Health Canada
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CANADA'S HEALTH CARE SYSTEM

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Canada's Health Care System.

CANADA'S HEALTH CARE SYSTEM

Canada has a predominantly publicly financed, privately delivered health care system that is best described as an interlocking set of ten provincial and three territorial health insurance plans. Known to Canadians as "Medicare", the system provides access to universal, comprehensive coverage for medically necessary hospital, in-patient and out-patient physician services.

This structure results from the constitutional assignment of jurisdiction over most aspects of health care to the provincial order of government. The system is referred to as a "national" health insurance system in that all provincial/territorial hospital and medical insurance plans are linked through adherence to national principles set at the federal level.

The management and delivery of health services is the responsibility of each individual province or territory. Provinces and territories plan, finance, and evaluate the provision of hospital care, physician and allied health care services, some aspects of prescription care and public health.

The federal government's role in health care involves the setting and administering of national principles or standards for the health care system (i.e., *Canada Health Act),* assisting in the financing of provincial health care services through fiscal transfers, and fulfilling functions for which it is constitutionally responsible. One of these functions is direct health service delivery to specific groups including veterans, native Canadians living on reserves, military personnel, inmates of federal penitentiaries and the Royal Canadian Mounted Police. Other federal government health-related functions include health protection, disease prevention, and health promotion.

PRINCIPLES OF MEDICARE

The *Canada Health Act* stipulates the criteria that provincial health insurance plans must meet in order for a province to qualify for its full federal transfer payments. The following five criteria are known as the "principles" of Canada's national health care system:

Public Administration

The health insurance plan of a province must be administered and operated on a non-profit basis by a public authority accountable to the provincial government.

Comprehensiveness

The plan must insure all medically necessary services provided by hospitals and physicians. Insured hospital services include in-patient care at the ward level (unless private or semi-private rooms are medically necessary) and all necessary drugs, supplies and diagnostic tests, as well as a broad range of out-patient services. Chronic care services are also insured, although some payment in respect of accommodation costs may be required by patients who more or less permanently reside in the institution.

Universality

The plan must entitle 100 percent of the insured population (i.e., eligible residents) to insured health services on uniform terms and conditions.

Accessibility

The plan must provide, on uniform terms and conditions, reasonable access to insured hospital and physician services without barriers. Additional charges to insured patients for insured services are not allowed. No one may be discriminated against on the basis of income, age, health status, etc.

Portability

Residents are entitled to coverage when they move to another province within Canada or when they travel within Canada or abroad. All provinces have some limits on coverage for services provided outside Canada, and may require prior approval for non-emergency out-of-province services.

How The System Works

Canada's health care system relies extensively on primary care physicians (e.g., general practitioners), who account for about 51% of all active physicians in Canada. They are usually the initial contact with the formal health care system and control access to most specialists, many allied providers, hospital admissions, diagnostic testing and prescription drug therapy.

Canada does not have a system of "*socialized medicine*", with doctors employed by the government. Most doctors are private practitioners who work in independent or group practices and enjoy a high degree of autonomy. Some doctors work in community health centres, hospital-based group practices or work in affiliation with hospital out-patient departments. Private practitioners are generally paid on a fee-for-service basis and submit their service claims directly to the provincial health insurance plan for payment. Physicians in other practice settings may also be paid on a fee-for-service basis, but are more likely to be salaried or remunerated through an alternative payment scheme.

When Canadians need medical care, in most instances, they go to the physician or clinic of their choice and present the health insurance card issued to all eligible residents of a province. Canadians do not pay directly for insured hospital and physicians' services, nor are they required to fill out forms for insured services. There are no deductibles, co-payments or dollar limits on coverage for insured services.

A number of allied health care personnel are also involved in primary health care to a certain extent. Dentists work independently of the health care system, except where in-hospital dental surgery is required. While nurses are generally employed in the hospital sector, they also provide community health care including home care and public health services. Pharmacists dispense prescribed medicines and drug preparations and also act as an independent knowledge source, by providing information on prescribed drugs, or by assisting in the purchase of non-prescription drugs.

Over 95% of Canadian hospitals are operated as private non-profit entities run by community boards of trustees, voluntary organizations or municipalities. Hospitals have control of the day-to-day allocation of resources provided they stay within the operating budgets established by the regional or provincial health authorities. Hospitals are primarily accountable to the communities they serve, not to the provincial bureaucracy. The for-profit hospital sector comprises mostly long-term care facilities or specialized services such as addiction centres.

In addition to insured hospital and physician services, provinces and territories also provide public coverage for other health services that remain outside the national health insurance framework for certain groups of the population (e.g., seniors, children and welfare recipients). These supplementary health benefits often include prescription drugs, dental care, vision care, assistive equipment and appliances (prostheses, wheelchairs, etc.) to independent living and services of allied health professionals such as podiatrists and chiropractors.

Although the provinces and territories do provide some additional benefits, supplementary health services are largely privately-financed and Canadians must pay privately for these non-insured health benefits. The individual's out-of-pocket expenses may be dependent on income or ability to pay. Individuals and families may acquire private insurance, or benefit from an employment-based group insurance plan, to offset some portion of the expenses of supplementary health services. Under most provincial laws, private insurers are restricted from offering coverage which duplicates that of the governmental programs, but they can compete in the supplementary benefits market.

Milestones in the Evolution of Universal Health Insurance

Canada's health insurance system evolved into its present form over five decades.

Prior to the late 1940's, private medicine dominated health care in Canada resulting in access to care being based on ability to pay. The trend to universal, publicly financed health insurance began in 1947 when the province of Saskatchewan introduced a public insurance plan for hospital services. In 1956, the federal government, seeking to encourage the development of hospital insurance programs in all provinces, offered to cost-share hospital and diagnostic services on a roughly fifty-fifty basis. By 1961, all ten provinces and the two territories had signed agreements establishing public insurance plans that provided universal coverage for at least in-patient hospital care that qualified for federal cost-sharing.

Public medical care insurance also began in the province of Saskatchewan, providing coverage for visits to, and services provided by, physicians outside hospitals. The federal government enacted medical care legislation in 1968 to cost-share, again on a roughly fifty-fifty basis, the costs of provincial medical care services. By 1972, all of the provincial and territorial plans had been extended to include physicians' services. Thus, by that year, the objective to have a national health insurance plan for hospital and medical care in Canada had been realized.

For the first twenty years, the federal government's financial contribution in support of Medicare was determined as a percentage—about half—of provincial expenditures on specified insured health services. In 1977, these cost sharing arrangements were replaced by per capita transfers to the provinces and territories, known as block funding. For the period 1977 to 1996, the federal contribution was based on a uniform per capita entitlement and took the form of a tax transfer (taxing power) [1] and cash payments.

With the arrival of block funding arrangements in 1977, the provinces' entitlement to the federal contribution became conditional solely on their compliance with the criteria set out in the federal hospital and medical care legislation. Because transfers were no longer tied to provincial spending on hospital and physician services, the provinces had the flexibility to invest in other approaches to health care delivery, such as extended health care services and community health centres, or to expand coverage for supplementary health benefits, such as prescription drugs for seniors or dental care for children.

In 1979, a health services review undertaken by the Hall Commission reported that health care in Canada ranked among the best in the world, but it warned that extra-billing by doctors—requiring patients to supplement what a doctor was paid by the provincial plan—and user fees levied by hospitals were creating a two-tiered system that threatened accessibility to care.

In response to these concerns, the federal government reaffirmed its commitment to a universal, accessible, comprehensive, portable, publicly-administered health insurance system when the Parliament of Canada passed the *Canada Health Act* in 1984. To discourage provincial user charges and extra-billing, the *Act* provides for a mandatory dollar-for-dollar penalty, deducted from federal transfer payments, if any province permits user charges or extra-billing for insured health services.

The federal government remains firmly committed to the principles of the *Canada Health Act*.

Funding

Health care in Canada is financed primarily through taxation, in the form of provincial and federal personal and corporate income taxes. Some provinces use ancillary funding methods which are

nominally targeted for health care, such as sales taxes, payroll levies and lottery proceeds. These funds, however, are not earmarked specifically for health and are added to the central revenues of the province. They play a relatively minor role in health care financing.

Two provinces (i.e., Alberta and British Columbia) utilize health care premiums. The premiums are not rated by risk in either province and prior payment of a premium is not a pre-condition for treatment, in accordance with the *Canada Health Act*.

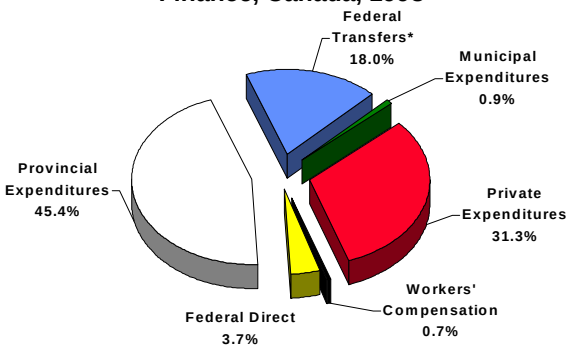
For the period 1977 to 1996, the federal contribution for insured health services was combined with that for post-secondary education and provided through a block funding transfer. The federal contribution was based on an equal per capita entitlement which was adjusted annually according to changes in Gross National Product and calculated independently of provincial costs.

Beginning in fiscal year 1996-97, the federal government's contribution to provincial health and social programs was consolidated in a new single block transfer, the Canada Health and Social Transfer. Federal funding is transferred to the provinces as a combination of cash contributions and tax points. As with the previous transfer arrangement, provincial health insurance plans must adhere to the principles of the *Canada Health Act* in order to be eligible for the full federal transfer payments.

To strengthen the health care system, the federal government announced in the 1999 Budget that provinces and territories will receive an additional $11.5 billion over the period from 1999-2000 to 2003-2004, specifically for health care under the Canada Health and Social Transfer.

The schematic diagram of the Funding Structure of the Health System in Canada (found at the end of this brochure) indicates that the flow of funds from individuals (on the left hand side of the diagram) inthe form of payment of taxes and premiums to governments, employers and private insurers, finance the health care delivery system and providers (on the right hand side of the diagram).

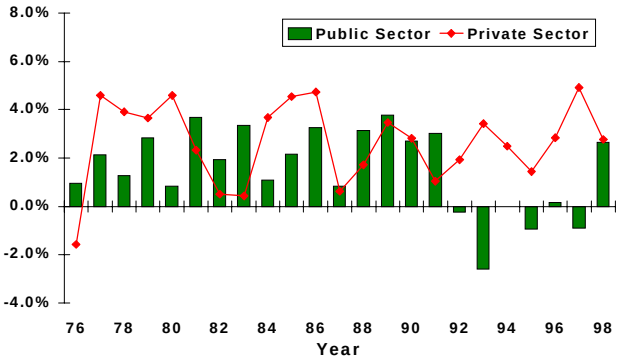
Figure A
Total Health Expenditures by Sector of Finance, Canada, 1998



* Federal Transfers are mainly the health portion of Canada Health and Social Transfer, estimated using the 1995-96 distribution of Established Programs Financing (EPF) and Canada Assistance Plan (CAP).

Source: Health Canada

Figure B
Percentage Change of Real Per Capita Public and Private Health Expenditures, Canada, 1976 to 1998



Source: Health Canada

Health Spending

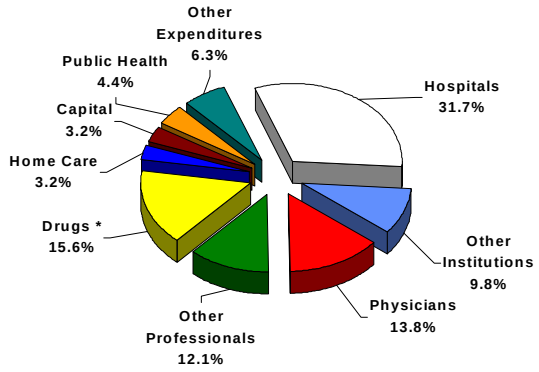
In 1998, total health expenditures in Canada (in current dollars) were $82.5 billion (Cdn) or $2,694 (Cdn) per capita (approximately $1,785 US per capita). Health expenditures accounted for 9.3% of Gross Domestic Product (GDP) in 1998, down from the 1992 peak level of 10.1% of GDP. Health care spending accounts for around one-third of provincial program expenditures.

Public sector funding represents about 68.7% of total health expenditures. The remaining 31.3% is financed privately through supplementary insurance, employer-sponsored benefits or directly out-of-pocket (Figure A & D). The controls inherent in the single-payer approach to health care are recognized as a major contributor to Canada's recent cost containment success.

The single-payer attribute of public insurance has enabled the provinces and territories to better control the growth of health expenditures in the public sector than has been the case in the private sector (Figure B). Provinces and territories have considerable power to manage health care spending. For example, a hospital's operating costs are paid out of the annual budget it negotiates with the provincial ministry of health, or with a regional authority given the devolution of many health planning and delivery functions to communities since the early 1990's. In most cases, proposals for the expansion of programs, services and health facilities must be approved by community and provincial authorities. The acquisition and distribution of expensive high-tech equipment among a region's hospitals is also subject to prior approval to avoid unnecessary duplication of services or their under-utilization.

Compensation for physician services is also negotiated between the provinces and the provincial medical associations on the basis of fee and utilization increases, subject to various forms of individual physician or global ceilings. Salaries for nurses' services are generally negotiated through collective bargaining between the unions and employers.

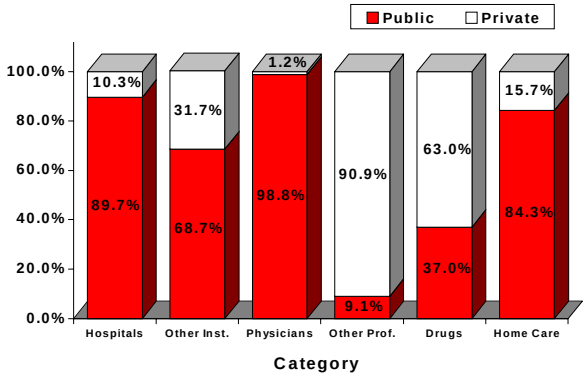
Figure C
Total Health Expenditures by Category, Canada, 1998



* Includes drugs in hospitals

Source: Health Canada

Figure D
Public and Private Shares of Health Expenditures by Category, Canada, 1998



Source: Health Canada

Benefits of Medicare

Health Status

One of the most important indicators of the system's success is the favourable health status of Canadians. The life expectancy for Canadians born in 1997 is 78.6 (81.4 years for women, and 75.8 years for men), among the highest in industrialized countries. The 1996 infant mortality rate of 5.6 per 1,000 live births is one of the lowest in the world. Canada's health care system is regarded as a major contributor to Canada's number one world ranking on the United Nations Human Development Index.[2]

Economic Benefits

Medicare provides a variety of economic benefits, which arise from efficiency and cost-savings associated with public financing and competitive

advantages it provides to Canadian business. Public financing spreads the cost of providing health services equitably across society. In addition to the benefits derived from the single-payer attributes of the Canadian health system, financing health insurance through the taxation system is efficient since it does not require the creation of a separate collection process.

> *The Canadian health care system is one of the central determinants of our industrial competitiveness and our quality of life* (Conference Board of Canada, 1998).[3]

A 1999 study by KPMG, the international business advisors, comparing business costs in North America, Europe and Japan found that Canada has the lowest business costs. A significant advantage was Canada's lower labour costs resulting from lower employee-sponsored benefits (ESB), especially medical insurance.[4]

Canadian business supports the health insurance program, not only because its efficiency has been proven, but also because it provides competitive advantages to the business sector. These advantages include lower employee benefit costs and the promotion of a healthy and mobile workforce. While universal access to quality health care services helps ensure a healthy population and, therefore, a healthy and productive labour force, the national character of Canada's health insurance system enhances labour force mobility, which can be very important in responding to changing business requirements and opportunities.

Public health insurance coverage in Canada is based solely on residency. The portability principle of the *Canada Health Act* ensures that residents are covered when they move or while they are temporarily absent from their province. Workers, therefore, need not fear losing health insurance coverage for themselves and their families because they change jobs or move to another province in search of employment.

NATIONAL FORUM ON HEALTH [5]

The National Forum on Health was launched in 1994 to engage the public and health stakeholders in a dialogue to chart a course for the future of health and health care in Canada. The Forum submitted its final report, *Canada Health Action: Building on the Legacy*, on February 4, 1997. The Forum's overall prescription for sustaining Canada's health system for the future is a balance of actions on non-medical determinants and actions within the health care system itself.

On economic grounds, the Forum says that the single-payer model of public health insurance (Medicare) is the best approach to controlling overall spending on health. The report concludes that a range of concerted actions, based on informed decisions, is needed to make the system more efficient, effective and more reflective of contemporary practice in health care delivery. Recommendations include:

- restructuring the organization, funding and delivery of primary care services; funding the care, rather than the provider or site; taking steps to bring home care and medically necessary drugs under the umbrella of the publicly funded health care system;
- a broad, integrated child and family strategy involving both programs and income support; the creation of a national foundation to strengthen community action; an Aboriginal Health Institute; and help for people trying to enter the work force; and
- the adoption of an evidence-based system at the clinical, management and policy level, and at the public information level - with federal leadership in this area through the development of a nationwide population health information system.

In the 1997 Budget, the Government of Canada provided some early responses to several forum recommendations in announcing $300 million over the next three years for: a new Health Transition Fund (focussing on evidence-based innovations in home care, pharmacare, primary care and integrated service delivery); a national strategy for an integrated Canadian Health Information System; and increased funding for community-based children and prenatal nutrition initiatives.

Renewing Canada's Health Care System

In the early 1980s, health care spending required larger portions of total provincial resources, to the point where they represented between 28% and 36% of provincial program expenditures. Accounting for such a large proportion of provincial expenditures, health care was targeted by most provinces for restraint and cost efficiencies. Provinces were able to undertake much of this cost-control by using the power of a single-payer structure.

There is a growing comprehension of a change in future population health needs, and an understanding of the actual impact of health care on the population's general health status. This is evident in the general policy shift away from discussions of the health care system to a focus on the *health system*, which recognizes that health is more than health care. The overall orientation of new provincial policy directions is the continuance of the shift away from an emphasis on health care towards a more comprehensive and integrated view of health.

The federal and provincial governments have responded to the need to adapt the system to today's realities in several ways, notably: by adopting a determinant of health framework which recognizes that while health care is obviously an important contributor to health, its role must be placed in context as only one component of a much broader set of determinants of health; by shifting the emphasis of the health care system away from institutionally-based delivery models (i.e., physicians and hospital-based care) to integrated community-based models which place increased emphasis on health promotion and prevention; and, by developing strategies for the coordinated management of the health care workforce, including the remuneration, geographical distribution and appropriate use of various health providers.

Governments, health providers and Canadians alike agree that all efforts to preserve and enhance Canada's health care system have to build upon the five fundamental principles of the *Canada Health Act* that guide the design and operation of our national health insurance system. Canadians regard health care as a basic right and they value their health system highly. They identify strongly with their health care system because it exemplifies many of the shared values of our society, such as equity, fairness, compassion, and respect for the fundamental dignity of all. Adherence to the

CANADA: SELECTED FACTS

Demographics	**#**	**Year**
Population	30.9M	1999*
% of Pop. aged 0 - 24	33.2	1998*
" " " " 25 - 44	32.3	1998*
" " " " 45 - 64	22.2	1998*
" " " " 65 +	12.3	1998*
Health indicators		
Life expectancy at birth (yrs)	78.6	1997*
Median age of women	36.1	1996*
Median age of men	34.5	1996*
Infant mortality rate per 1,000 live births	5.6	1996*
Potential years of life lost per 100,000 pop.	3,483	1996*
Major causes of death (% of total causes)		
Cancer	27.2	1997*
Heart disease	26.6	1997*
Cerebrovascular diseases (mainly stroke)	7.4	1997*
Hospitals and other institutions		
Hospital inpatient days per 1,000 pop.	1,132.0	1996-97*
Average length of stay (inpatient days)	10.7	1996*
Hospital beds per 1,000 pop.	5.6	1993-94*
Residential care beds per 1,000 pop.	8.1	1993-94*
Average hospital costs per day	$623	1995-96✦
Hospital staff per bed	3.0	1995-96✦
Health care providers		
Total # of physicians	55,243	1997✦
Active physicians per 100,000 pop.	183	1997✦
# of GP's	28,108	1997✦
% of physicians who are GP's	50.9	1997✦
# of Specialists	27,135	1997✦
% of physicians who are specialists	49.1	1997✦
Specialists per 100,000 pop.	90	1997✦
Registered nurses	229,813	1997✦
Registered nurses per 100,000 pop.	763	1997✦

* Statistics Canada ✦ Canadian Institute for Health Information

principles of the *Canada Health Act* will remain an important characteristic of Canada's health care system as it continues to evolve to respond to the needs of Canadians.

Conclusion

Canada has been successful in its efforts to contain national health expenditures. In the mid-1990s health expenditures levelled off and declined somewhat further. While cost containment within specific sectors remains a priority in order to provide for the reallocation of resources, the pragmatic concerns of containing overall costs have been largely addressed. Canada is now turning its attention toward longer-term considerations about the future of the national health care system. These longer-term considerations are focusing on ensuring that the health care system remains responsive to Canadians' health needs now, and in the future, and appropriate for achieving good health outcomes and health status. There is general agreement that in order to make the health care system more responsive and accountable to the public, it is necessary to move toward an integrated, high quality health care system that can provide the needed care in an effective and affordable manner. Canadians expect to be informed of the performance of the health care system and to be involved in the transition of the system to address their needs in the twenty first century and beyond.

In the 1999 Budget, the Government of Canada announced key steps to strengthen health care in Canada, improve the health of Canadians and enhance health research. Transfer payments to the provinces/territories for health services will increase by $11.5 billion over the five year period from 1999-2000 to 2003-2004. In addition to increased transfers, the 1999 Budget injected $1.4 billion over three years into such key areas as research, information and technology, First Nations and Inuit health systems and programs, and enhancements to health promotion and health protection programs. This investment in the health of Canadians and their health care system represents the largest single new investment ever made by the Government.

It is anticipated that the Canadian health care system will continue its development through an evolutionary process as it is renewed to reflect the new vision of a health system. While health care, with its focus on hospital and medical care, continues to play a prominent and vital role, it is increasingly being recognized as one element of a larger health care system encompassing a broader range of services, providers and delivery sites. Support for, and adherence to, the national principles of the *Canada Health Act* across the country will ensure that the essential elements and character of the Canadian health care system remain as the foundation upon which the health system will evolve.

NOTES

1. "Tax transfer" refers to the transfer of a given number of income and corporate tax points from the federal government to the provinces; in other words, the federal government agrees to lower its personal and corporate income tax so that the provinces can step in and raise their own taxes by the same percentage points as the corresponding federal tax reduction.

2. The United Nations Human Development Index ranks countries according to their citizens' education, access to health care and average income. Canada has topped the index six consecutive years in a row (1994-1999). United Nations Development Programme (selected years), *Human Development Report*, New York: Oxford University Press.

3. Conference Board of Canada; *Performance and Potential 1998:* Ottawa.

4. KPMG (1999); *The Competitive Alternative: A comparison of business costs in North America, Europe and Japan*: KPMG Canada and Prospectus Inc.

5. National Forum on Health (1997); *Canada Health Action: Building on the Legacy*, Final report of the National Forum on Health, Ottawa.

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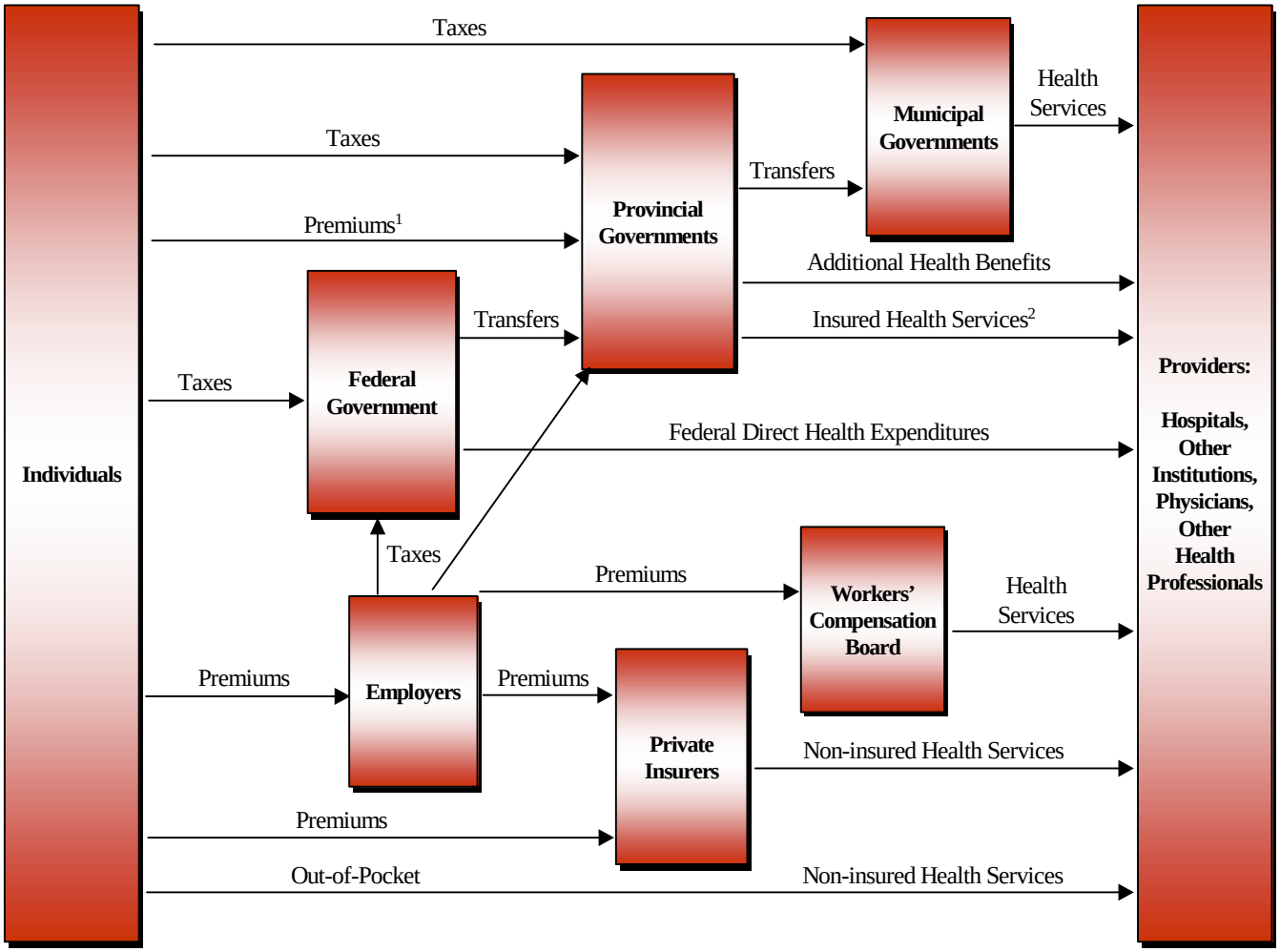
The Funding Structure of the Health System in Canada



1. Two Provinces, British Columbia and Alberta levy health premiums.
2. Medically-necessary hospital and physician services.

Our mission is to help the people of Canada maintain and improve their health.

Health Canada Santé Canada