from British Columbia and Alberta a third group, comprising respondents from the other eight provinces is also used.[9]

Only households comprised of a single economic family containing a single individual, a couple, a lone parent with one child or two parents with two children are used in this study. This is because interpreting the finances and expenditures of households comprised of two or more economic families and families with more complex composition than those noted above is very difficult. It was decided to test lone parent families with one child and two parent families with two children as these were the modal number of children for each of the two forms of parenting in the sample. Children are those who were never-married and living with their parent(s) from ages 0-24. The age

24 was selected as it corresponded to the last age category for children and youth contained in the data set and also because it better reflects the lengthening duration for which young-adults are commonly dependent on parental support than would a cut-off at age 18 (Boyd and Noris 1999). One likely consequence of restricting the sample in these ways was to cut the number of lower income families in the study. This is because sharing accommodations either with non-family members or among generations, is a common financial coping strategy. Families containing seniors are also excluded as the special programs both provinces have adopted to meet their health care needs makes a separate analysis of their out-of-pocket health costs a necessity. These decision rules produce a substantial reduction in the number of cases available for analysis.

A total of ten comparisons are made between Albertans, British Columbians and respondents from the other eight provinces. These consist of comparisons for all households included in this analysis and those belonging to different sub-samples defined by household structure and by income quintiles (after-tax-and-transfer income). These were constructed for each year and then combined into one categorical ordinal variable. So as to facilitate comparisons across time the data for out-of-pocket health expenditures and income were converted to constant 1992 dollars before the analysis. 1992 was chosen as it is the base year for one of the most common tools used for such calculations (Statistics Canada's Consumer Price Index) and the initial year for which data is presented in this paper.

Results for this comparison are presented in two forms. First a line graph is provided for each of the ten comparisons that are made, displaying across-time changes in the average out-of-pocket expenditures for all cases in each provincial group and each

sub-population. Second, a table is displayed beneath each line graph. It shows the mean scores and "N" as well as significance scores for the ANOVA (analysis of variance) test and associated inter-group comparisons which were performed for each year of the data presented in each graph. In that equality of variance could not be assumed, the statistic used to assess significance in the overall comparisons is Welch's Robust test. For similar reasons the significance of the inter-group comparisons are assessed using Tamhane's T2. These tests are generally more conservative in assessing significance than are the usual F statistic and inter-group comparisons such as the commonly used Bonferroni procedure (Norusis 2000: 259-280).

RESULTS AND ANALYSIS

The results are displayed in the ten page statistical appendix at the conclusion of this paper. The first chart and table display the results for the entire sample for each year. As can be seen, from 1997 through 2001 (other than for 1998) there is a statistically significant difference between the mean out-of-pocket spending on health care between the other eight provinces Alberta and British Columbia. However in 2002 the gap between mean spending in Alberta and British Columbia closes to become statistically insignificant. The gap between mean spending in the other eight provinces and the two westernmost provinces is statistically significant throughout the time period under study. The most likely cause of this is the presence of provincial health insurance premiums in both Alberta and British Columbia (an out-of-pocket expense absent in every other province during this time period). On the surface, this table seems to provide reasonable evidence for the predictions made at the start of the paper. As the 1990s wore on the

difference in average out-of-pocket expenditures between Alberta and British Columbia opened up and then closed again after the change of government in British Columbia following the 2001 election. Second, mean out-of-pocket expenditures in British Columbia moved towards the mean for the other eight provinces (other than for 1998) until 2001 when they move towards Alberta again. However, the case would be stronger if there were no significant differences between British Columbia and the other eight provinces or a trend towards insignificant differences that breaks back after 2001.

The nine subsequent tables and charts, where results are displayed for the sub-samples, tend to cloud the issue further. In all nine examples, mean out-of-pocket spending for British Columbians tends to be between that for Albertans and for respondents from the other eight provinces. It is when we move from exploring the charts to reading the tables that problems emerge. For example chart and table ten (which depicts mean out-of-pocket spending for two parent families with two children) shows significant differences between the mean for the other eight provinces and the mean for both Alberta and British Columbia. However, there is no significant difference in most cases between the mean for Alberta and British Columbia. Based on this evidence it is difficult to argue that the mean out-of-pocket expenditures for two parent, two child families differs between Alberta and British Columbia in any of the years under study other than 2001. In chart and table nine (lone parents with one child) there is a relatively persistent significant difference between mean out-of-pocket spending between families in the other eight provinces and Alberta but not between the other eight and British Columbia. On the other hand there is generally no significant difference between spending by families in British Columbia and Alberta. This pattern with British

Columbia almost splitting the distance between the other eight provinces and Alberta would tend to confirm the third hypothesis (that mean spending in Alberta will be further from the average for the other eight provinces than that for British Columbia). However, it does not allow us to confirm the first hypothesis (that there is any difference in mean spending between Alberta and British Columbia. It also fails to confirm the second hypothesis that the change in government that occurred in British Columbia after the 2001 election will lead to convergence between British Columbia and Alberta.

CONCLUSIONS

The principal question that this article sought to answer was whether the decision-making freedom allowed Canadian provinces in the field of health care matters? Does the decentralized structure of decision-making institutions (highly decentralized even in federal terms) and constitutional priority which they enjoy in this policy area translate into autonomy, or does the federal framework and day-to-day realities of politics in a democratic society make this autonomy less generous than it appears on paper. It was decided to test this by comparing average out-of-pocket health expenses for households in Alberta and British Columbia and to compare both these provinces to the average for households in the other eight Canadian provinces. The key difference between these two provinces is that their respective voters chose to go in separate directions in the early 1990s. Those in British Columbia elected a social democratic party to power in 1991. Those in Alberta chose to return a traditional Tory party to power in 1993 after it had undergone a neoliberal transformation. Given the ideological differences between the two governments and the degree of policy-making autonomy Canadian provinces are said

to have in the health care field (Banting and Corbett 2002), it was hypothesized that differences would emerge with Alberta families paying more out-of-pocket for health care than comparable families in British Columbia. It was further hypothesized that this difference would be reduced for 2002 after the change of government that followed the 2001 election in British Columbia.

Supporting these hypotheses were the pronouncements made quite regularly by members of Alberta's ruling party the PCP, including Premier Klein, and the governments advisors, that families ought to shoulder a greater share of their own health costs and the attempts they made to bring this about. Given that health insurance is the one form of coverage within the Canadian welfare state more in keeping with the social democratic than the liberal model, it was also assumed that average out-of-pocket charges in British Columbia would be more similar to those in the other eight provinces than would those incurred by households from Alberta.

On the other hand Siguardson (1996) points out that there are substantial constraints that limit the degree to which any provincial government can follow its ideological disposition including the federal frame-work within which much of public policy is made as well as economic and political considerations. Furthermore, when Benard and Saint Arnaud (2004) studied the overall nature of provincial welfare state regimes they found only modest differences between the four largest provinces (Ontario, Quebec, British Columbia and Alberta) and Canada's overall positioning within the universe of welfare states.

The results presented here somewhat confirm the above three hypotheses. There are meaningful differences in the out-of-pocket health expenditures faced by families in

the two provinces and these can be interpreted as reflecting the ideological dispositions of the British Columbia and Alberta governments. However, they are also modest and in several cases fail to rise to the level of statistical significance. As well in the case of the overall comparison, the average out-of-pocket paid by households from both Alberta and British Columbia were significantly above those paid by households in the other eight provinces. Some of the blame for this poor showing by British Columbia was placed on the existence of health insurance premiums in that province, a highly regressive impost that persisted in spite of a decade of social democratic government. In general, while it is possible to say that the initial hypotheses have been supported, the data also points towards the validity of Siguardson's (1996) claim that provincial policy making autonomy is in fact constrained and the findings reached by Bernard and Arnaud (2004) that overall, variation among provincial welfare state regimes is modest.

Given the "glass is half empty or half full" nature of this conclusion, further work on this problem is probably warranted. Specifically, it will be interesting to see what will happen when further observations are added for 2003 and beyond. Second it might be useful to add observations prior to 1992. At present the impact of neoliberalism is assumed a bit too confidently. If data were added back to the 1970s it would be possible to test a variety of other counter arguments such as whether general budgetary restraint as opposed to restraint motivated by a specific form of government was the cause of the pattern. Third an effort probably needs to be made to break out the other eight provinces into individual units. Finally some attempt needs to be made to employ more sophisticated methods such as panel analysis where the units of analysis would be the mean out-of-pocket spending for different family structures in the provinces for various

years. In this arrangement other data sources such as provincial spending on different aspects of the health system could be introduced as could the presence or absence of various reforms or policy changes and changes in government.

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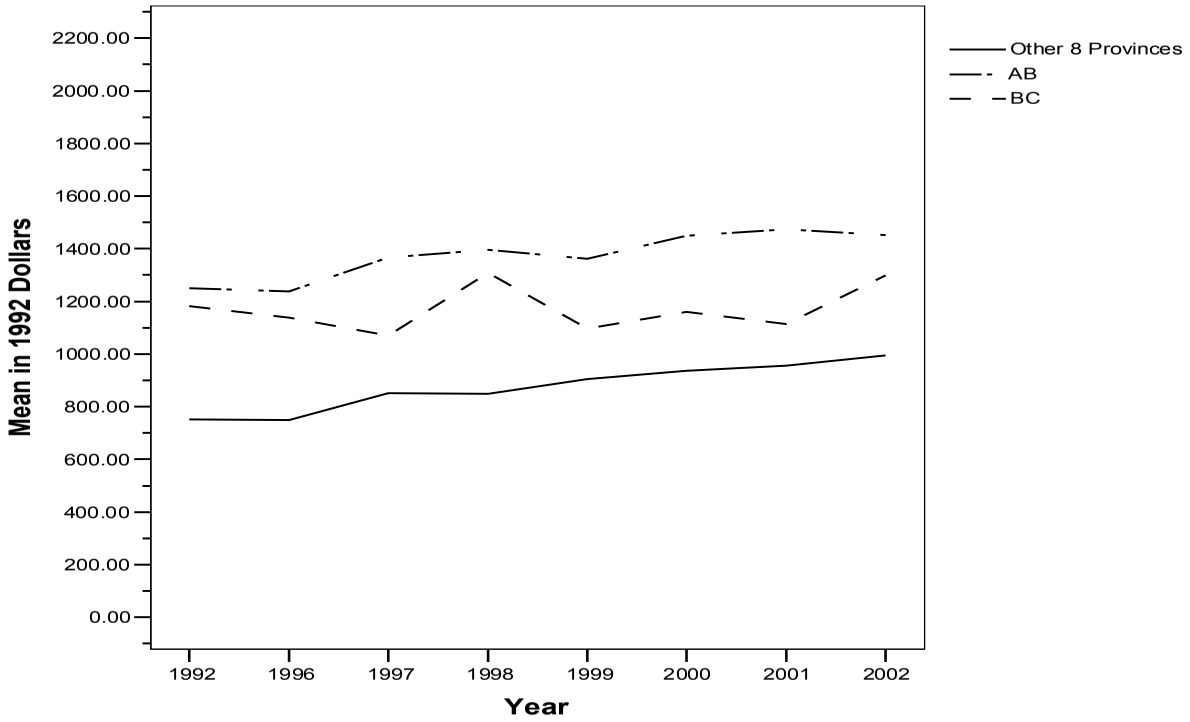
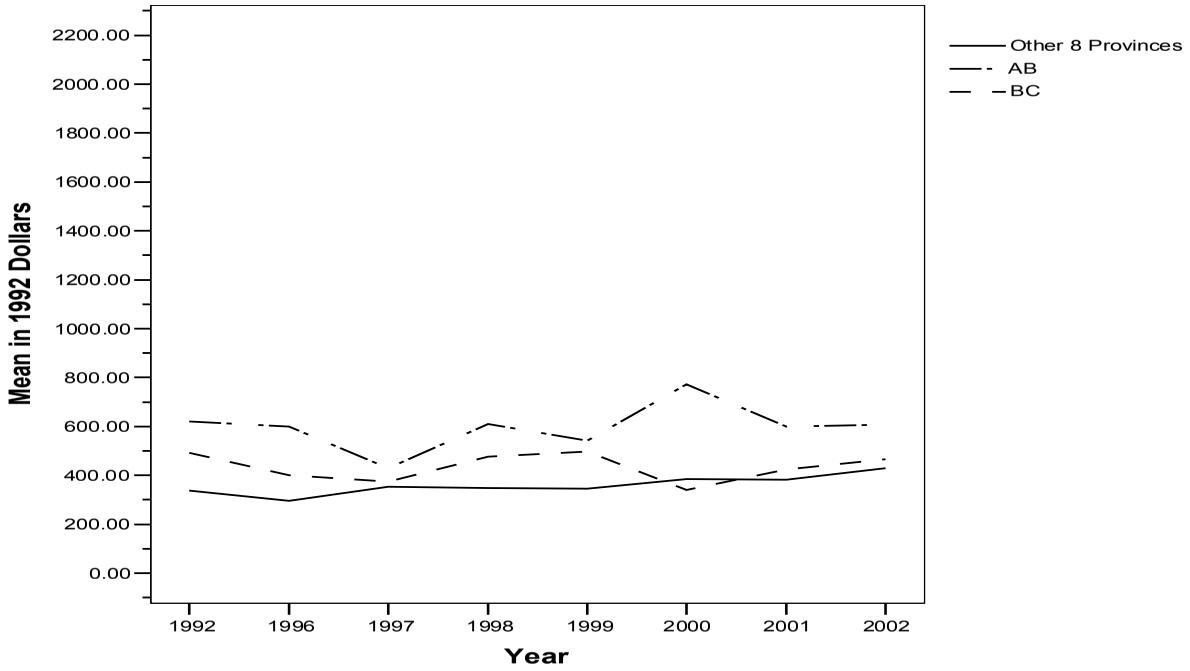
Statistical Appendix

1. Mean Out-of-pocket Spending on Health Care 1992-2002 Full Data Set
(Single, Couple, Lone Parent with One Child & Two Parent with Two Child Families) for Alberta, BC & Other Provinces (1992 $s)



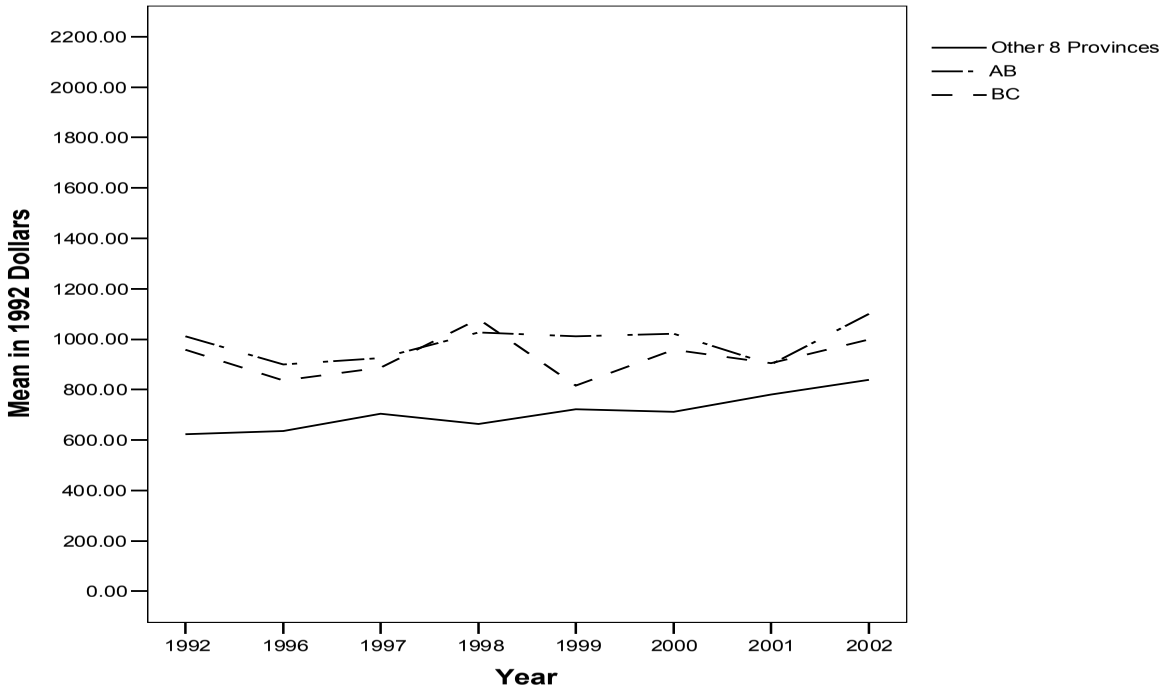
Sig. Test	Comparison	1992	1996	1997	1998	1999	2000	2001	2002
	Other 8 Mean / N	752.94 / 3530	748.43 / 3637	850.35 / 6087	849.65 / 5202	905.95 / 5952	935.93 / 5319	956.43 / 5898	995.12 / 5399
	AB Mean / N	1249.86 / 458	1237.27 / 386	1366.96 / 951	1395.25 / 739	1361.14 / 906	1450.08 / 743	1472.81 / 873	1452.59 / 727
	BC Mean / N	1183.03 / 448	1138.83 / 686	1070.76 / 933	1309.55 / 823	1096.76 / 988	1159.98 / 872	1113.19 / 938	1299.38 / 849
Welch	Overall	.000	.000	.000	.000	.000	.000	.000	.000
Tamhane	Other 8 - AB	.000	.000	.000	.000	.000	.000	.000	.000
	Other 8 - BC	.000	.000	.000	.000	.000	.000	.000	.000
	AB - BC	.788	.413	.000	.528	.000	.000	.000	.081

2. Mean Out-of-pocket Spending on Health Care 1992-2002 Income Quintile 1 (lowest) (After Tax and Transfer) for Alberta, BC & Other Provinces (1992 $s)



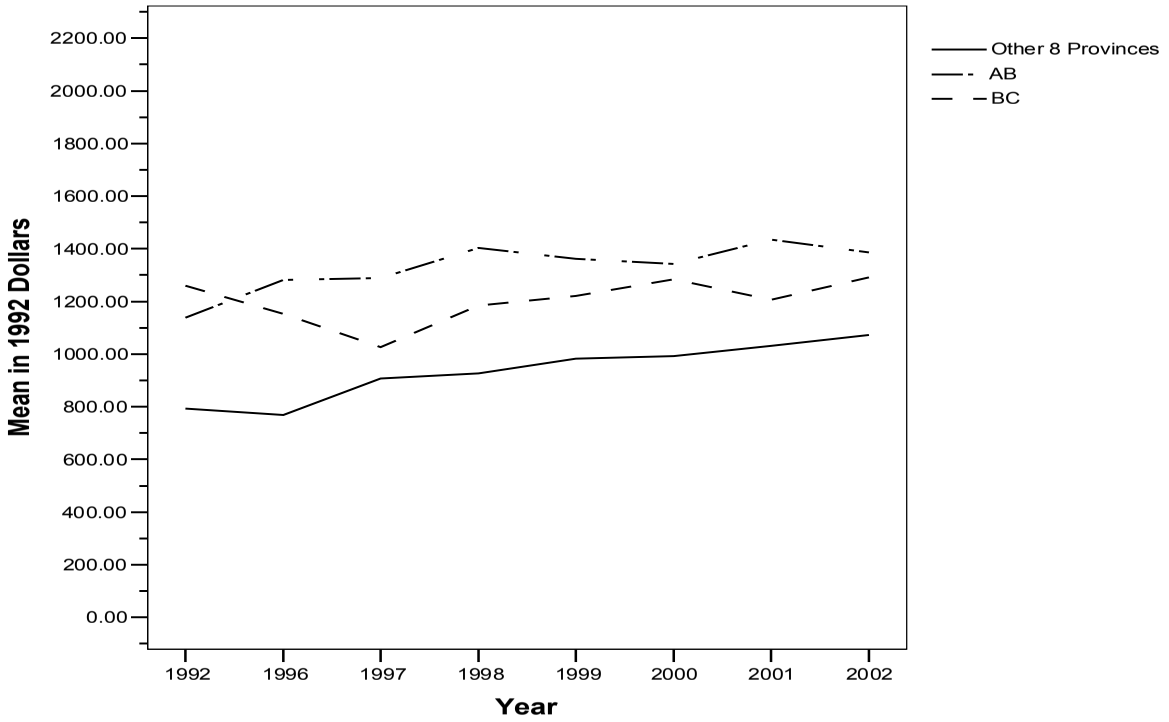
Sig. Test	Comparison	1992	1996	1997	1998	1999	2000	2001	2002
	Other 8 Mean / N	338.59 / 733	296..99 / 774	354.14 / 1306	348.20 / 1121	345.74 / 1270	384.93 / 1129	382.70 / 1250	429.07 / 1152
	AB Mean / N	620.90 / 72	598.25 / 59	428.86 / 153	610.11 / 106	542.94 / 136	773.55 / 97	600.56 / 117	607.49 / 95
	BC Mean / N	491.18 / 83	400.37 / 113	373.33 / 166	476.98 / 154	496.79 / 198	341.03 / 167	425.05 / 196	466.25 / 160
Welch	Overall	.001	.001	.317	.000	.001	.003	.015	.166
Tamhane	Other 8 - AB	.005	.004	.352	.010	.007	.005	.015	.185
	Other 8 - BC	.092	.153	.971	.320	.032	.723	.803	.933
	AB - BC	.539	.153	.784	.593	.927	.002	.144	.532

3. Mean Out-of-pocket Spending on Health Care 1992-2002 Income Quintile 2 (After Tax and Transfer) for Alberta, BC & Other Provinces (1992 $s)



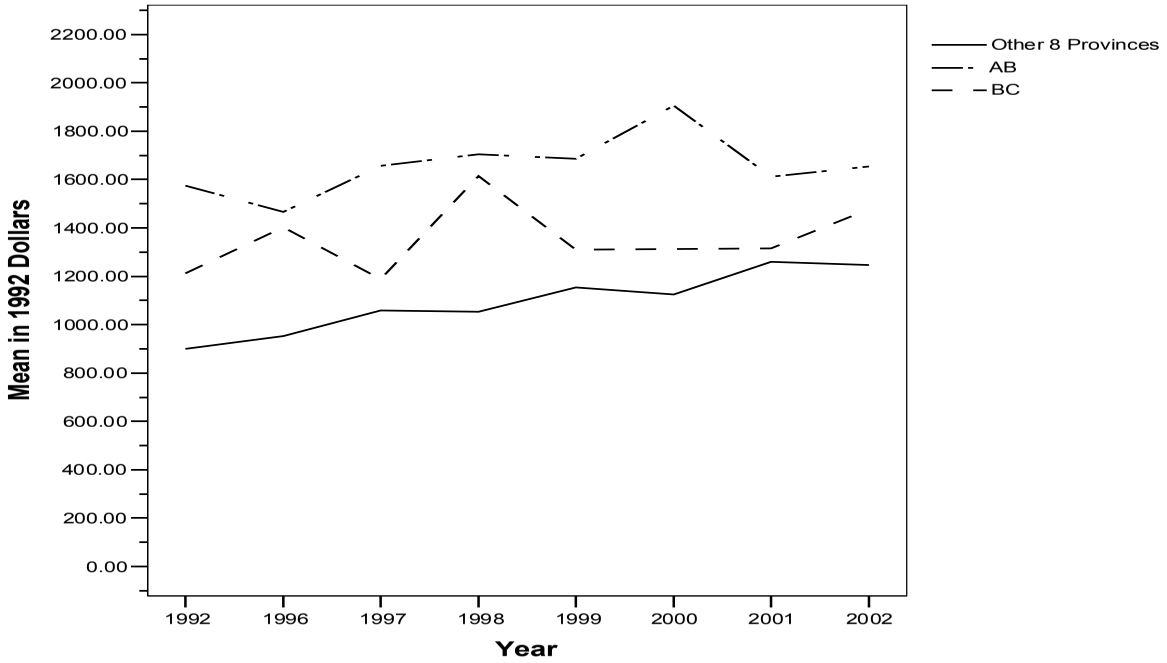
Sig. Test	Comparison	1992	1996	1997	1998	1999	2000	2001	2002
	Other 8 Mean / N	622.93 / 714	636.16 / 755	703.89 / 1294	664.79 / 1102	721.67 / 1271	713.30 / 115	780.49 / 1258	840.24 / 1148
	AB Mean / N	1012.35 / 91	900.94 / 54	924.21 / 162	1027.08 / 134	1010.55 / 159	1021.90 / 137	898.97 / 137	1100.08 / 123
	BC Mean / N	958.15 / 84	835.09 / 135	887.06 / 164	1081.37 / 145	815.15 / 164	958.86 / 149	984.46 / 177	997.90 / 138
Welch	Overall	.000	.001	.001	.000	.001	.000	.109	.011
Tamhane	Other 8 - AB	.000	.015	.007	.000	.001	.000	.358	.034
	Other 8 - BC	.002	.007	.024	.000	.442	.009	.287	.196
	AB - BC	.965	.898	.970	.951	.138	.903	.999	.814

4. Mean Out-of-pocket Spending on Health Care 1992-2002 Income Quintile 3 (After Tax and Transfer) for Alberta, BC & Other Provinces (1992 $s)



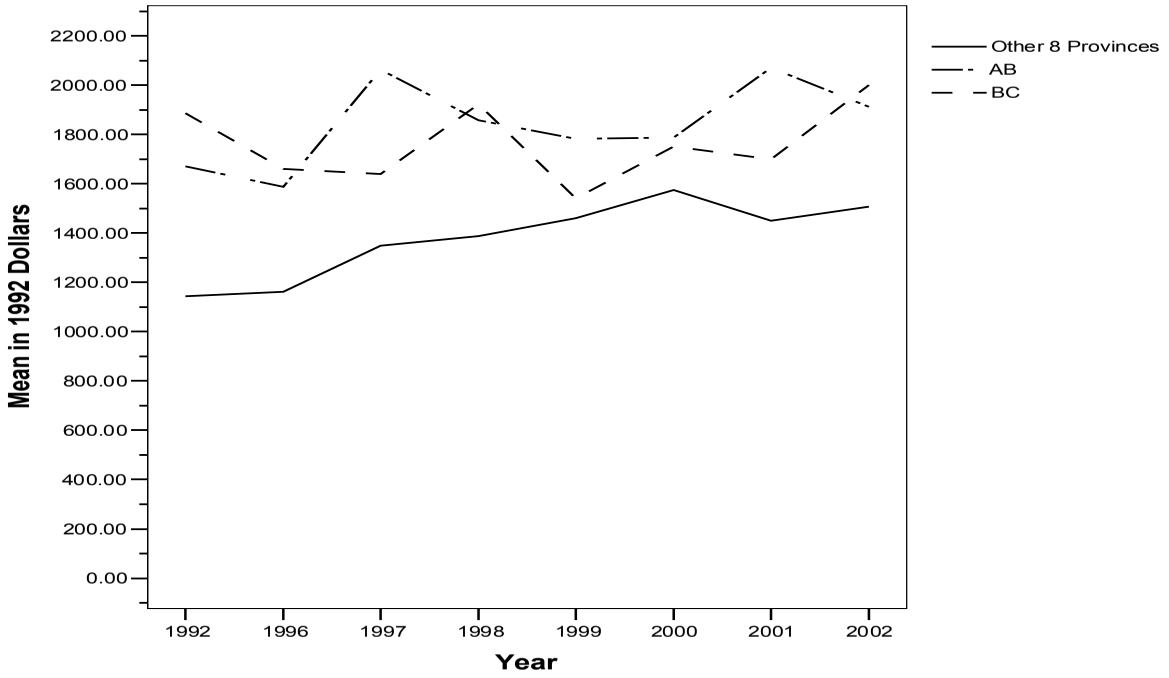
Sig. Test	Comparison	1992	1996	1997	1998	1999	2000	2001	2002
	Other 8 Mean / N	792.80 / 712	743.67 / 726	906.99 / 1249	927.38 / 1068	982.15 / 1233	991.85 / 1090	1032.40 / 1233	1072.40 / 1108
	AB Mean / N	1138.62 / 90	1281.68 / 95	1289.69 / 187	1403.64 / 158	1361.28 / 167	1342.81 / 151	1434.10 / 158	1385.82 / 136
	BC Mean / N	1259.74 / 87	1152.07 / 134	1025.60 / 171	1183.75 / 148	1220.97 / 199	1283.60 / 156	1206.57 / 173	1292.58 / 160
Welch	Overall	.000	.000	.000	.000	.000	.000	.001	.001
Tamhane	Other 8 - AB	.000	.000	.000	.000	.000	.000	.001	.003
	Other 8 - BC	.042	.000	.381	.027	.011	.011	.200	.124
	AB - BC	.905	.712	.045	.201	.526	.950	.294	.827

5. Mean Out-of-pocket Spending on Health Care 1992-2002 Income Quintile 4 (After Tax and Transfer) for Alberta, BC & Other Provinces (1992 $s)



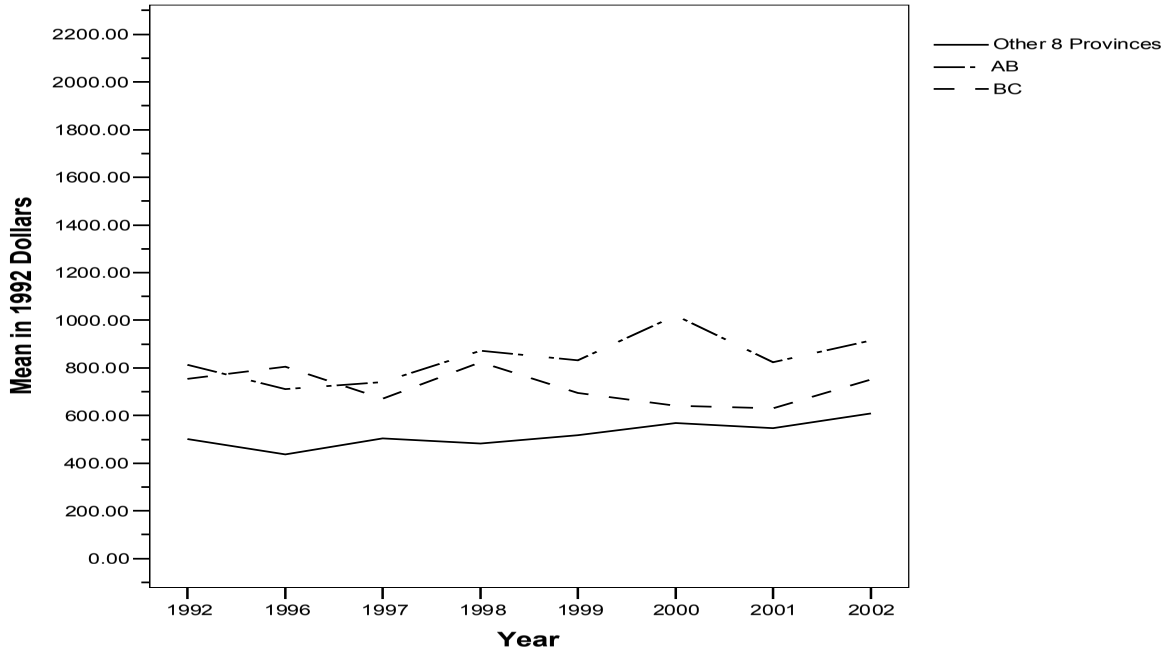
Sig.Test	Comparison	1992	1996	1997	1998	1999	2000	2001	2002
	Other 8 Mean / N	900.42 / 692	952.77 / 729	1058.93 / 1199	1053.28 / 1033	1153.35 / 1160	1124.35 / 1016	1260.49 / 1158	1247.74 / 1059
	AB Mean / N	1574.60 / 98	1466.34 / 88	1657.33 / 204	1703.94 / 165	1685.73 / 205	1906.58 / 163	1612.83 / 194	1654.43 /151
	BC Mean / N	1212.28 / 99	1403.84 / 140	1189.53 / 205	1615.63 / 164	1310.18 / 213	1313.61 / 204	1314.51 / 194	1475.98 / 187
Welch	Overall	.000	.000	.000	.000	.000	.000	.002	.000
Tamhane	Other 8 - AB	.000	.000	.000	.000	.000	.000	.002	.000
	Other 8 – BC	.012	.001	.239	.006	.310	.064	.905	.067
	AB - BC	.115	.974	.000	.959	.019	.000	.055	.476

6. Mean Out-of-pocket Spending on Health Care 1992-2002 Income Quintile 5 (highest) (After Tax and Transfer) for Alberta, BC & Other Provinces (1992 $s)



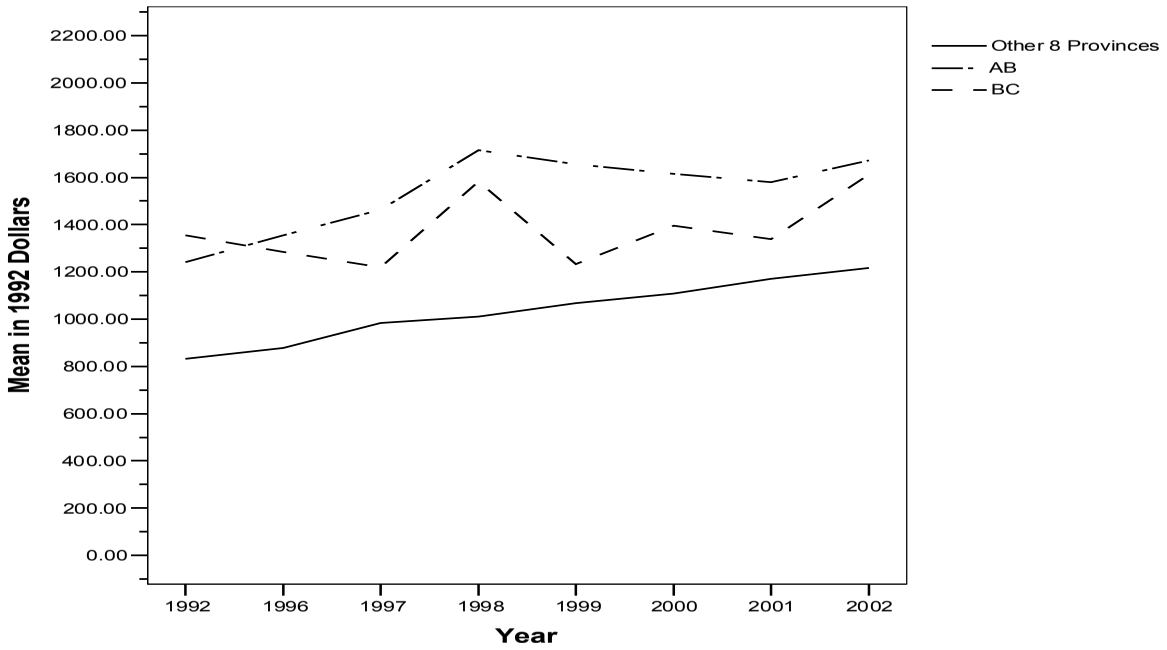
Sig. Test	Comparison	1992	1996	1997	1998	1999	2000	2001	2002
	Other 8 Mean / N	1144.85 / 679	1161.79 / 653	1347.72 / 1039	1388.24 / 877	1460.74 / 1018	1573.60 / 969	1449.62 / 999	1506.66 / 932
	AB Mean / N	1671.22 / 107	1587.13 / 90	2062.75 / 245	1857.22 / 175	1781.44 / 239	1788.90 / 195	2070.65 / 257	1913.17 / 222
	BC Mean / N	1885.59 / 95	1660.62 / 164	1640.27 / 227	1921.47 / 212	1539.76 / 214	1752.40 / 196	1700.66 / 198	2000.19 / 204
Welch	Overall	.000	.000	.000	.000	.005	.084	.000	.000
Tamhane	Other 8 - AB	.000	.002	.000	.000	.003	.190	.000	.003
	Other 8 – BC	.000	.001	.012	.000	.824	.317	.047	.000
	AB - BC	.610	.965	.007	.963	.159	.993	.016	.933

7. Mean Out-of-pocket Spending on Health Care 1992-2002 Single Persons for Alberta, BC & Other Provinces (1992 $s)



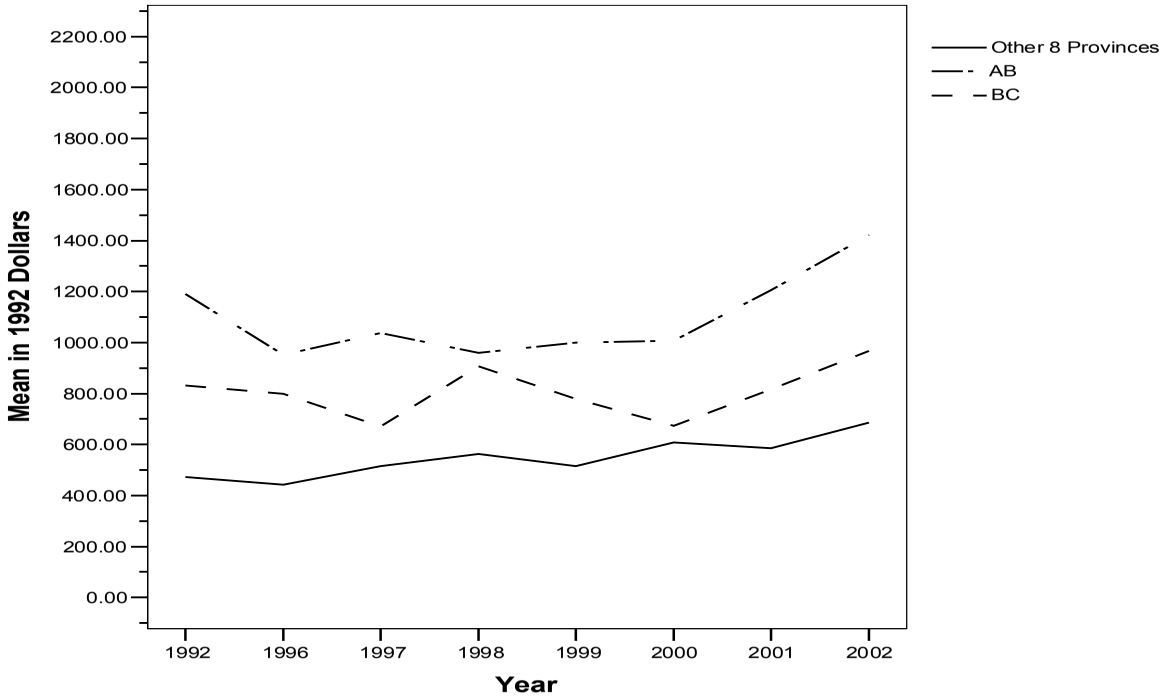
Sig. Test	Comparison	1992	1996	1997	1998	1999	2000	2001	2002
	Other 8 Mean / N	502.38 / 1032	437.34 / 1074	505.07 / 1728	481.84 / 1504	516.19 / 1715	567.76 / 1571	547.77 / 1793	609.44 / 1677
	AB Mean / N	813.07 / 139	710.27 / 102	741.58 / 296	871.48 / 230	833.04 / 284	1018.83 / 226	824.04 / 266	914.56 / 224
	BC Mean / N	754.97 / 145	804.46 / 232	672.01 / 301	824.76 / 279	693.81 / 249	640.35 / 284	631.44 / 339	752.36 / 289
Welch	Overall	.000	.000	.000	.000	.000	.000	.000	.000
Tamhane	Other 8 - AB	.000	.000	.000	.000	.000	.000	.000	.000
	Other 8 – BC	.064	.000	.002	.000	.002	.382	.177	.021
	AB - BC	.953	.672	.646	.950	.245	.000	.013	.170

8. Mean Out-of-pocket Spending on Health Care 1992-2002 Couples for Alberta, BC & Other Provinces (1992 $s)



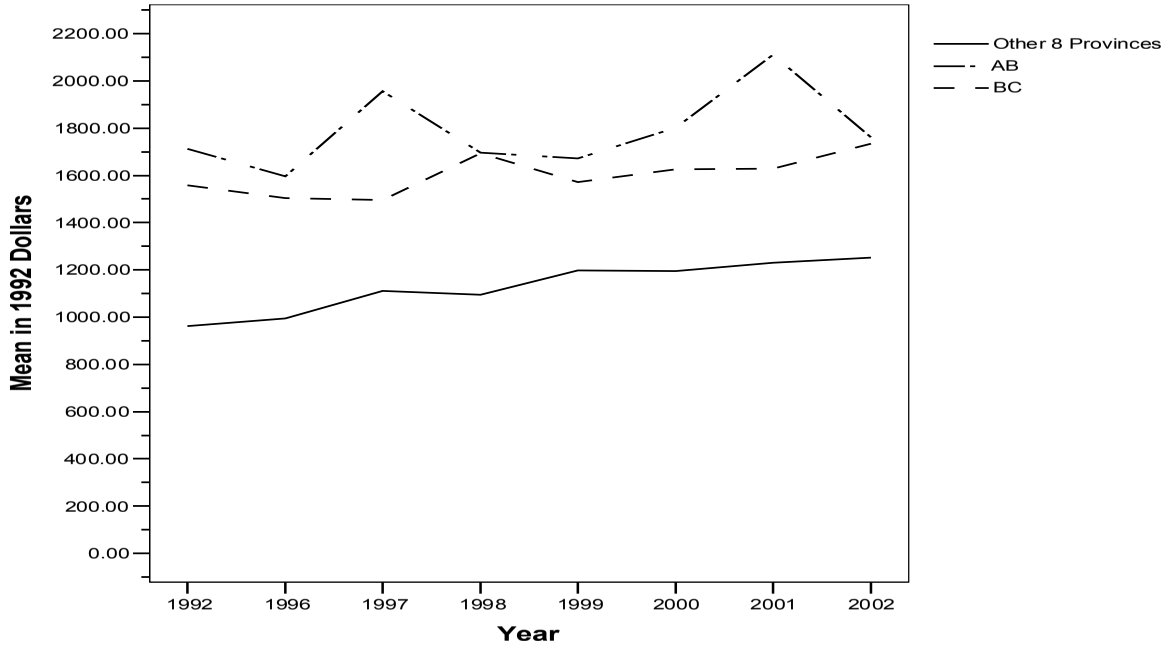
Sig. Test	Comparison	1992	1996	1997	1998	1999	2000	2001	2002
	Other 8 Mean / N	833.28 / 1077	877.42 / 1153	984.35 / 2031	1010.49 / 1724	1067.29 / 2067	1108.18 / 1819	1169.29 / 2062	1215.63 / 1894
	AB Mean / N	1241.22 / 149	1355.69 / 139	1463.45 / 307	1715.41 / 249	1655.83 / 292	1614.90 / 264	1579.24 / 307	1671.21 / 253
	BC Mean / N	1355.48 / 151	1284.20 / 218	1219.60 / 299	1583.20 / 282	1232.81 / 320	1394.43 / 316	1258.10 / 298	1612.87 / 266
Welch	Overall	.000	.000	.000	.000	.000	.000	.000	.000
Tamhane	Other 8 - AB	.000	.000	.000	.000	.000	.000	.000	.000
	Other 8 - BC	.000	.000	.002	.000	.022	.000	.087	.000
	AB - BC	.747	.897	.025	.588	.000	.128	.050	.954

9. Mean Out-of-pocket Spending on Health Care 1992-2002 Lone Parents with One Child for Alberta, BC & Other Provinces (1992 $s)



Sig. Test	Comparison	1992	1996	1997	1998	1999	2000	2001	2002
	Other 8 Mean / N	472.50 / 257	442.66 / 293	516.30 / 476	562.22 / 391	515.92 / 440	608.69 / 397	586.20 / 410	684.67 / 425
	AB Mean / N	1189.28 / 32	952.13 / 23	1037.60 / 54	959.29 / 51	999.46 / 57	1007.55 / 44	1204.44 / 57	1421.86 / 36
	BC Mean / N	831.34 / 29	799.04 / 57	670.00 / 80	906.65 / 54	779.86 / 69	672.65 / 56	815.45 / 72	966.56 / 69
Welch	Overall	.033	.000	.025	.006	.003	.070	.003	.003
Tamhane	Other 8 - AB	.132	.009	.035	.045	.008	.070	.009	.012
	Other 8 - BC	.211	.012	.598	.059	.247	.938	.172	.121
	AB - BC	.746	.807	.326	.992	.667	.277	.253	.266

10. Mean Out-of-pocket Spending on Health Care 1992-2002 Two Parents with Two Children for Alberta, BC & Other Provinces (1992 $s)



Sig. Test	Comparison	1992	1996	1997	1998	1999	2000	2001	2002
	Other 8 Mean / N	962.67 / 1164	994.61 / 1117	1111.44 / 1852	1094.94 / 1583	1198.77 / 1730	1193.74 / 1532	1229.28 / 1633	1252.50 / 1403
	AB Mean / N	1713.20 / 138	1596.72 / 122	1956.33 / 294	1696.62 / 209	1670.82 / 273	1801.37 / 209	2111.48 / 243	1762.48 / 214
	BC Mean / N	1558.87 / 123	1503.35 / 179	1495.99 / 253	1693.42 / 208	1572.60 / 250	1626.54 / 216	1628.11 / 229	1733.44 / 225
Welch	Overall	.000	.000	.000	.000	.000	.000	.000	.000
Tamhane	Other 8 - AB	.000	.000	.000	.000	.000	.000	.000	.000
	Other 8 - BC	.000	.000	.000	.000	.001	.000	.000	.000
	AB - BC	.659	.911	.000	.999	.780	.457	.001	.996

[1] The federal government has primary jurisdiction over a number of areas that are indirectly involved in providing care, such as licensing therapeutic products and in directly provides care to a small minority of Canadians including Aboriginal peoples and the Armed Forces.

[2] British Columbia nevertheless qualified for "equalization payments" in fiscal 2002. This is a subsidy paid to provinces when their per capita revenue resources fall below a benchmark established by the federal government. British Columbia's qualification for the payment has helped to re-enforce calls that the program be reformed (Wall 2005: 7).

[3] Following the path trod by Ralph Klein after taking power, the BCLP appointed a committee of business leaders to go over the province's books. The Fiscal Review Panel noted that the provisions in the last NDP budget were legitimate and the budget roughly balanced. However the panel members still managed to conclude that the province would be running a $3.8 billion deficit if nothing were done BEFORE even calculating the impact of the tax cuts introduced by the BCLP on its first day in power. This was especially odd in that soon after issuing its report the province's Office of the Auditor General released his own review of the NDP years and concluded that the provinces fiscal situation was both stable and sustainable (2002: 22-24).

[4] In 2004 Ontario reverted to charging a premium style health tax.

[5] These figures are not exact as both provinces use an "adjusted" net income, reducing each family's taxable income by a variety of factors, such as the presence of seniors or children in the household or their eligibility for different tax credit schemes.

[6] This particular program was introduced as one of Alberta's social reinvestment" following the creation of the Canadian National Child Benefit.

[7] Some of these clinics are using what their owners see as legal loopholes so as to charge patients directly for provincially insured medicare services and thereby provide a form of queue-jumping. In 2004, the federal government began levying small penalties against British Columbia for allowing this (Beatty 2004). In the mid 1990s Alberta briefly allowed private clinics to charge "facility fees" paid by the patient or their insurer, on top of the compensation provided to the physician by the province. This ended when Ottawa declared the policy a violation of the *Canada Health Act* and public opinion moved against the scheme (Bhatia and Coleman 2003).

[8] A small minority of individuals account for an inordinate amount of health expenditures (Reid et al. 2003). In that out-of-pocket expenses are likely related to the amount of health care consumed it is reasonable to assume that they will vary with health status. There is no Canadian source that regularly tracks both out-of-pocket health expenditures and health status in a manner similar to the Medical Expenditure Panel Survey in the United States.

[9] Respondents from the three northern territories are excluded as the political, economic and social context of these polities are markedly different from those of the ten provinces.