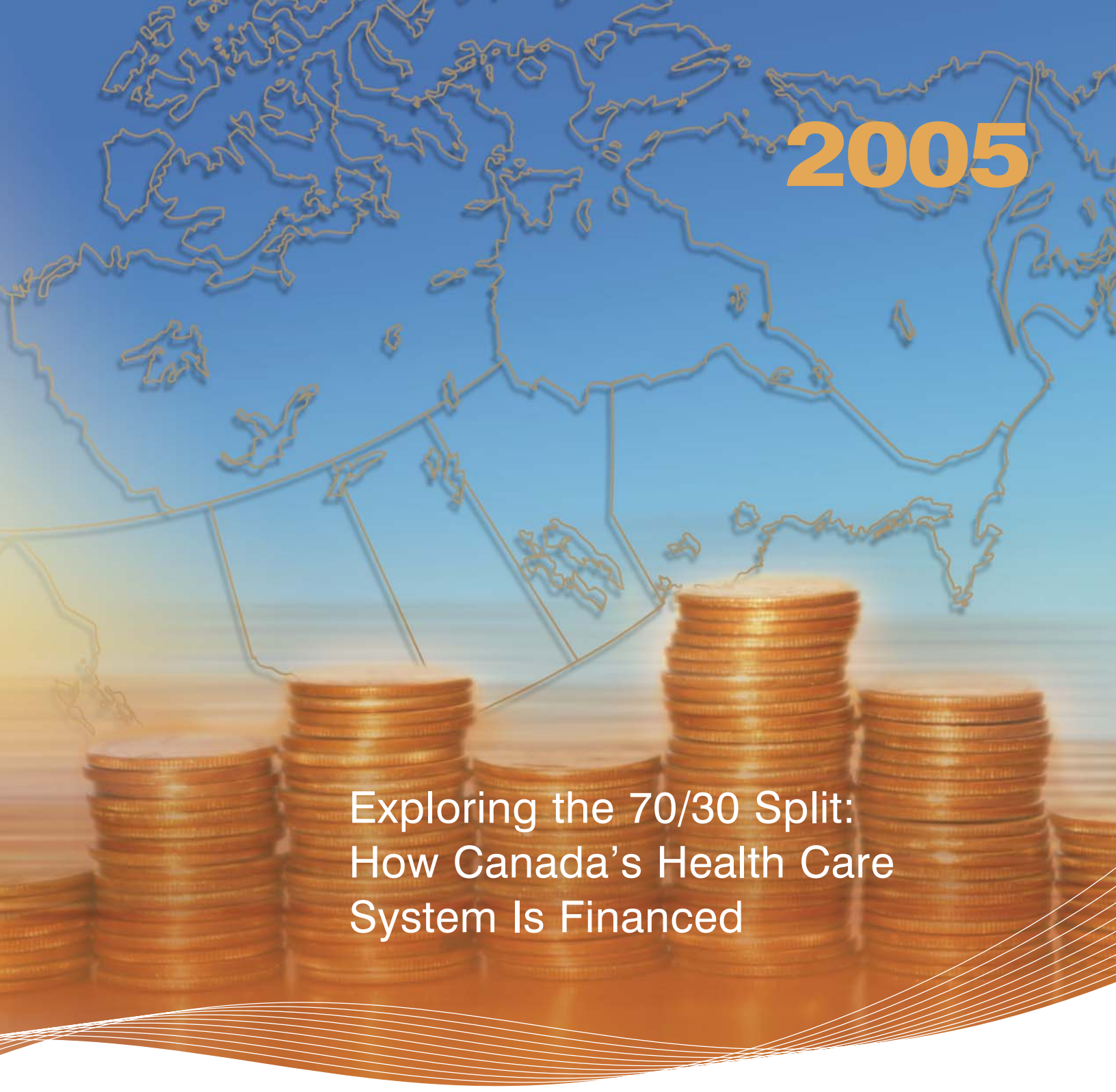

2005

Exploring the 70/30 Split: How Canada's Health Care System Is Financed

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ISBN 1-55392-655-2 (PDF)

Cette publication est aussi disponible en français sous le titre :
Le ratio 70/30 : Le mode de financement du système de santé canadien
ISBN 1-55392-668-4 (PDF)

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Acknowledgments

The Canadian Institute for Health Information (CIHI) would like to acknowledge and thank the many individuals and organizations that have contributed to the development of this report.

We would like to express our appreciation to the members of our expert group, who provide invaluable advice throughout the development process, including reviewing a draft of the report. Members include:

- **Mr. Steven Lewis**, President, Access Consulting Ltd.;
  Centre for Health and Policy Studies, University of Calgary
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It should be noted that the analyses and conclusions in the report do not necessarily reflect those of the individuals listed above or their affiliated organizations.

The editorial committee for this report included Jennifer Zelmer, Jack Bingham, Jacinth Tracey, Jenny Lineker and Patricia Finlay. Health Reports staff who contributed to the development of the report were Cheryl Gula, Sharon Gushue, Chad Gyorfi-Dyke, Luciano Ieraci, Thi Ho, Tina LeMay, Maraki Merid, Mary Neill and Anne Tenenbaum.

Production of this report involves many people and many aspects of the CIHI organization. We want to thank all CIHI staff for their contribution to this report, including individuals from publications, translation, communications, clinical administrative databases, classifications, health expenditures, health human resources, distribution services and the Web.

We would also like to acknowledge Marlene Orton for her writing/editing work.

This report could not have been completed without the generous support and assistance of many other individuals and organizations who compiled data, assisted with quality assurance, or otherwise supported the development of this report.

About This Report

In a 2004 contest sponsored by CBC Television, viewers were asked to name "the greatest Canadian." The winner was the late Tommy Douglas, popularly known as the "father of Medicare.

When Canada's health care system—known widely as "medicare"—was created, hospitals and doctors provided most health services. Medically necessary services were paid for primarily out of the public purse. Over time, the health system has grown to embrace an ever-broadening range of services.

The 70/30 Split

Total spending on health care has risen, and private spending by individuals or insurers has been growing more quickly than public spending. Today, about 70% of total Canadian health expenditures comes from the public purse. The remainder (about 30%) comes from private sources. In this report, we look at trends in financing and at variations in this 70/30 split across provinces and territories. This includes a close examination of several specific health services. We hope that this report, which aims to provide a clear, detailed and comparative picture of health financing in Canada, will assist policy-makers and Canadians in understanding who pays for what types of care.

The report is divided into three parts:

Part A: Setting the Stage

Chapter 1—*Health Financing* looks at the different ways that health financing systems are structured in Canada and other Organisation for Economic Co-operation and Development (OECD) countries.

Chapter 2—*The Canadian Reality* outlines how Canada's current health system evolved, examines the legislative framework that sustains it and looks at the scope of public health coverage.

Part B: A Primer on Canada's Health Care System—What It Costs

Chapter 3 takes an in-depth look at health spending in Canada. It shows provincial/territorial comparisons, outlines the public- and private-sector contributions to health care spending and provides international comparative data.

Part C: Snapshots of Spending on Health Services

Part C explores the use of specific health care services in Canada as well as the public and private insurance coverage and private spending on each. These health care services include:

Chapter 4—*Hospital Services*

Chapter 5—*Physician Services*

Chapter 6—*Retail Drug Sales*

Chapter 7—*Oral Health Care Services*

Chapter 8—*Eye Care*

Chapter 9—*Continuing Care*

Chapter 10—*Mental Health Services*

Chapter 11—*Complementary and Alternative Services*

The result is a rich body of information, compiled in one place for the first time. But many important questions remain. For example, our information base is much stronger for some types of health care than for others. And we know relatively little about some funding flows (for example, subsidies through the tax system for out-of-pocket spending and health insurance purchases). Over time, we hope to continue working with our partners to improve our collective understanding of a system that now consumes more than $130 billion per year.

1 Health Financing in Canada and the World

What would a perfect health care system look like, and how would we pay for it? Over the last decade, many countries have explored alternative ways of organizing and financing health services in an attempt to answer these questions. In Canada, the debate over whether what we have can be sustained—and whether what we have is what we want—has spawned several provincial and federal reports. More recently, the Supreme Court of Canada also weighed in on the debate.

Canada is not alone in wrestling with these questions. Health care systems throughout the world reflect historical, geographical, cultural, social and economic factors that are unique to each country. However, economically developed countries' health care systems share many similar features and face common challenges. The most pressing may be the speed with which health care costs have been growing, sometimes faster than the countries' economies as a whole.[1] This chapter examines major themes in the debate about how to finance health services.

How Did It All Start?

Health insurance in Canada dates as far back as the 17th century. In 1655, the Hôtel-Dieu de Montréal hospital initiated a medical plan under which physicians would dress wounds and prescribe treatment for an annual fee.[2] However, the concepts behind what we now recognize as "medicare" developed in Europe in the late 1800s. The systems now found in most Organisation for Economic Co-operation and Development (OECD) countries are based to varying degrees on the models that emerged at that time.

Health care systems evolve in response to many factors, including changing concepts in the broader political economy. Because these concepts are common to many OECD countries, health reform initiatives tend to converge around similar themes.[3] For example, the concept of "classic universalism" took root after World War II. According to this notion, all people should have equal access to health care services, and these services should be available free of charge, regardless of age, sex or health status.[4] By the early 1960s, many OECD governments had begun to invest more heavily in social programs, including health care.[3] In the 1970s, many countries saw a significant rise in health care costs, although there was little evidence that this directly resulted in better population health. Some experts worried that this marked the beginning of the time when "there seemed no natural limit to health care spending, and it appeared that demand could increase infinitely."[3]

Containing costs became a focus in many parts of the world, although approaches and results differed. More recently, total health expenditures have begun to rise again in many countries. Government budgets in particular have felt the strain because, on average, three-quarters of OECD spending for health care comes from public funds.[1]

The Public/Private Mix

Using the words "privatization" and "health care" in the same sentence is enough to spark debate in many countries. In a 2002 report, the World Health Organization noted that "privatization has become one of the most controversial and value-laden terms in the European health care lexicon."[5]

The role of the private sector can be controversial, because for many people the debate about who should finance health care goes to the heart of societal values. In most OECD countries, health care is seen not as a commodity, but as a public good.[3] Also, health care is part of wider social security systems, where governments are responsible for ensuring that public policy goals are met.[5]

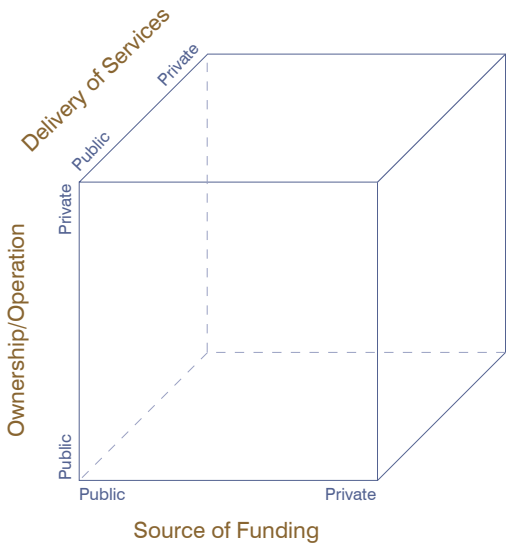
Linguistic Landmines?

In the search for solutions to health care financing challenges, language can become an issue in itself. The meanings of words are often influenced by the particular context in which they are used. Terms that mean one thing in one country may acquire a completely different meaning in another. As one expert noted, "the symbolic import of the language of health reform should never be underestimated."[3]

Another challenge is that the phrase "private health care" means different things to different people. This may be partly because of confusion over relationships between the various dimensions of the health care system. These are summarized below:

Canada's Health System

Financing, Ownership and Delivery



Financing: about 70% of financing for health care in Canada comes from public sources, 30% (about $39 billion) comes from non-public sources.

Ownership: may include public agencies as well as privately owned and/or traded companies.

Delivery: the public and private sector both deliver health services to Canadians, with the private sector playing a significant role.

Source: Adapted from I. McKillop, J. Alpenberg, R. G. Evans, et al., *Private Sector Delivery: Scope and Extent in Canada's Health Care System*, (Waterloo: University of Waterloo, 2004).

In recent years, many OECD countries have been looking at ways to increase the private financing of health care in order to shift cost pressures from public systems to the private sector.[6] Some are focusing on expanding private delivery of services. Others are looking to increase private financing as a means of containing public spending on health. Measures include introducing or expanding private (voluntary) insurance, cost sharing and reducing the services covered by public health insurance plans.[5] While there is evidence that the introduction or expansion of private financing measures may help lower public-sector health care spending (but not total health expenditures) in some countries, researchers suggest that it may also negatively affect access and equity.[6–8] A recent study suggests that the dynamics and effects may depend on the nature of the relationship between public and private financing. The authors identify four basic models for structuring this relationship:

Parallel public and private systems: private financing exists as an alternative to public insurance for a given range of services.

Copayments (a form of cost sharing): payment is partly financed through the public sector for various services. The remainder is financed through out-of-pocket payments and/or private insurance. In many countries, income is a factor that determines levels of copayments.

Group-based: only certain sectors of the population are eligible for public coverage; the rest may be covered by private health insurance.

Sectoral: certain health care sectors are fully financed by public insurance. Others are dependent to varying degrees on private-sector funding.[7]

Private Financing—Out of Whose Pocket?

Private-sector funding—primarily through private health insurance and out-of-pocket payments—accounts for between one-fifth and one-third of health expenditures in most OECD countries. At 30% in 2004, Canada falls within this range. The private sector mainly pays for services beyond hospital and physician care, such as drugs, dental and vision services. Canada's private share is similar to those of Spain and Australia, but higher than that of the United Kingdom, France, Germany and Sweden.[9]

Most private-sector health spending in many OECD countries comes through out-of-pocket payments. In 2002, private health insurance accounted for less than 10% of total health expenditures, except in Canada, the United States, France and the Netherlands. In Canada, private health insurance and out-of-pocket payments pay for roughly equal shares of private-sector spending.[9] In the other three countries, payments through private insurance exceeded those made out-of-pocket by individuals.

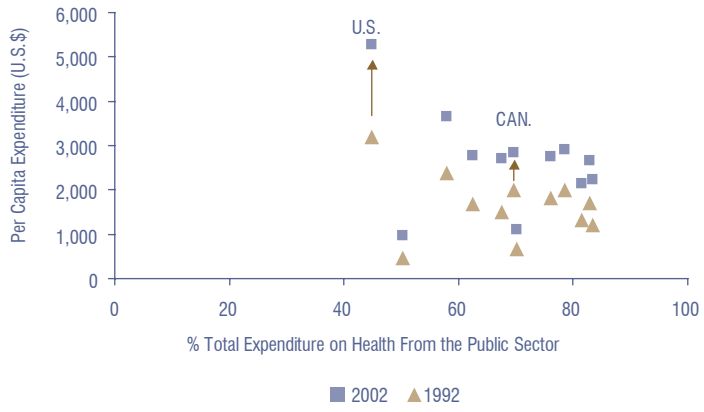
Subsidizing Private Spending

In some countries, private health insurance premiums and out-of-pocket health care expenses are fully or partially tax-deductible. For example, researchers estimate that when tax breaks are taken into account, nearly 60% of health spending in the U.S. is publicly financed.[8] In Canada, the Child Disability Benefit, the Disability Tax Credit and the Medical Expense Tax Credit cost about $1 billion in 2004.[11] Other tax subsidies also exist.

Studies have shown that countries with multiple payers—that is, many different sources of financing—are among those with the highest health expenditures.[1] Researchers suggest that this may partly be because countries tend to apply cost-containment measures only to the public system. Studies have also shown that administrative costs are also higher in systems with multiple payers—and can be significant.[6, 10]

1 What Happened in the 1990s?

All OECD countries saw health spending per person rise in the 1990s (not adjusted for inflation). This occurred across countries with very different mixes of public and private financing, as shown in the graph below.



Notes: Expenditures are converted to U.S. dollars using purchasing power parities (PPPs) for gross domestic product (GDP), which are designed to eliminate differences in price levels between countries. The OECD asks that member countries report health expenditures according to their system of health accounts. The 12 countries that most closely follow the proposed system of health accounts are Australia, Canada, Denmark, France, Germany, Hungary, Japan, South Korea, the Netherlands, Switzerland, the UK and the U.S.

Source: OECD Health Data 2005, OECD.

Over the past decade, less than half of OECD countries reporting data saw increases in the private share of health spending, while for others it was constant or decreased. Other countries saw public-sector spending growth outpace that in the private sector. Canada's private share rose from 28% in 1994 to 30% in 2004. This was primarily due to increased payments through private health insurance plans.

How private money is *spent* also differs significantly between countries. Unlike many others, Canada funds hospital and physician services almost entirely through taxes. User fees and copayments for these services are relatively common in other parts of the world. About half of western European countries apply some form of copayment for first contact care, while others apply it only to outpatient care.[5] Private insurance and out-of-pocket payments in Canada tend to be higher for services not covered under the *Canada Health Act*.[8]

Out-of-Pocket Payments

Out-of-pocket payments include all costs directly met by consumers. This covers cost sharing through copayments, user fees, purchases of over-the-counter medication and health supplies and similar costs. Out-of-pocket payments can be grouped into three categories:

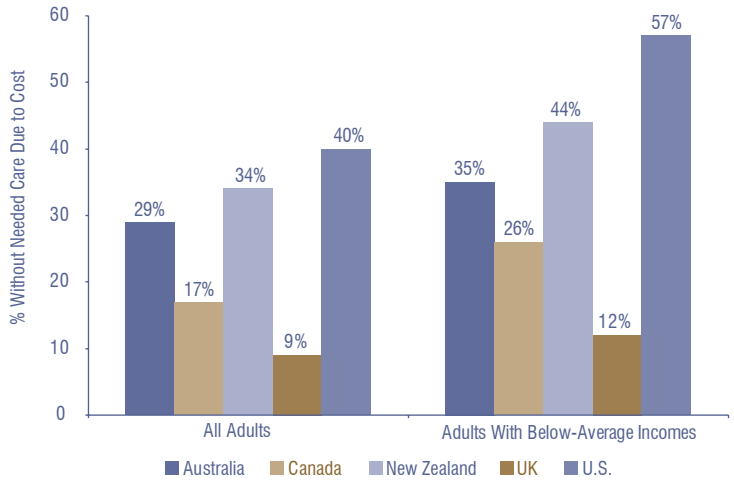
Direct payments for goods and services that are not covered by any form of pre-payment, insurance, or public funding;

Cost sharing (also referred to as "copayments"), where the individual pays part of the cost of care received. The user may pay a fixed fee, a fixed proportion of a fee for an item or service or some combination of the two; and

Informal payments, which are unofficial payments for goods and services, sometimes referred to as "under-the-table payments."[10]

2 Going Without Needed Care

In 2004, a Commonwealth Fund study asked adults in five countries whether in the past year there had been a time when they went without care that they needed because of costs. In all countries, adults with below-average incomes were more likely to say yes than the population as a whole. Canada's rates fell in the middle of those reported by other countries, as the graph below demonstrates.



Source: 2004 Commonwealth Fund International Health Policy Survey.

In 2002, individual Canadians paid an estimated $17 billion (out-of-pocket) to cover various health care services, up from $13 billion in 1998. For example, they spent $3.6 billion out-of-pocket health care dollars on over-the-counter drugs and personal health supplies. Personal health supplies include oral hygiene products, diagnostic supplies (for example, diabetic test strips) and medical supplies (such as incontinence products). Other major areas of out-of-pocket spending include dental care ($3.4 billion), prescribed drugs ($2.9 billion), nursing homes and other institutions ($3.0 billion) and vision care ($2.0 billion).

Effect of Copayments

Although most Western countries allow or impose copayments for some services covered by public insurance, there are large variations in the size and range of these payments. Most copayments come from individuals—only a few countries, such as France and New Zealand, allow the use of private insurance to cover copayments.[6, 7]

What effect do copayments have on access to care and outcomes? Probably the best-known study to address this question is the Rand Health Insurance Experiment in the U.S.[12] It randomly allocated participants to insurance plans with different copayment structures. The study found that those in plans with higher user fees, particularly individuals with low incomes, used fewer services. But sick people were more likely to die when user charges were in place, and rates of inappropriate antibiotic use and hospital admissions were about the same regardless of the level of user fees.

A large Canadian study based on the experience in Saskatchewan in the 1970s found similar results. When copayments were in effect, the poor used fewer physician services.[7] Moreover, because high-income residents used more physician services and physician fees increased, overall health care costs were not lower when copayments were in place. Studies have shown that in both New Zealand and France it is primarily those with lower incomes who use health services less when they have to pay user fees.[6, 7] And, as in Saskatchewan, the introduction of copayments in Switzerland did not reduce total health expenditures.[13]

American, Canadian and Western European studies have also found that cost sharing for out-of-hospital pharmaceuticals decreases utilization for the elderly and those in lower-income groups. This has been linked to adverse health outcomes and higher utilization of emergency departments among these groups.[7, 10, 14] Likewise, New Zealand research suggests that some people avoid seeking help for early symptoms and may end up in emergency rooms because they are unable or unwilling to pay a user fee (about CA$30) to consult with a family physician.[13]

Private Health Insurance

Research suggests that in most OECD countries private health insurance plays a supporting role in publicly financed systems.[6] In 2002, private health insurance accounted for an average of 7.2% of total expenditures on health and about 22% of private health spending in comparator OECD countries. Over the last decade, there has been relatively little change in the percentage of total health expenditure covered by private health insurance across the OECD.[9]

The role of private health insurance varies from country to country. For example, in France, the Netherlands and Canada, it accounts for anywhere from 10 to 17% of total spending on health. This represents about half of all private spending. In OECD countries with significant levels of private health insurance, a large proportion of it is usually provided by employers.

For example, a recent study found that this was true for 90% of private insurance policies in the U.S. and Canada, 60% in the Netherlands and 50% in France.[6]

In Canada, insurance company costs amounted to $14 billion in 2002, up from $9 billion in 1998. Together, prescribed drugs and dental care accounted for more than two-thirds (67%) of spending through private insurance. A further $2.3 billion went towards pre-payment administration for private health insurance plans.

A recent study identified five distinct roles played by private insurance.[10] Two or more of these roles overlap in many countries. Researchers suggest that:

- In the U.S., private health insurance is *dominant*. That is, it is a principal method of financing health care. Private health insurance, which is purchased voluntarily, accounted for almost 37% of total expenditure on health in the U.S. in 2003.[9]

- In Switzerland, the purchase of private health insurance is *compulsory*. The private health insurance industry is tightly regulated. The regulations ensure open enrolment, community-rated premiums and a standardized minimum package of benefits.

- *Substitutive* insurance is designed for those excluded from, or allowed to opt out of, public health insurance plans. For example, in the Netherlands and in Germany, individuals with higher incomes are not eligible for public health insurance.

The Australian Experience

Australia's universal, publicly financed system includes physician services, inpatient hospital care, pharmaceutical benefits and a range of other services. There is also a smaller, parallel private insurance system that covers inpatient hospital care, among other services.[15] In the mid-1990s, less than a third of the population had private hospital insurance. Following the recommendations of a government-commissioned report, Australia introduced incentives to encourage purchase of private hospital insurance. By 2000, coverage reached 43% before dropping off again.[15]

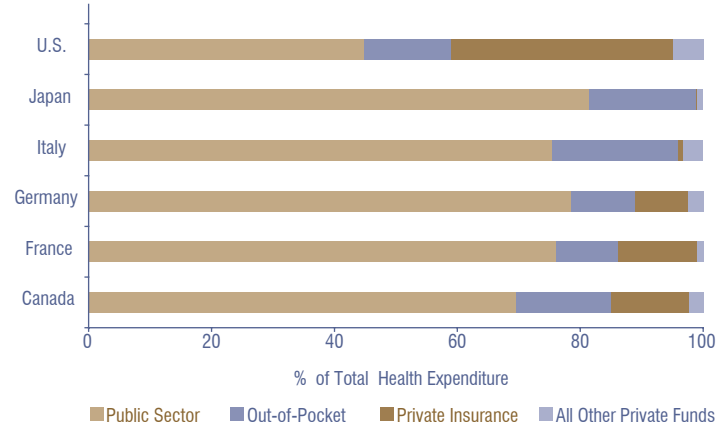
Studies have shown that the incentive scheme did not reduce *overall* public spending on health care, because the cost of the incentives (in 2000, 6% of all public spending on health care) exceeded any potential savings to the public purse. There was also no reduction in wait times. Finally, Australia regulated the private insurance industry—requiring it to offer community-rated premiums to all enrollees regardless of their health.[7]

- *Complementary* insurance covers services excluded from or only partially covered by public insurance. In Canada, complementary insurance is available for outpatient drug costs, dental care and many other services not covered under provincial and territorial plans. In a few cases, complementary insurance may also cover copayments for publicly insured services. Countries that allow such practices include France, Denmark and Sweden.

- *Supplementary* insurance usually covers services provided by public health insurance systems and may be referred to as "double coverage." It is mainly positioned as a tool to increase choice—either of provider (that is, private physician) or of facility (that is, access to private hospitals or to private facilities in a public hospital)—but it may also be marketed as a way to receive faster access to care. This form of public health insurance is available in many European countries and is the main form of private insurance in Spain, Sweden and the UK. Prior to a June 2005 Supreme Court decision striking down a prohibition in Quebec against using private health insurance to pay for publicly insured services, it was illegal to use private insurance to pay for physician and hospital services covered by provincial insurance plans in six of Canada's 10 provinces. In the other four, such insurance remains rare.[12]

3 Where the Money Comes From

Some economically developed countries rely, to a varying extent, on the public sector, private insurance and out-of-pocket payments by individuals to cover the costs of health care. The figure below shows the proportion of health spending coming from each of these sources for 2002. Canada's private sector funds a larger share of health spending than all other countries except the U.S. Within this envelope, we rely more on out-of-pocket payments than many other countries.



Note: Public and private expenditure figures for France are estimates; public expenditure figures for Japan are estimates.

Source: OECD Health Data 2005, OECD.

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2 The Canadian Reality

Health spending and health care renewal have been key political issues for many years in Canada. Now the courts are also involved. Within the past year, the Supreme Court of Canada faced two decisions with important implications for health policy. In the Auton case, parents of autistic children in British Columbia argued that the failure of the government to fund intensive (and expensive) behavioural services, known as ABA/IBI therapy, violated the *Canadian Charter of Rights and Freedoms*. In its unanimous decision, the Supreme Court disagreed. It found that provinces and territories had the right to limit provision of "non-core" benefits.[1]

The Chaoulli case in Quebec asked whether it was constitutionally justifiable to prohibit private health insurance from covering medical and hospital services. A court challenge by Quebec resident George Zeliotis and his physician, Dr. Jacques Chaoulli, pushed this question to the forefront of the health care debate in 2005. Mr. Zeliotis waited a year for hip replacement surgery in 1997. In his challenge, Dr. Chaoulli held that when the public system does not provide "reasonable" access to services, this prohibition violates both the Quebec Charter and the *Canadian Charter of Rights and Freedoms*. He further argued that doctors who have opted out of medicare (which is legal) should have the same access to hospitals to treat their private-paying patients as other doctors. The Quebec courts acknowledged that the patient's rights to security of the person were indeed violated, but felt that the violation was defensible because of an overriding public interest. However, the Supreme Court of Canada, by a 4:3 majority, allowed Dr. Chaoulli's appeal. It ruled that the ban on private health insurance to obtain medically necessary treatment in Quebec violated Quebec's *Charter of Human Rights and Freedoms*.[2]

These decisions have fuelled the fires of the health care financing debate. But it's far from the first time that Canadians have faced difficult questions about what services should be covered, for whom and at what price.[3]

In 1947, Saskatchewan was the first province to establish public universal hospital insurance.[4] A decade later, the Government of Canada enacted the *Hospital Insurance and Diagnostic Services Act* to help pay for these services. By 1961, almost all Canadians (99%) were covered by various provincial and territorial hospital insurance plans.[5]

Key Dates in Canadian Health Care Policy

1867: *British North American Act* establishes the basis for provincial responsibility for hospitals.

1947: Saskatchewan introduces Canada's first publicly funded universal hospital insurance program.

1957: The federal government passed the *Hospital Insurance and Diagnostic Services Act*. All provinces and territories were covered under the cost-sharing program for hospital insurance by 1961.

1961: Saskatchewan passes the *Saskatchewan Medical Care Insurance Act* providing government insurance for physician services.

1966: The federal *Medical Care Act* introduces federal and provincial cost-sharing for physician services outside hospitals. By 1972, all provinces and territories are participating in the program.

1974: Marc Lalonde, the federal health minister, releases a report called A *New Perspective on the Health of Canadians*. It reinforces the idea of broad determinants of health (including human biology, the environment, lifestyle choices and health care organization) and calls for a reorientation of health care services toward health promotion.

1977: *The Established Programs Financing Act* introduces a program of federal transfers that are not directly tied to the costs of the provincial and territorial programs.

continued on next page

Key Dates in Canadian Health Care Policy continued from previous page

1979: Emmett Hall is commissioned to study the operation and financing of health care in Canada. His report (1980) recommends abolishing extra billing and user fees and suggests a collaborative means of establishing provincial physician payment rates.

1984: *The Canada Health Act* reinforces the basic principles provinces and territories must follow to qualify for federal health funding (public administration and operation, comprehensiveness, universality, portability and accessibility). It penalizes extra billing and out-of-pocket charges for services covered under the Act.

1996–1997: The federal contribution to health and social services is consolidated into the *Canada Health and Social Transfer (CHST)*. This represented a major change in federal, provincial and territorial cost-sharing arrangements for health services.

2004: Based on recommendations of the 2003 *First Ministers' Accord on Health Care Renewal*, the CHST is split into two transfers: the Canada Health Transfer (CHT) and Canada Social Transfer (CST). They consist of pre-determined cash contributions and equalized tax transfers for health and social programs until 2007–2008. The CHT also consists of five-year ($16 billion) funding directed toward accelerating reform in areas identified by first ministers, such as primary health care, home care and catastrophic drug coverage. This funding is known as the Health Reform Transfer, or HRT.

Source: Compiled by CIHI.

It was not until 1962, however, that Saskatchewan introduced a medical insurance plan, following a dramatic strike by the province's doctors.[6] Shortly afterwards, the federal *Medical Care Act* was passed. Within six years (by 1972), all provinces and territories had joined.[5]

Heated controversy about extra billing and user charges led to a review of this framework in the late 1970s. Extra billing occurs when patients pay for insured health services over and above what their provincial or territorial insurance plan pays. User fees are charges for an insured health service permitted by a provincial or territorial health plan that are not payable by the plan itself.[7, 8]

Based on a recommendation by the late Emmett Hall (a former Supreme Court of Canada justice) to abolish extra billing and user fees,[5] the *Canada Health Act* was passed in 1984. It replaced the two earlier Acts. This legislation not only guarantees Canadian residents "reasonable access" to medically necessary insured services without direct user charges, it also outlines specific criteria and conditions related to publicly insured health care services. These criteria establish a set of principles that all provinces and territories must meet in order to receive the full federal contribution under the transfer mechanism now known as the *Canada Health Transfer* (CHT).[4] While the Act does not strictly

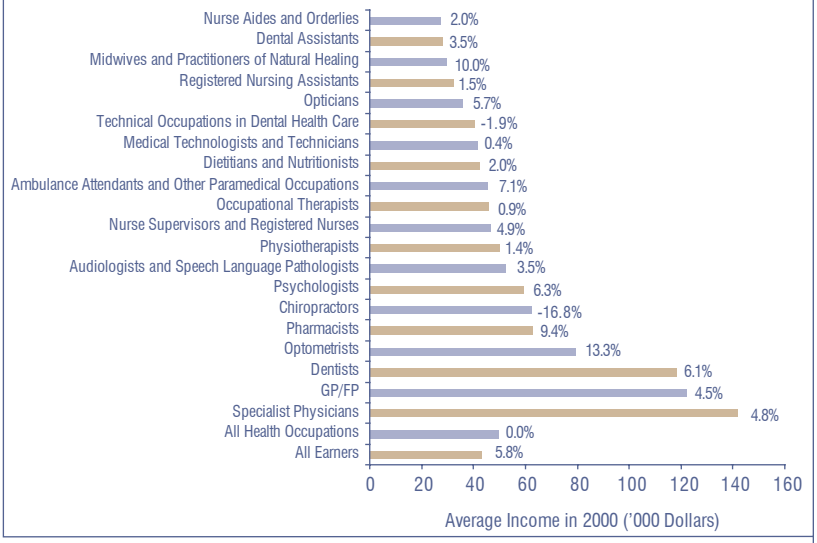
prohibit user fees and extra billing, they are discouraged. If extra billing or user fees occur, deductions to the federal cash transfers to the province or territory in question may be made accordingly. As well, non-compliance with one of the five criteria or two conditions* can lead to discretionary penalties.[7]

Looking Forward From the *Canada Health Act*

Over several decades, Canada's health system has evolved into a vital and complex segment of the economy. A tenth of our economic output—or $130 billion—goes to health care. Health care costs as a share of the gross domestic product (GDP) rose sharply in the early 1980s, and then again in the early 1990s, when the economy stalled during two periods of recession. The economy began to recover in the 1990s, but growth in health spending slowed until 1997. This led to a decrease in health care's share of the GDP. In recent years, however, this trend has reversed. Among Organisation for Economic Co-operation and Development (OECD) countries, only the United States, Switzerland, Germany and France devote a larger share of their GDP to health care.

4 Changing Incomes: Percentage Change (1995 to 2000)

The average income for health professionals in some occupations is more than three times that in others. This figure shows average annual employment incomes for Canadians who worked full-time for the full year in selected health occupations in 2000, compared with the overall averages for health occupations and all earners. It also shows the percent change in those averages since 1995, adjusted for inflation.



Source: Census of Population, Statistics Canada; Labour Force Survey, Statistics Canada.

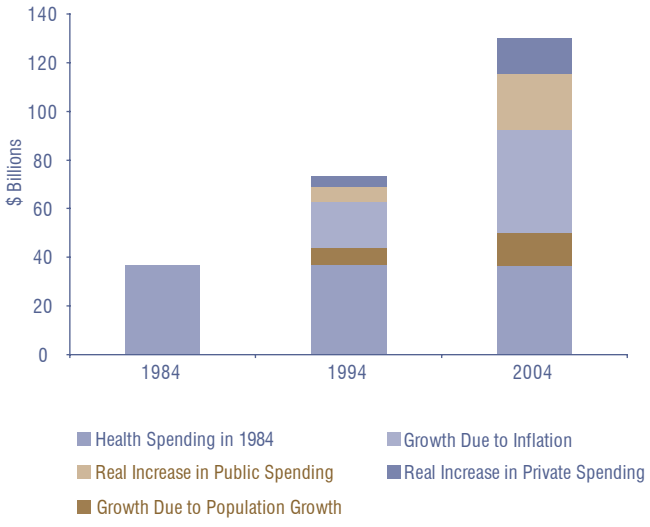
Forecasts for 2004 show health spending in Canada at $4,078 per person, up 5% from 2003. Growth drivers include inflation, structural factors such as population growth, more use of existing and new services (for example, changes in the average number of prescriptions consumed), changes in how services are organized and delivered and a range of other factors, not all of which are fully understood.

To unpack these effects, we studied changes in health spending in the two decades since the *Canada Health Act* was introduced. Between 1984 and 2004, Canada's combined public and private health care bill increased by over 250%, rising by almost $94 billion.

* This includes providing information to the federal Minister of Health in relation to insured health services and extended health care services for the purpose of the *Canada Health Act,* as well as recognizing federal financial contributions toward both insured and extended health care services.

5 Accounting for Spending Growth

Between 1984 and 2004, total health spending in Canada grew by almost $94 billion. Why the increase? Many factors—from population growth and inflation to a rise in real (inflation-adjusted) public and private spending on health care per person—contributed.



Note: Data for 2004 are forecast.

Source: National Health Expenditure Database, CIHI.

What explains this increase?

- Start with the $37 billion spent in 1984.
- Now add $13 billion, because 6.2 million **more people lived in Canada** in 2004 than in 1984. It would have cost that much to provide them with health services at the 1984 average level of per capita expenditure. That's about 14% of the overall increase in health spending.
- **Inflation** in the health sector (for example, higher wages for health professionals) accounted for a further $42 billion, or about 45% of the growth in total spending.**
- After a brief dip in the mid-1990s, **public-sector spending per person**, adjusted for inflation, also rose steadily. The result was that we spent $23 billion more on health care through the public sector in 2004 than in 1984. This means that about 25% of overall growth went towards net additional care funded from the public purse. This reflects both more care (for example, higher rates of hip and knee replacements or more CT scans) and new types of care (for example, vaccines against the chicken pox or new drug therapies), offset by any service reductions or efficiencies that occurred over this period.

Wage Trends

The people who provide care are the core of our health care system. Their wages and other payments for their services account for a large part of what we spend on health care. Between 1997 and 2001, Statistics Canada's Labour Force Survey shows that, on average, weekly wages for full-time workers in the health sector increased by just under 9%, compared to 10% for workers in all parts of the economy. Likewise, Census data show that, on average, employment incomes for full-time workers in health occupations rose at about the rate of inflation between 1995 and 2000. That compares to almost a 6% after-inflation increase for all earners.

** This calculation is based on the health component of the consumer price index (for private-sector spending) and implicit price indices for government current expenditure (for public-sector health care spending), both from Statistics Canada. A 2000 review showed that the latter corresponds closely to the sub-component related to government health expenditure, which is not publicly available. (V. Hicks, G. Fortin and G. Ballinger, *Price Indexes Used in National Health Expenditures: Feasibility Study* (Ottawa: CIHI, 2001), [online], from <www.cihi.ca/cihiweb/en/downloads/spend_nhexenhance_e_PriceIndexes.pdf>.

- **Private-sector spending** per person also rose between 1984 and 2004, accounting for the remaining $15 billion increase in spending over this period (16% of the growth).

Who Pays and What the Money Covers

In Canada, like in other OECD countries, a mix of public- and private-sector payers finance health services. Public spending—$91 billion in 2004—covers most public health programs, hospital care, physician services and care for Status Indians and Inuit. The public sector also pays part of the cost of other services, such as home care, prescription drugs and ambulances. The provinces and terri-

The Sustainability Challenge

In 2003, Canada's premiers and the Prime Minister identified sustainability as a key objective for health care renewal.[9] "Sustainability" is a complex concept. Many groups, both academic and government-sponsored, have proposed frameworks to describe it. Some focus strictly on health expenditure growth, particularly in the context of the fiscal challenges of governments. Others argue that it's not just about money. They identify issues such as the future availability and distribution of health care providers, the acquisition and use of new technologies and changing patterns of practice as keys to sustainability.

Still another approach is to look at options for achieving sustainability by improving value for money. This may include exploring the effectiveness and efficiency of health services (for example, reducing overuse of ineffective interventions, underuse of appropriate health services and adverse events) or looking ahead at how to reduce future needs for care through a population health perspective.

Both first ministers and the Commission on the Future of Health Care in Canada[10] identified three essential dimensions of sustainability:

- the needs of Canadians;
- the services required to satisfy those needs; and
- the availability of resources required to provide those services.

This perspective suggests that it is the balance and interaction of these dimensions that determine sustainability. Part of the challenge is the ongoing evolution in each of these areas, as well as in public expectations about health and health services. While health care may be as much a part of the Canadian social fabric as hockey or maple syrup, specific preferences and expectations may differ across the country or among population groups. They undoubtedly also evolve over time.

In this context, various options for promoting sustainability have been put forward, including (but certainly not limited to) expanding user fees, setting limits on government health spending, improving efficiency and effectiveness of health services and increasing disease prevention and health promotion.[11]

6 Who Pays for What

Public and private payers cover part of the cost of health care in all OECD countries. However, countries that spend about the same amount on health care often finance these costs very differently. The table below shows the public sector's share of spending for different types of services in Canada and the three OECD countries with the most similar levels of total per capita expenditure on health in 2003.

	Canada	Germany	The Netherlands	France
Total expenditure on health	70%*	78%	62%	76%*
Physician services	98%	85%	N/A	74%
Curative and rehabilitative inpatient care	93%	84%	74%	92%
Pharmaceuticals and other medical non-durable goods	38%	75%	57%	67%
Long-term nursing care	78%	75%	98%	100%
Dental services	5%	68%	N/A	36%

Note: *Public expenditure figures as a proportion of total health expenditure for Canada and France are estimates.

Source: OECD Health Data 2005, OECD.

tories administer the bulk of the public-sector health budget, part of which is financed through federal transfers of cash and tax points. Direct federal programs, municipal governments, Workers' Compensation Boards and other social security programs also play a role in public-sector financing.

The rest—$39 billion in 2004—comes from private sources, such as insurance plans, out-of-pocket payments and non-consumption expenditure (for example, hospital revenue from donations, parking lots, investments and other sources). Drugs, dental care and vision care account for most private spending. Indirectly, governments bear part of these costs through foregone tax revenues. For example, firms can deduct insurance premiums from their taxable income, but employees do not pay taxes on these benefits.

The *Canada Health Act* establishes "medically necessary" hospital, physician and surgical-dental services as publicly insured services. In some cases, other "extended" health care services may also be paid for by public funds. Examples include nursing home care, home care and ambulatory care.[12]

While the Act sets out a broad framework, many decision points remain. For example, the Act does not explicitly define the term "medically necessary." Some suggest that this opens the door for differences in what health services are included across the country.[13-15] Others argue that a strict definition of medically necessary would prevent provinces and territories from addressing the unique health care needs and values of their own populations.[13, 15] These factors may also influence what services provinces and territories choose to fund beyond those outlined in the *Canada Health Act*.[10, 16, 17]

The end result is a core of services that is funded publicly in all jurisdictions, but the mix and extent of coverage for others varies. For instance, a study by the Canadian Diabetes Association showed that persons with diabetes qualify for very different coverage in different parts of the country.[18]

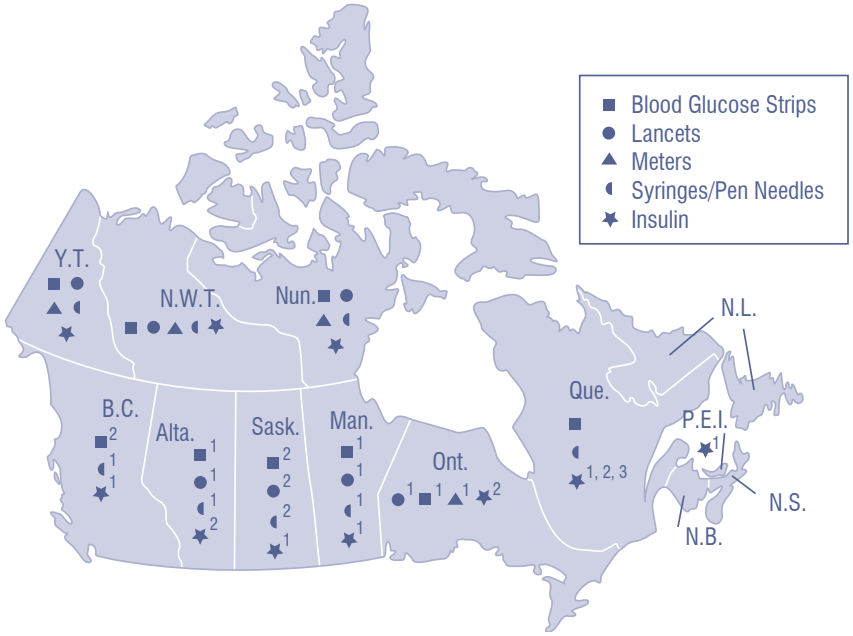
The *Canada Health Act* Principles

The *Canada Health Act* outlines several requirements that provinces and territories must meet through their health insurance plans in order to qualify for full federal funds under the *Canada Health Transfer*, including:

1. **Public administration**: Health insurance plans are administered and operated on a non-profit basis by a public authority responsible to provincial and territorial governments.
2. **Comprehensiveness**: Provincial and territorial health insurance plans must insure all health services insured under the Act (that is, physician, hospital and surgical-dental) and, where permitted, services rendered by other health practitioners.
3. **Universality**: Every eligible resident of a province or territory is entitled to insured health services covered by the insurance plans. Residents are generally required to register in order to get coverage.
4. **Portability**: Residents receive coverage regardless of where they live and whether they move between provinces and territories. Coverage must be extended by the home province or territory for up to three months during the waiting time for new coverage.
5. **Accessibility**: Provinces and territories must provide reasonable access to insured health services without discrimination on any basis, including ability to pay. This entitles residents to insured services in the location where services are provided and as services are available.

7 Where You Live Matters

Jane is 23 years old and was diagnosed with Type I diabetes as a child. Every day, she needs insulin injections in order to control her blood glucose levels. These injections require syringes or pen devices. Jane also needs to monitor her glucose levels daily using a lancing device, test strips and a metre to read the results. Jane's annual income is less than $15,000. She currently has no private health insurance and does not receive social assistance. The supplies Jane needs to manage her diabetes are partly or fully covered in some parts of the country—and not in others, as the figure below illustrates. The amount that she needs to pay for her care depends on which part of the country she lives in.



Source: Canadian Diabetes Association; provincial and territorial ministries of health.

Footnotes to Diabetes Map

B.C.
1. For insulin, syringes, pen needles: no deductible. Pharmacare immediately provides 70% coverage. Once annual maximum is reached, Pharmacare covers 100% of eligible expenses.
2. Coverage of blood glucose strips is dependent on recipient having a training certificate from a Diabetes Education Centre.

Alta.
1. Government provides up to $550 per year under the Alberta Monitoring for Health Program for blood glucose strips, lancets, and syringes.
2. Under Alberta Blue Cross Non-Group Coverage Program: for eligible prescription drugs, recipient is responsible for paying 30% of the cost to a maximum of $25 per drug prescribed up to a maximum of $25,000 per year.

Sask.
1. Through the Special Support Program, a 3.4% deductible is paid (for insulin prescriptions), based on adjusted family income.
2. One -time assistance through the Drug Plan for medications and diabetic supplies listed on provincial formulary.

Man.
1. Under the Manitoba Pharmacare Program, a deductible of 2.44% of income (less than or equal to $15,000 per year) is paid out. Once the deductible is met, Pharmacare will pay 100% of eligible prescription drug coverage and diabetic supplies such as blood glucose strips, lancets, and syringes.

Ont.
1. Monitors for Health (MFH) provide 65% government copayment to a maximum of $500 per year for blood glucose strips and lancets and 65% coverage up to a maximum of $75 for a metre once every five years for those who are insulin dependent.
2. Trillium Drug Program provides provides a deductible based on income and $2 for every prescription.

Que.
1. 28%Twenty-eight percent co-insurance up to a maximum of $71.42 per month for drug costs. Deductible of $10.25 per month. Premium to Quebec prescription drug insurance plan to be paid. Amount paid ranges from $0 to $494 per adult per year, depending on income.

P.E.I.
1. Must be registered with the Diabetes Control Program. A copayment of $6 to $16 per prescription for insulin.

Y.T.
1. A deductible of $250 per person, then 100% coverage. Deductible may be waived in cases of hardship.

Making the Decisions: What to Include in the "Basket" of Health Services?

Determining what's in and what's out of the publicly funded basket of services is a bit like umpiring a baseball game. Some calls are clear; others are very hard to make—and there's no instant replay to help out.

Experts agree that no insurance program—public or private—can realistically cover every service for everyone indefinitely.[10, 19, 20] In this context, deciding which health services to fund publicly and which to delist is a difficult task.[21–23]

Many, but not all, public coverage decisions are made at the provincial/territorial level. Others are in the hands of health regions and other health care providers, individual clinicians or clinical programs. As the environment changes and as new types of care or new knowledge emerge, questions about adding to coverage or delisting services often surface.[25]

The public coverage decision process is often complex. Questions about what constitutes medically necessary care, as well as the criteria used to define it, have been the source of much debate. Experts suggest that the meaning of medical necessity may depend on how people interpret and use the concept[25] as new definitions emerge over time.[10]

Other factors also count in coverage decisions, not all of which are well understood. Financial resources, public expectations, clinical expertise and knowledge and the evolution of technologies are among the considerations in deciding which services to publicly insure.[10] Within each province and territory, there may be varying degrees of involvement by the ministry of health, professional associations or other stakeholders.[19, 26]

Over time, provinces and territories add and subtract different types of care from the basket of insured services. For example, many provincial and territorial governments stopped funding certain health services in the mid-1980s and 1990s, partly in response to funding crunches. This process is known as "delisting." Some delisted services were later reinstated after public protest.[25] Examples of services fully or partially delisted in some parts of the country include routine eye examinations, newborn circumcision, physiotherapy and chiropractic care.

While some services have been dropped, others have been added. For example, in September 2004, the premiers and the Prime Minister agreed on the Ten-Year Plan to Strengthen Health Care. Among the Plan's provisions is a commitment to provide first-dollar coverage by 2006 for certain home care services, based on assessed need.

First-dollar coverage applies to any form of insurance (public or private) in which the insured individual is fully (100%) covered for all eligible expenses. The Ten-Year Plan to Strengthen Health Care includes first dollar coverage for:

- "short-term acute home care for two-week provision of case management, intravenous medications related to the discharge diagnosis, nursing and personal care;"[28]
- "short-term acute community mental health home care for two-week provision of case management and crisis response services; and"
- "end-of-life care for case management, nursing, palliative-specific pharmaceuticals and personal care at the end of life."[25]

Did You Know?

In 2004, Pollara asked almost 2,000 Canadian adults whether they would be willing to pay more for an increased range of services or to improve the timeliness of care they receive.[24] Over half (54%) said yes, down from 69% just two years earlier. Conversely, when asked about how government might deal with the costs of health care services, 21% of respondents said that they would support or strongly support restricting the range of services offered. That's up from 19% in 2003.

8 Changes in Coverage

For many types of health care, which health services are funded from the public purse and the extent of coverage varies across the country. Researchers at the University of Toronto tracked coverage changes over the 1990s for private practice physiotherapy, speech therapy, dental care, optometry and chiropractic services. (Note: This does not include, for example, services provided in hospital or through public health programs, or funded for specific population groups, such as those on social assistance or covered by workers' compensation boards. In some cases, copayments or additional conditions may apply.)

Province	Physiotherapy		Optometry	
	Coverage in 1994?	Changes to Coverage in 1990s	Coverage in 1994?	Changes to Coverage in 1990s
B.C.	12 visits/year for those <65 and 15 visits/year for 65+	No*	One visit every 24 months for those between 19 and 64 years of age and no limit for those <19 and 65+ years of age	No**
Alta.	$250/year	Yes, in 1995: not covered except for those considered high need on standardized assessment form	Exam/diagnostic procedure every 2 years for those between 19 and 64 years of age and once a year for those <19 and 65+ years of age	Yes: no coverage for those >18 and <65 years of age.
Sask.	No	No	One visit/year for those <18 years of age	No
Man.	No	No	One visit every 2 years	Yes, in 1996: no coverage for those between 19 and 64 years of age; same coverage for those <19 and 65+ years of age
Ont.	Yes	Yes, in 1998: 150 visits/year	Oculo-visual assessment covered in private practice	Yes, in 1998: 1 oculo-visual assessment and 1 follow-up oculo-visual minor assessment/ 2 years for those between 20 and 64 years of age; every year for those <20 and 65+ years of age
Que.	No	No	One visit/year for those <18 and 65+ years of age	Yes, in 1996: one visit/2 years for those <18 and 65+ years of age
N.B.	No	No	No	No
N.S.	No	No	Yes	Yes, in 1997: no coverage for those between 19 and 64 years of age; same coverage for those <19 and 65+ years of age
P.E.I.	No	No	No	No
N.L.	No	No	No	No

Notes:

* In 2001, British Columbia limited patients to a combined total of 10 visits per year for chiropractic, massage, naturopathic, physical therapy or non-surgical podiatric visits.

** In 2001, in British Columbia, routine optometry visits every two years were eliminated for everyone 19 to 64 years of age.

By reviewing legislative records, the researchers identified the major changes in service reimbursement shown below. They then looked at Statistics Canada survey data to see whether coverage changes were linked to changes in the use of services. The answer was complex. While use of physiotherapy and eye examinations decreased after coverage changes, speech therapy and chiropractic service use increased in some instances. And, in the case of physiotherapy, those who reported using services before coverage changes tended to use more services afterwards.

Dental		Speech Therapy		Chiropractic Care	
Coverage in 1994?	**Changes to Coverage in 1990s**	**Coverage in 1994?**	**Changes to Coverage in 1990s**	**Coverage in 1994?**	**Changes to Coverage in 1990s**
No	No	No	No	Limit of 12 visits/year for those <65 and 15 visits/year for those 65+	No*
No	No	Yes (no details)	Yes, in 1995: not covered	Limit of $300/year	Yes, in 1995: limit of $200/year
No	No	No	No	Yes	No
No	No	No	No	Limit of 15 visits/year based on the per-visit cost of $11.56 ($12.72 in northern Manitoba); limit of $220/year	Yes, in 1999: limit of $150/year
No	No	Yes	No	No	No
No (except for those <10 years of age)	No	No	No	No	No
No	No	No	No	No	No
No	No	No	No	No	No
No	No	No	No	No	No
No (except for some coverage for those <12 years of age)	No	No	No	No	No

Source: M. Stabile and C. Ward, "The Effects of De-listing Publicly Funded Health Care Services," (forthcoming).

9 Get Immunized

All provinces and territories have recently begun to cover four new vaccines: adolescent pertussis (whooping cough), varicella (chicken pox), meningococcal conjugate and pneumococcal conjugate. However, as illustrated in the table below, who is eligible varies somewhat across the country, as does when the vaccines are administered. There are even larger variations for some other immunization programs. For example, all jurisdictions except Prince Edward Island now pay for flu shots for some residents. Most cover at-risk individuals, seniors and health care workers. Ontario and the Northwest Territories cover flu shots for all residents.

Provinces/ Territories	Whooping Cough	Chicken Pox	Meningococcal Conjugate Type C	Pneumococcal Conjugate	Influenza
B.C.	Grade 9	12 mos. ‡	2,12 mos. ‡ ■	2, 4, 6, 18 mos. ‡	65+ yrs. ◉ ‡, 6–23 mos.
Alta.	Grade 9	12 mos. ‡	2, 4, 6 mos. ‡ ■ ◉	2, 4, 6, 18 mos. ‡	6–23 mos. ■ ‡ ◉ 65+ yrs.
Sask.	Grade 8	12 mos. ‡	12 mos. ‡ ■	2, 4, 6,18 mos. ‡	65+ yrs. ‡ ▣
Man.	Grade 9	12 mos. ‡ ■	Grade 4 ‡	2, 4, 6, 18 mos. ‡	6–23 mos. ‡ ◉ 65+ yrs. ■
Ont.	14–16 years	15 mos. ‡	12 mos. ‡	2, 4, 6, 15 mos. ‡	★
Que.	Grade 10	‡	12 mos. ‡ ■	2, 4, 12, mos. ‡	60+ yrs. ‡ Health Workers ■
N.B.	Grade 9	12 mos.	12 mos. ‡ ■	2, 4, 6, 18 mos. ‡	6–23 mos. 65+ yrs. ‡ ▣
N.S.	Grade 10	12 mos. ‡	12 mos. ‡	2, 4, 6, 18 mos. ‡	6–23 mos. 65+ yrs. ‡ ■ ◉
P.E.I.	Grade 9	12 mos. ‡	12 mos. ‡	2, 4, 6, 18 mos. ‡	Not covered: cost is $15/dose
N.L.	Grade 9	12 mos.	12 mos. ■	2, 4, 6, 18 mos. ‡	6–23 mos. 65+ yrs. ‡ ◉ ▣
Y.T.	Grade 9	‡	2, 6 mos. ‡	2, 4, 6, 12 mos. ‡	6–23 mos. 18+ yrs.
N.T.	Grade 9	12 mos. ‡	2, 4 mos. ‡ ■	‡ (except Aboriginal children)	★
Nun.	Grade 9	12 mos.	■	2, 4, 6, 15 mos.	‡ ◉ ▣ ■ essential workers

Legend

- ‡ High Risk
- ■ Contacts of Cases or Outbreak Control
- ◉ Health Care Workers
- ★ Universal/All Residents
- ▣ Residents of Any Age in Nursing Home/Chronic Care Facility

Notes: Data are as of June 6, 2005. For specific provincial high-risk definitions, please refer to the Public Health Agency of Canada's Definitions of High Risk for Three New Publicly-Funded Vaccines by Province/Territory, at http://www.phac-aspc.gc.ca/im/ptimprog-progimpt/table-5_e.html. For NACI high-risk definitions, please refer to the Canadian Immunization Guide, Sixth Edition, 2002 (National Advisory Committee on Immunization), at <http://www.phac-aspc.gc.ca/publicat/cig-gci/index.html>.

Sources: 1. Public Health Agency of Canada, *Publicly Funded Immunization Programs in Canada—Routine Schedule for Infants and Children* (June 6, 2005), [online], from <www.phac-aspc.gc.ca/im/ptimprog-progimpt/table-1_e.html>.

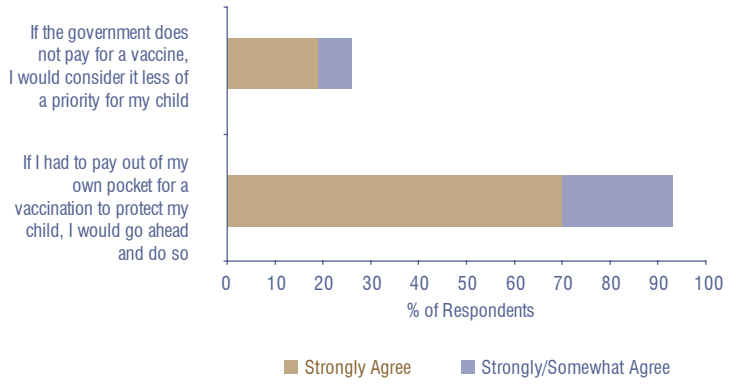
2. Public Health Agency of Canada, *Publicly Funded Immunization Programs in Canada—High Risk Groups* (June 6, 2005), [online], from <www.phac.aspc.gc.ca/im/ptimprog-progimpt/table-2_e.html>.

3. Provincial and territorial ministries of health data, compiled by CIHI.

The provinces and territories also agreed to develop, assess and cost options for catastrophic pharmaceutical coverage. Furthermore, the Plan recognizes commitments to a national immunization strategy. The strategy is designed to support the introduction of new and recommended childhood and adolescent vaccines as proposed by the National Advisory Committee on Immunization.

10 Paying for Childhood Vaccinations

According to a 2004 Ipsos-Reid survey, many Canadian parents believe that immunizations are as important to their children's health as healthy food and physical activity. Given the importance placed on immunizations, it is perhaps not surprising that 93% of parents say they would pay out-of-pocket for immunizations if they were not covered by a public plan. In fact, many parents see immunizations as beneficial to the health system in general. About 93% of parents believe that vaccinations prevent illness and reduce the burden on hospitals.



Source: Ipsos-Reid, "Childhood Vaccinations," *Health Check III* 19, 5 (September/October 2004): pp. 37–43.

What's In and What's Out?

In 2002, the University of Toronto's Medicare to Home and Community Research Unit asked more than 2,500 health professionals and stakeholders across Canada what health services should be publicly funded.[27] A quarter (25%) responded to the survey.

The majority of respondents (ranging from 82% to 90%, depending on the health professional/stakeholder group) strongly supported the continuation of full public payment for insured hospital services, specifically acute inpatient care, day surgery, diagnostic services and laboratory tests. There was less support (ranging from 2% to 33%) for universal coverage of what the researchers called "innovative" health services, such as genetic tests (for example, prenatal screening or disease propensities in adults), elective cosmetic surgery and complementary/alternative therapies. Support for coverage of non-mandated services, such as immunizations, palliative care at home, telephone-based advice from doctors and emergent ambulance transport ranged from 59% to 89%.

For More Information

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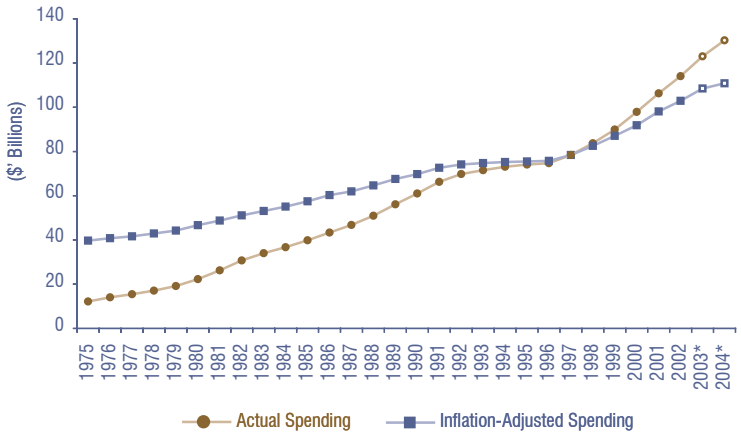
3 A Primer on Canada's Health Care System—What It Costs

Have you ever prepared index cards or highlighted your text with key facts when you studied for exams? This chapter saves you the trouble. We've assembled a set of key tables and graphs that offer highlights of health care financing in Canada. For more information, including results by province or territory, please consult the detailed tables in the Appendix.

Health Spending Trends in Canada

11 Total Health Spending ($ Billions)

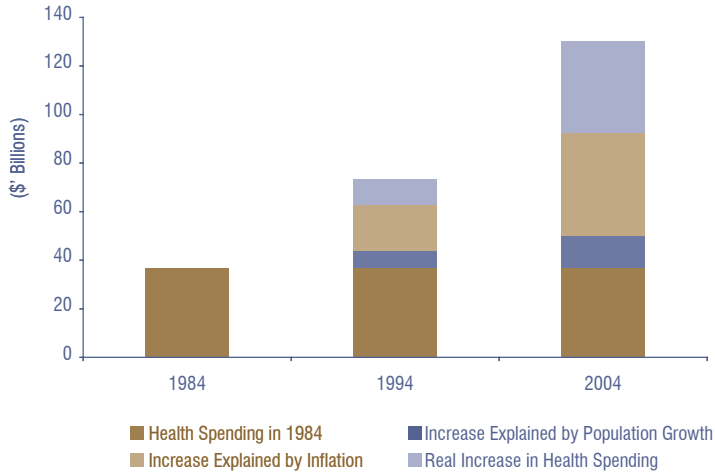


Note: Data for 2003 and 2004 are forecasts.

Source: National Health Expenditure Database, CIHI.

- Growth in total expenditure on health care has outpaced inflation for most of the last 30 years.
- Between 1975 and 2004, inflation-adjusted health spending increased by 179%.
- In 2004, Canada spent an estimated $130 billion on health care, or $4,078 per person (forecast).

12 Components of Growth in Health Spending ($ Billions)

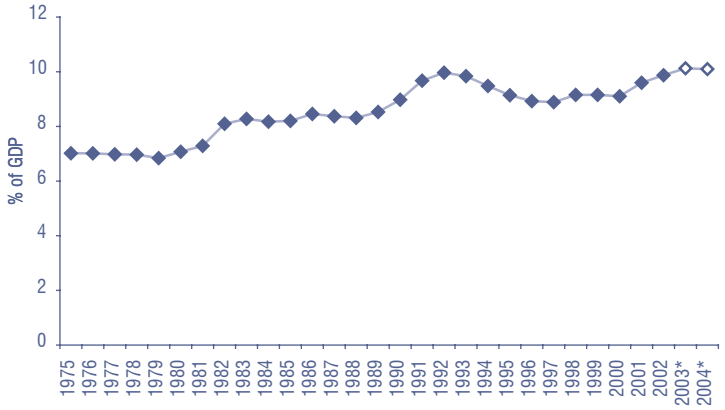


Note: Data for 2004 are forecast.

Source: National Health Expenditure Database, CIHI.

- Health spending increases can be partially explained by population growth and inflation.
- Between 1984 and 1994, population growth and inflation accounted for almost 72% of total growth in health spending. Together, they explain 60% of the increase between 1984 and 2004.
- The purchase of more or different health services per person (net of other factors), as well as the introduction of new technologies and services, also accounted for part of the growth in health spending over the past two decades.

13 Total Health Spending as a Proportion of GDP



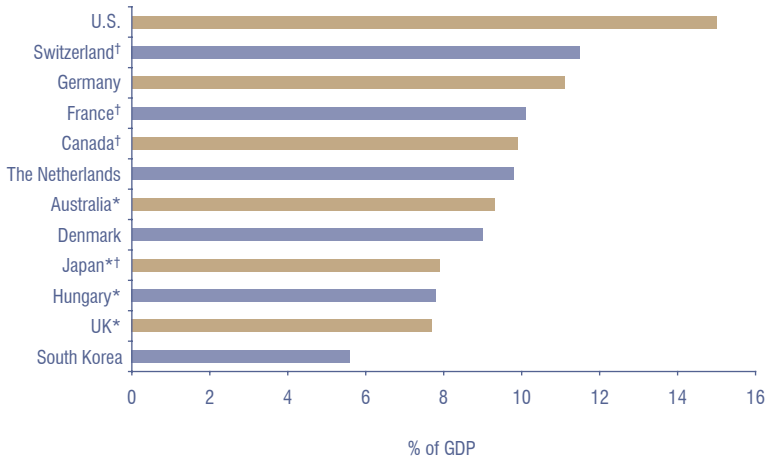
Note: Data for 2003 and 2004 are forecasts.

Source: National Health Expenditure Database, CIHI.

- Trends in health spending as a proportion of the gross domestic product (GDP) reflect changes in both health spending and the total market value of all goods and services produced within a country. In Canada, this ratio increased significantly during the early 1980s and again in the early 1990s, peaking at 10% of GDP in 1992.
- A dip in the mid-1990s was followed by steady increases. Health spending surpassed 10% of GDP in 2003 and 2004.

- Health spending as a proportion of GDP varies internationally—from almost 6% in South Korea to 15% in the U.S.—among selected Organisation for Economic Co-operation and Development (OECD) countries.
- Canada ranks in the middle third among OECD countries, with health spending representing approximately 10% of GDP in 2003. This is similar to ratios in the Netherlands and France.

14 International Comparison of Health Spending as a Percentage of GDP in 2003

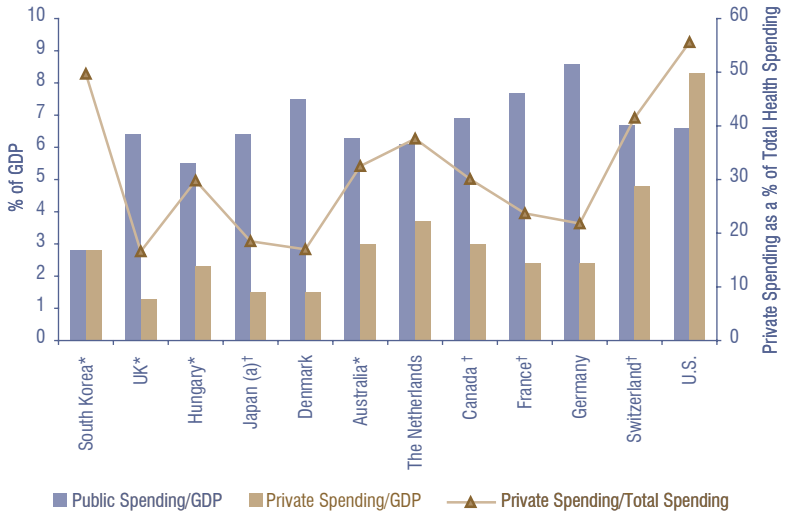


Note: *Data are for 2002. †Data are estimates.
The Organisation for Economic Co-operation and Development (OECD) asks member countries to report health expenditures according to their system of health accounts. The 12 countries that most closely follow the proposed system of health accounts are Australia, Canada, Denmark, France, Germany, Hungary, Japan, South Korea, the Netherlands, Switzerland, the UK and the U.S.

Source: OECD Health Data 2005, OECD.

Health Spending Compared

15 International Health Spending by Sector and as a Percentage of GDP in 2003

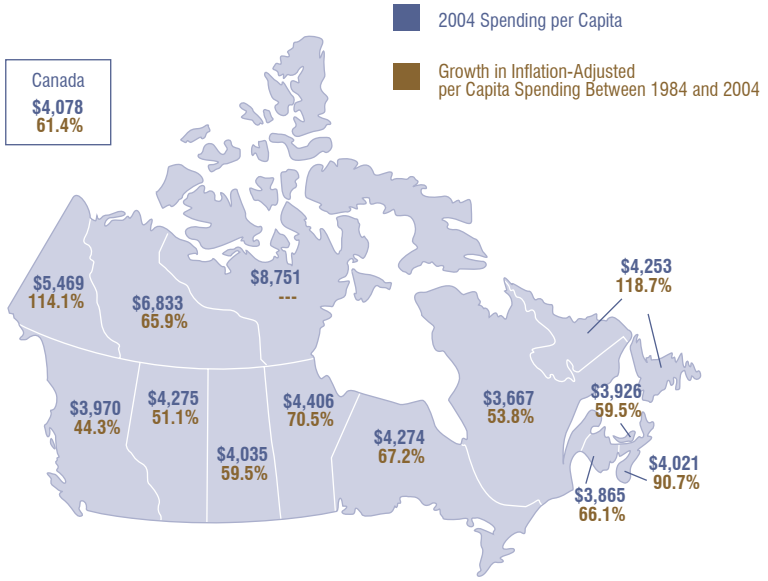


Note: *Data are for 2002. †Data are estimates. (a) Data are for 2001.
The Organisation for Economic Co-operation and Development (OECD) asks member countries to report health expenditures according to their system of health accounts. The 12 countries that most closely follow the proposed system of health accounts are Australia, Canada, Denmark, France, Germany, Hungary, Japan, South Korea, the Netherlands, Switzerland, the UK and the U.S.

Source: OECD Health Data 2005, OECD.

- Public-sector health spending as a proportion of GDP is larger than private spending in most of the comparison countries. The exception to this is the U.S., where private-sector spending represents 8% of GDP—compared to that of the public sector, at less than 7% of GDP.
- Private-sector health spending as a proportion of total health spending is the highest in the U.S., at 55% of the total. Private-sector spending is the lowest (proportionally) in the UK, at less than 17% of total health spending. In Canada, private-sector spending is approximately 30% of total health spending.

16 Health Spending per Person (1984 to 2004)

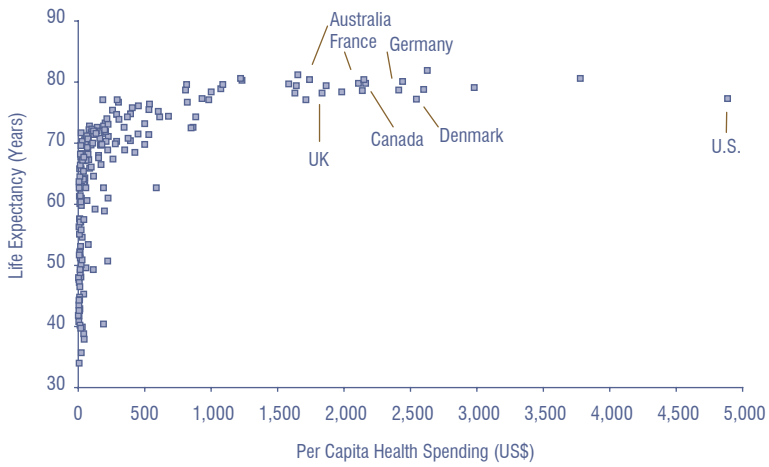


Note: Data for 2004 are forecast. Figures are not adjusted for inflation.

Source: National Health Expenditure Database, CIHI.

- In 2004, health spending per person in the provinces ranged from $3,667 in Quebec to $4,406 in Manitoba.
- Spending was significantly higher in the territories. This is partly due to low population density spread over large geographic areas. For example, in 2002, the Northwest Territories spent approximately $360 per person on ambulance and other medical transportation, while Alberta spent roughly $13 per person.
- All provinces and territories have seen increases in health spending per person of at least 160% since 1984. After adjustment is made for inflation, increases range from 44% to 119%.

17 Health Spending and Life Expectancy

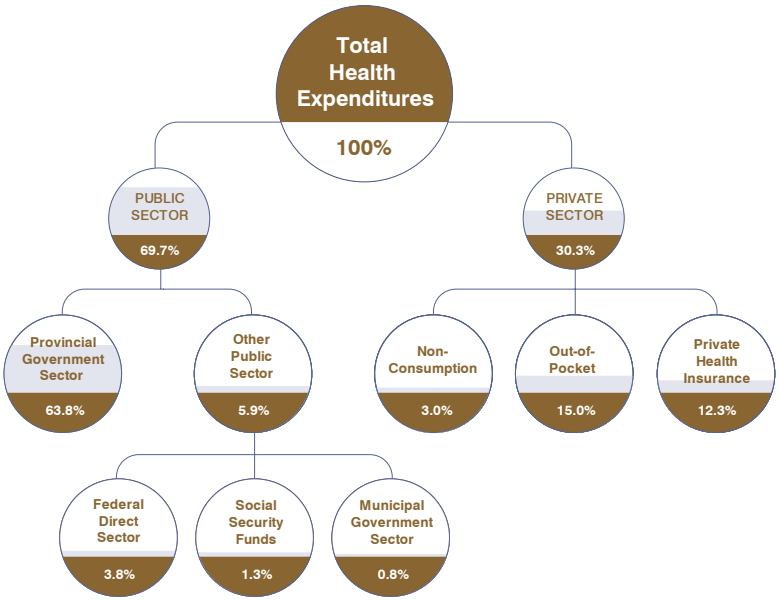


Notes: Expenditures are converted to U.S. dollars using purchasing power parities (PPPs) for gross domestic product (GDP), which are designed to eliminate differences in price levels between countries. The OECD asks that member countries report health expenditures according to their system of health accounts. The 12 countries that most closely follow the proposed system of health accounts are Australia, Canada, Denmark, France, Germany, Hungary, Japan, South Korea, the Netherlands, Switzerland, the UK and the U.S. Life expectancy data are for 2002; health expenditure data are for 2001.

Source: World Health Organization, The World Health Report Statistical Annex.

- Per capita health spending varies across OECD countries, with some spending significantly more than others. There is an even larger variation globally.
- While countries spending very small amounts on health services per person tend to have lower life expectancy, this relationship does not always hold at all levels of spending. For example, the U.S. spends considerably more than Canada per person, but Canadians tend to live longer.

18 Who Spends What in Canada?



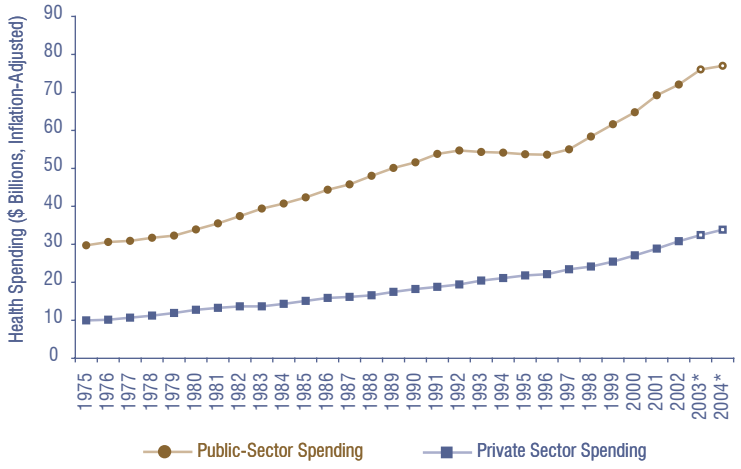
Note: Data are for 2002.

Source: National Health Expenditure Database, CIHI.

- In Canada, health care is financed by both the public sector and the private sector. The public sector is comprised of the provincial, territorial and federal governments, municipal governments and social security funds. Private-sector spending includes out-of-pocket spending by individuals and private insurance coverage.
- The National Health Expenditure Database reports health spending by responsibility for payment. Therefore, federal transfers to provincial and territorial governments are included in provincial and territorial government health spending.

The Public/Private Financing Split

19 Inflation-Adjusted Health Spending



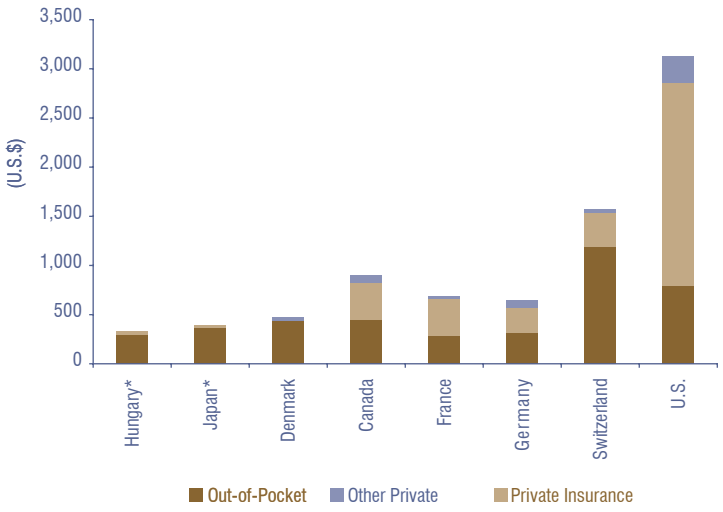
Note: Data for 2003 and 2004 are forecasts.

Source: National Health Expenditure Database, CIHI.

- Between 1975 and 2004, real inflation-adjusted public-sector health spending increased by 3.3% per year on average, compared to 4.3% for private-sector spending.
- The relative amounts of public and private health financing shifted after the period of government fiscal restraint during the mid-1990s. Inflation-adjusted public spending per person on health declined by 2% between 1992 and 1996, while private-sector health spending grew by almost 14% over this period.
- From 1997 to 2004, public-sector spending increased on average 4.9% annually. Private-sector spending over the same period increased on average 5.4% per year.

- Private health spending is financed primarily through out-of-pocket payments and private health insurance.
- In Canada, out-of-pocket payments represent half of total private health spending. Among selected OECD countries, this proportion varies from 25% in the U.S. to 93% in Japan and Denmark

20 International Private-Sector Spending



Notes: Expenditures are converted to U.S. dollars using purchasing power parities (PPPs) for gross domestic product (GDP), which are designed to eliminate differences in price levels between countries. The OECD asks that member countries report health expenditures according to their system of health accounts. The 12 countries that most closely follow the proposed system of health accounts are Australia, Canada, Denmark, France, Germany, Hungary, Japan, South Korea, the Netherlands, Switzerland, the UK and the U.S.
*Data are for 2002. Data for Australia and the UK were not available.

Source: OECD Health Data 2005.

21 Private-Sector Spending in Canada for 2002

(in $' Millions)

	Out-of-Pocket Spending	Insurance	Non-Consumption	Total
Hospital Accommodation	$579.3	$867.6	$1,379.7	$2,826.5
Other Institutions*	$2,973.4	N/R	N/A	$2,973.4
Physician Care	$257.3	$2.4	N/A	$259.8
Other Professionals				
Dental Care	$3,389.2	$4,441.3		$7,830.5
Vision Care	$1,951.5	$607.6	N/A	$2,559.2
Other	$860.3	$643.3		$1,503.5
Drugs				
Prescribed Drugs	$2,934.1	$5,004.1		$7,938.2
Over-the-Counter Drugs	$1,885.2		N/A	$1,885.2
Personal Health Supplies	$1,710.2			$1,710.2
Capital	N/A	N/A	$1,216.1	$1,216.1
Other Health Spending				
Prepayment Administration		$2,305.0		$2,305.0
Health Research*			$754.4	$754.4
Other Health Care Goods	$198.9	$74.6		$273.5
Other Health Care Services	$397.2	$69.9		$467.1
Total Spending	**$17,136.5**	**$14,015.8**	**$3,350.2**	**$34,502.5**

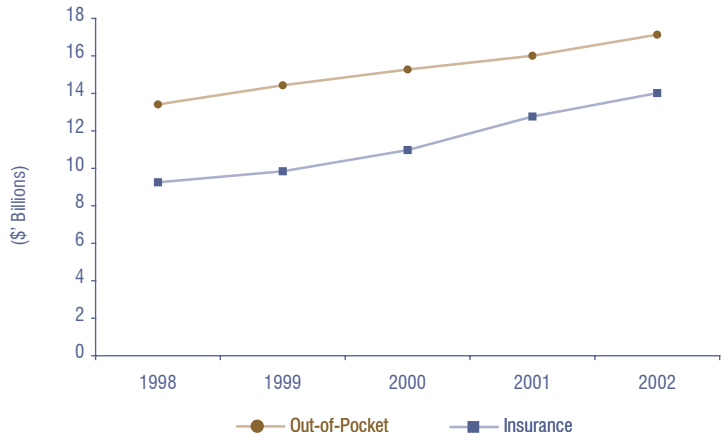
* Data cited for other institutions and health research are forecasts.
N/R = not reported
N/A = not applicable

Source: National Health Expenditure Database, CIHI.

- Private-sector spending for health care reached $34.5 billion in 2002.
- Out-of-pocket spending accounted for almost half the $34.5 billion, at $17.1 billion. Private health insurance paid for $14 billion, while non-consumption expenditure made up the remainder, approximately $3.4 billion.

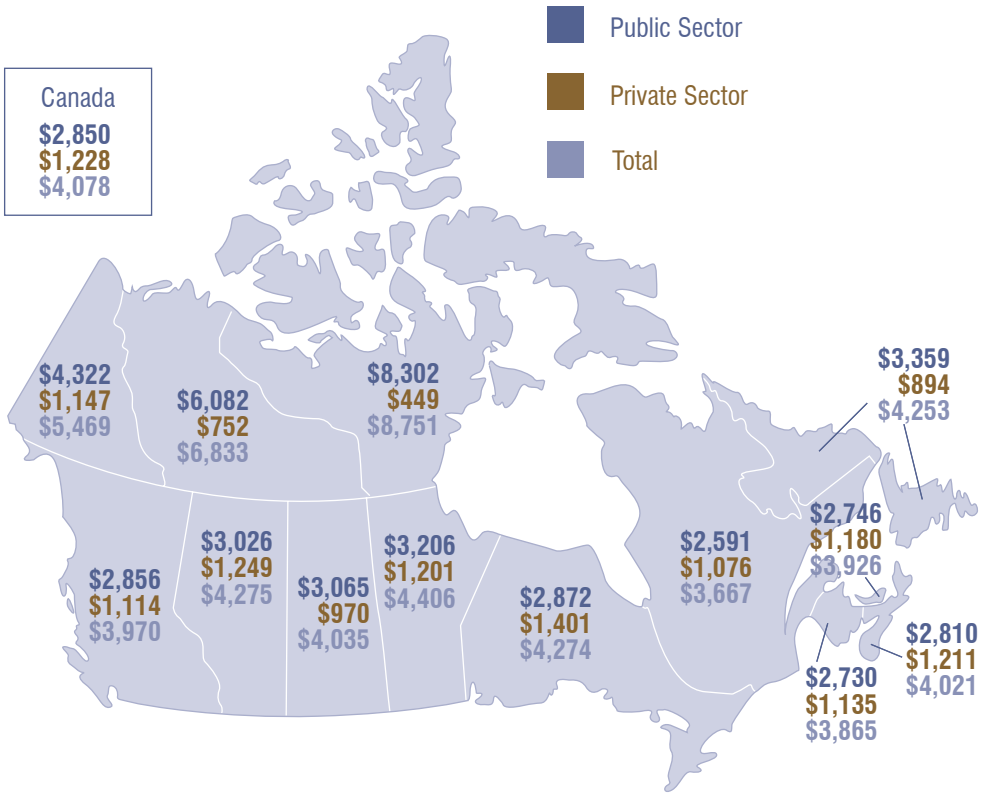
22 Trends in Private-Sector Health Spending

- Between 1998 and 2002, out-of-pocket spending by Canadians increased by almost 28%, an average annual increase of approximately 6.3%.
- Spending by health insurance companies increased by 51% over the same period, at an annual average increase of 11%.
- Total health spending grew at an average annual rate of 8% between 1998 and 2002.



Source: National Health Expenditure Database, CIHI.

23 Public and Private Spending in 2004



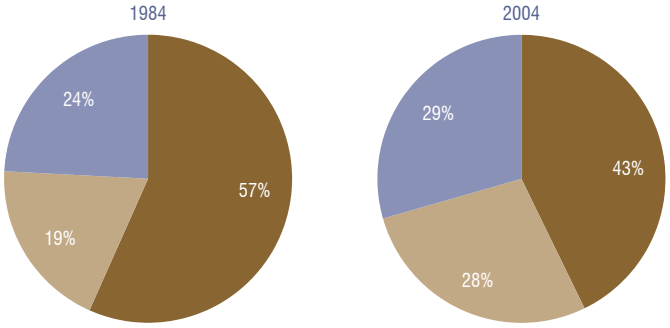
Note: Data for 2004 are forecast. Components may not sum to total due to rounding.

Source: National Health Expenditure Database, CIHI.

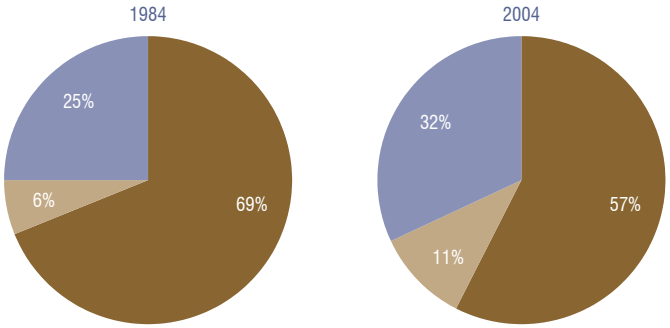
- Approximately 70% of health spending is provided by the public sector. However, the proportion varies across Canada. For example, in Newfoundland and Labrador, the public sector paid $79 of every $100 spent per person on health. This compares to $67 spent in Ontario. In the territories, the public sector pays for a significantly larger proportion of total health costs.

24 Shifts in Health Spending

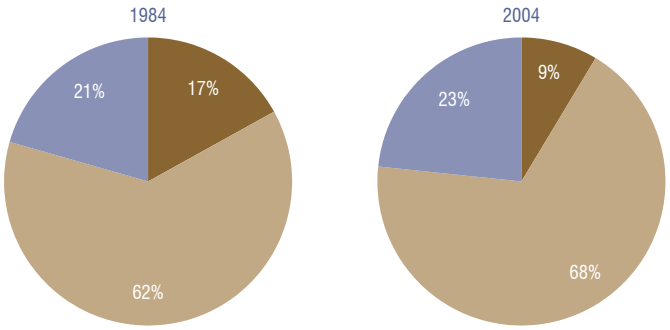
Proportion of Total Health Spending by Category of Expenditure



Proportion of Public Health Spending by Category of Expenditure



Proportion of Private Health Spending by Category of Expenditure



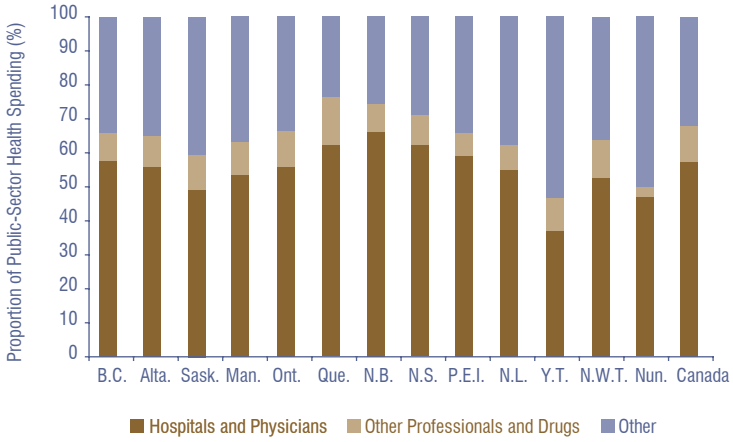
Hospitals and Physicians | Other Professionals and Drugs | Other Spending

Note: Data for 2004 are forecast.

Source: National Health Expenditure Database, CIHI.

- The distribution of how health dollars are spent in Canada has changed over time. In 2004, hospitals and physicians represented 57% of public-sector health spending—down from almost 70% in 1984.
- On the other hand, spending on retail drugs rose over this period—from 9% of total health spending in 1984 to 16% in 2004. This shift is evident in both public- and private-sector spending.
- Private-sector spending on hospitals (including insurance and out-of-pocket spending) covers items such as private rooms, parking and donations. For physicians' services, it can include check-ups mandated by employers or insurance companies and other non-insured services. In 2004, hospitals and physicians' services represented 9% of private health spending—down from 17% in 1984.

25 Public-Sector Health Spending in the Provinces and Territories in 2004



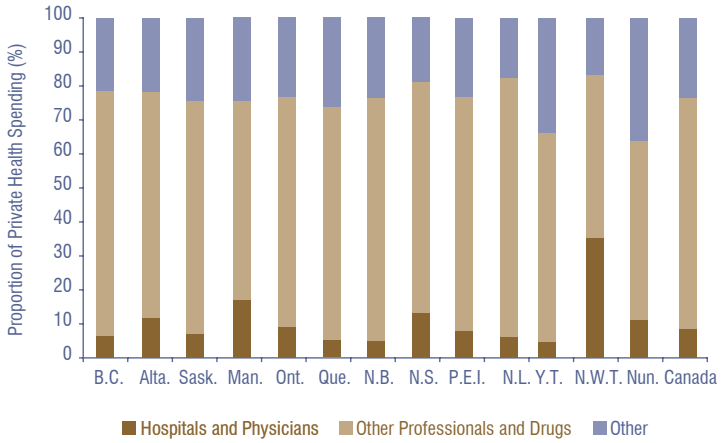
Note: Data for 2004 are forecast.

Source: National Health Expenditure Database, CIHI.

- The way in which we spend public-sector health care dollars varies across the country. For example, in 2004, Canada spent 39% of total public-sector health dollars on hospitals. However, this figure ranged from 25% in the Yukon Territory to 48% in New Brunswick.
- Similarly, on average Canada spent 9% of public-sector health expenditures on retail prescribed drug sales. However, this varied among the provinces, from 6% in P.E.I. to 12% in Quebec.

26 Private-Sector Health Spending in the Provinces and Territories in 2004

- In 2004, approximately 8% of private-sector health spending went to hospitals. This varied among the provinces and territories, from 4% in New Brunswick to 16% in Manitoba.
- In 2004, approximately 34% of private-sector health spending went to retail drug sales. This varied from 24% in the Yukon to 49% in Newfoundland and Labrador.
- In 2004, approximately 34% of private-sector health spending was spent on other health professionals. This varied from 20% in Nunavut to 42% in British Columbia.

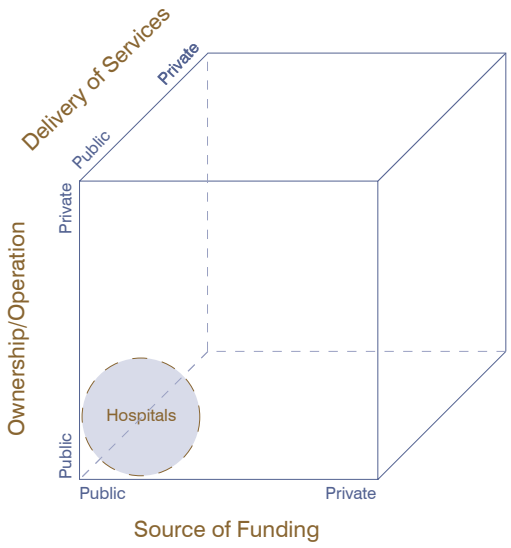


Note: Data for 2004 are forecast.

Source: National Health Expenditure Database, CIHI.

4 Hospital Services

Canada's Health System
Financing, Ownership and Delivery



Source: Adapted from I. McKillop, J. Alpenberg, R. G. Evans, et al., *Private Sector Delivery: Scope and Extent in Canada's Health Care System*, (Waterloo: University of Waterloo, 2004).

Quick Facts

Use

- 8% of Canadian teens and adults were hospitalized in 2003; this rate has been stable since 1994–1995.

Coverage

- Medically necessary services provided in hospitals are covered by provincial and territorial health insurance plans.
- Other areas of hospital spending, such as patient accommodation and capital investment, are paid for by a combination of sources, including the public sector, individuals, private insurance companies, donations, investment revenue and other sources.

Spending

- In 2004, Canada spent **$39 billion** on hospital care, about 30% of total health spending.
- 86% or more of funding for hospitals has been provided by the public sector since 1994; the national figure is currently at 92% (forecast for 2004).

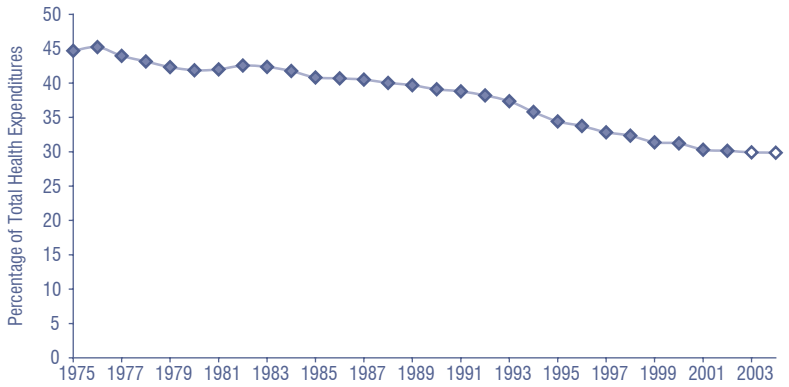
Watching the American television series "ER" or "House," one might think that hospitals mostly provide emergency care and major surgery. These services *are* an important part of what Canada's hospitals do. In 2002–2003, Canada's 744 active hospitals had more than 14 million emergency department visits and admitted almost 3 million patients. But most also have a large number of medical beds to provide non-surgical diagnostic and treatment services, such as medical imaging, day surgery and clinics. Some hospitals also have separate groups of beds, wings or buildings for long-term care.

Hospitals have traditionally taken the largest single slice of health care dollars. In 2004, they spent a record $39 billion (forecast). That's about $1,200 per Canadian. To put this in historical perspective, hospital spending first passed $800 per person in 1989 and $1,000 in 2001. Except for a few years in the mid-1990s, hospital spending per capita (not adjusted for inflation) has grown steadily since the mid-1970s.

In spite of these increases, hospitals' share of total health dollars has fallen steadily over time due to higher spending growth for other types of care. Hospitals accounted for 45% of the total in 1975, falling to 36% by 1994. Today, their costs add up to roughly 30% of all health care spending. Among the provinces, hospital care accounted for between 26% (Saskatchewan) and 35% (New Brunswick) of total health care expenditure in 2004.

27 The Paradox of Hospital Spending

Hospital spending continues to rise, but other major areas of health care expenditure are growing more quickly. As a result, hospitals account for a smaller proportion of total health spending. The graph below shows the percentage of total health care spending on hospitals between 1975 and 2004. Note that percentages for 2003 and 2004 are forecasts.



Source: National Health Expenditure Database, CIHI.

Hospital Services and Health Regions

Almost all hospitals in Canada are not-for-profit institutions. Governments, regional health authorities and religious organizations own most of our hospitals.

In most parts of the country, hospitals are now part of—or funded through—regional health authorities. Quebec was the first province to regionalize its health care system.[1] Others followed, but organizational models differ in size, structure and scope of responsibility and continue to evolve. In the spring of 2005, Ontario—the last province to regionalize its health care system—established 14 Local Health Integration Networks (LHINs). According to the Ontario Ministry of Health and Long-Term Care, LHINs will "plan, co-ordinate, integrate, and fund the delivery of health services at the community level."[2] They will not replace existing boards in programs and facilities or directly provide services themselves. At about the same time, Prince Edward Island moved in the opposite direction, returning regional health authority functions to the provincial department of health.

Other provinces have also recently restructured the administration of their health systems. In December 2003, for example, Quebec adopted a law laying out a plan to create a new organizational structure in each of the province's 18 health regions by providing multidisciplinary care through local integrated networks. In June 2004, the province created 95 networks. At the heart of these new networks are centres for health and social services, called "centres de santé et de services sociaux."[1, 3] Newfoundland and Labrador also recently changed its regional structures, replacing 14 health and community service boards with four Regional Integrated Health Authorities. Previously, there were separate boards for institutional and community services. The new boards (whose mandates may be the broadest in Canada) will be responsible for a wide range of services, including medical clinics, health promotion and prevention, youth and family services, community corrections, public health, cancer care, mental health, hospitals and residential care programs and health care premiums.[4]

Who Uses Canada's Hospitals?

According to Statistics Canada, roughly 8% of Canadian teens and adults reported being hospitalized in the previous year in 2003, a percentage that has remained constant since 1994–1995.[5] In 2003, 10% of women aged 12 or older said that they were hospitalized in the past year, compared to 6% of men. Childbirth partly accounts for the differences in hospital use by men and women.

Overnight hospital stays have become less common in recent years. Between 1994–1995 and 2002–2003, the number of overnight stays in acute care hospitals fell by 15%. Bed counts are also shrinking. Between 1999–2000 and 2002–2003, the number of beds in general acute care, rehabilitation and psychiatric hospitals fell by 3%, 6% and 24% respectively.

While inpatient hospitalization rates are down overall, that's not the case for all types of care. For example, more patients than ever before are now having hip and knee replacements, open heart surgery and some types of cancer surgery. Circulatory diseases (15%), pregnancy and childbirth (14%) and respiratory diseases (11%) were the three leading causes of inpatient hospitalization in acute care facilities in 2002–2003.

Day surgery programs are also taking more and more of the load. For example, hernia repair used to mean several days in hospital. Now, most patients go home within 24 hours. The number of day surgery cases grew by 28% between 1995–1996 and 2002–2003.[6] In some parts of the country, about half of all operations are now done in day surgery.

Where Does a Hospital's Money Go?

Health care is all about people—those who need care and those who provide it. Not surprisingly, the bulk of hospital spending goes towards staff salaries and benefits. They accounted for $21 billion in 2001–2002. That's about 68% of total hospital spending. Hospitals also spent $1.5 billion on physician compensation, $1.3 billion on drugs and $6.9 billion on other supplies (medical and non-medical) and sundries.

The biggest spenders among hospital departments are those that provide direct patient care. In 2001–2002, inpatient nursing services (30%) and diagnostic and therapeutic services (20%) alone accounted for half of all spending. Add to this 6% for operating rooms and 12% for emergency and ambulatory care. Support services—such as maintenance, laundry and food services—took another 17% of the total, down from 20% in 1996–1997.

28 How Has Hospital Spending Changed?

Hospital costs shift over time, both between departments and in terms of how money is spent. The table below shows how much the various areas in Canada's hospitals spent on staff salaries, physician compensation and drugs in 2001–2002. It also highlights how expenditures have changed since 1996–1997 (not adjusted for inflation). Note that changes in physician payment may partially reflect the introduction of alternative payment plans.

	Salaries		Physician Compensation		Drugs	
Functional Centre	2001–2002 Spending (in Millions)	% Change From 1996–1997 to 2001–2002	2001–2002 Spending (in Millions)	% Change From 1996–1997 to 2001–2002	2001–2002 Spending (in Millions)	% Change From 1996–1997 to 2001–2002
Administration and Support*	4,113	26	83	38	7	18
Inpatient Nursing**	6,793	40	334	183	390	60
Operating Room***	727	10	20	80	85	38
Emergency	963	92	176	336	75	131
Ambulatory Care	1,244	59	201	255	253	58
Diagnostic and Therapeutic	3,279	36	647	39	292	30
Research and Education	422	33	56	-25	0.3	-89
All Other	294	-9	16	102	139	161
TOTAL	**18,091**	**38**	**1,551**	**85**	**1,337**	**70**

Note: All numbers are rounded to the nearest million or percentage.

* Includes spending in such areas as human resources, communications and finance. Support includes materiel management, housekeeping services, plant maintenance and operation, among others.
** Includes ambulatory care clients for facilities without ambulatory care functional centres and expenses for physicians contracted in specific inpatient nursing units.
*** Units used for surgical interventions, including post-anaesthetic recovery rooms.

Source: Annual Return of Health Care Facilities-Hospitals, Statistics Canada.

29 Paying to Operate Health Technologies

The figure below shows the percentage distribution of operating revenue by source for selected types of medical imaging equipment and total number of machines installed in hospitals and free-standing imaging facilities in Canada, as of January 1, 2004

	Hospital-Based Equipment		Free-Standing Facilities	
Sources of Operating Funds	CT	MRI	CT	MRI
Provincial and Territorial Governments	93.1%	87.4%	20.0%	5.0%
Workers' Compensation Boards	0.3%	0.8%	1.5%	1.3%
Private Health Insurance, Other Private Insurance, Out-of-Pocket Payments	0.3%	1.3%	58.5%	73.8%
Other Types of Funding	6.3%	10.5%	20.0%	20.0%
Total Number of Machines	**286**	**103**	**10**	**20**

Note: Data pertains only to facilities reporting sources of funds.

Source: National Survey of Selected Medical Imaging Equipment (2004), CIHI.

Paying for Diagnostic Imaging

The ability to look inside the body using medical imaging is essential to modern medical care. Buying the machines can be costly, and operating expenses also add up. In 2002–2003, hospitals spent $2.1 billion, or 5% of their budgets, on these costs. The bulk (65%, or $1.3 billion) went to pay physicians and other staff. Supplies accounted for another 21%.

Where does this money come from? Provincial and territorial governments paid the vast majority of the operating expenses for MRI and CT scans in hospitals in 2004. Insurance and out-of-pocket payments accounted for less than 2% of revenue. The relative shares are reversed in freestanding imaging facilities. There, the provinces and territories paid 5 to 20% of operating costs, compared with 58 to 74% from private health insurance and out-of-pocket sources.

Source: Canadian Institute for Health Information, *Medical Imaging in Canada, 2004* (Ottawa: CIHI, 2004).

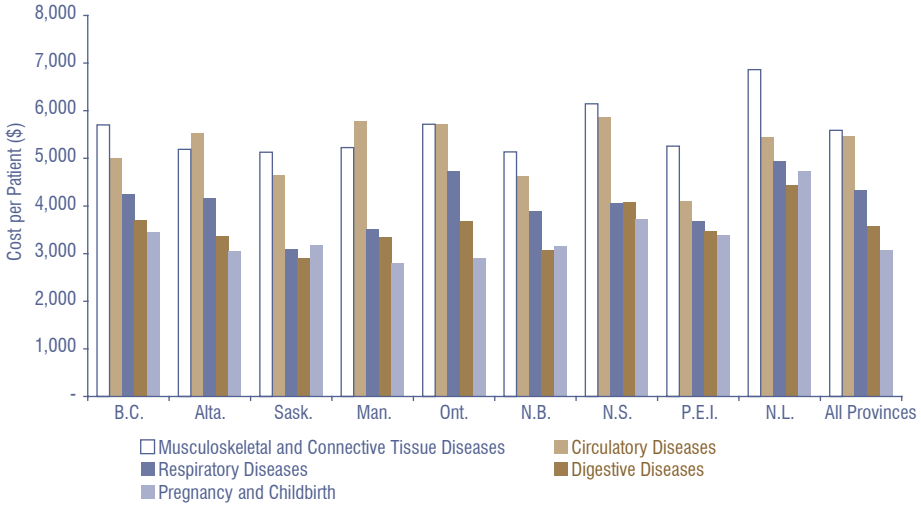
While a small part of the total, hospital spending on community services has grown most quickly in recent years. This area includes spending on primary care clinics (such as walk-in clinics), crisis intervention support (such as crisis lines), home care (such as rehabilitative and palliative care) and similar services. In 1996–1997, this category accounted for $210 million, or 1% of hospital spending. Five years later, that figure had risen to almost $580 million (approximately 2%).

The Cost of Treating Patients

The bulk of hospital dollars are used to treat circulatory diseases, pregnancy and childbirth, digestive diseases, musculoskeletal and connective tissue disorders and respiratory diseases. However, when the cost per patient is considered, the order changes. For example, mental health ranks fifth in total hospital expenditures, but these patients are among the most costly to treat on an individual basis.

30 Hospital Costs for Selected Patient Groups

Across patient groups, the average cost of a hospitalization tends to be highest for patients with musculoskeletal and connective tissue diseases, and circulatory diseases. However, even within these groups, costs can vary significantly. For example, it costs many times as much to provide an adult heart transplant as to treat someone with heart failure. Average costs for inpatient hospitalizations in acute care facilities are compared below for 2002–2003.



Notes: Comparable (representative) data not available for Quebec, the territories and Nunavut. Only typical patients were included in the analysis of acute care inpatient records; stillbirths and cadaveric donors are excluded.

Source: Canadian MIS Database, Discharge Abstract Database, CIHI.

Did You Know?

In 2002–2003, the average cost per inpatient visit in an acute care hospital was roughly $5,100. Rehabilitation facilities and psychiatric hospitals tend to have longer average lengths of stay. They also have higher average costs per patient—approximately $16,870 and $38,120 respectively.

Within acute care hospitals, costs vary substantially by type of care. The table below shows average costs in 2002–2003 for typical adult patients who have a selection of health problems and/or treatments, but no associated conditions that would make their care more complex.

Patient Group	Average Cost per Patient ($)
Bone marrow transplant	36,804
Non-extensive burns with skin graft	14,874
Multisystemic or unspecified site infections with surgery	13,550
Extensive procedures for injury or complication of treatment	11,673
Major intestinal and rectal procedures	8,650
Schizophrenia and other psychotic disorders w/o ECT or Axis III diagnosis	8,460
Intracranial procedures with femur procedures for trauma	8,383
Knee replacement	8,002
Specific cerebrovascular disorders except transient ischemic attacks	5,520
Reconstructive ear, nose and throat procedures	5,429
Heart failure	4,060
Skin graft and wound debridement for dermatologic disease (except ulcer or cellulitis)	3,926
Simple pneumonia and pleurisy	3,616
Penis procedures	3,320
Major gynecological procedures for ovarian or adnexal malignancy	3,197
Red blood cell disorders	3,000
Nutritional and miscellaneous metabolic disorders	2,766
Vaginal delivery	2,636
Transurethral prostatectomy	2,590
Laparoscopic cholecystectomy	2,585
Retinal procedures	2,538
Neonates weight >2,500 grams (normal newborn)	793

Notes: Comparable (representative) data was not available for Quebec, the territories and Nunavut. Only typical patients were included in the analysis of acute care inpatient records; stillbirths and cadaveric donors are excluded.

Source: Canadian MIS Database, Discharge Abstract Database, CIHI.

Who Pays for Hospital Care?

The public sector pays for most hospital care in Canada (93% in 2004). This is the case in some, but not all, OECD countries. In 2000, for example, the public share for curative and rehabilitative inpatient care was lowest in the United States, at 59%. This result is different from other OECD countries. Among other countries reporting data, the public share ranged from 72% in Switzerland to 95% in Denmark. Interestingly, hospital services are a case where private financing and private delivery do not always go hand-in-hand. France, for instance, has more privately provided hospital care than Canada, but its public share of spending (91.6%) was about the same as ours (91.9%) in 2000.[7]

In most parts of the country, health regions receive funds from government and distribute them among the mix of services for which they are responsible. A team of researchers found that governments usually fund hospital services based on some combination of the following:

- who is served (for example, the proportion of seniors in an area) or what types of services are provided (for example, the number of hip replacements performed);
- how much the hospital spent in the past, either overall or for particular types of costs; and
- criteria related to the government's political platform and the needs of constituents as identified by elected members of the legislature (for example, special funding for priority programs).[8]

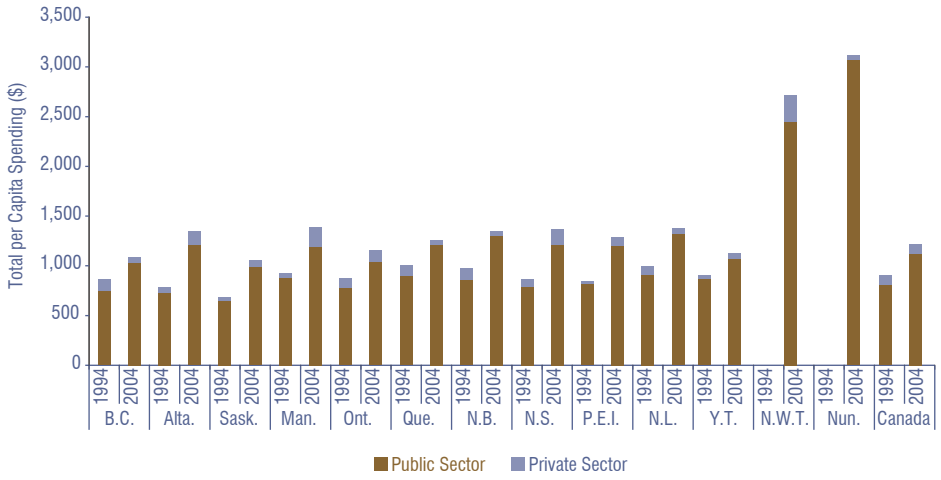
A Helping Hand

Some choose to donate their money; others give their time. Volunteers are an important resource for hospitals. In 2000, Canadians volunteered 97 million hours in hospitals and other health organizations, up from 93 million hours in 1997. That's the equivalent of more than 49,000 full-time jobs. Statistics Canada estimates that if the health sector had had to pay for this work, it would have cost about $1.3 billion.

Even more Canadians provide care or support to the sick or elderly on their own (not through a formal organization). According to Statistics Canada, about 6.8 million adults said that they did so in 2000—many more than the number that work in the health sector. Of this total, almost 2 million individuals said that some or all of this care was provided to someone recovering from a short-term illness after being discharged early from a hospital.[10]

31 Public and Private Spending on Hospitals

Hospital spending per person has grown steadily in recent years. Public-sector spending has increased across the board, but private-sector trends are mixed. The figure below shows public-and private-sector hospital spending per person for each of the provinces and territories in 1994 and 2004 (not adjusted for inflation).



Note: Data for 2004 are forecasts. Comparable data for 1994 for Nunavut and the Northwest Territories are not available.

Source: National Health Expenditure Database, CIHI.

In total, Canadian hospitals received about $3.1 billion from sources other than the public sector in 2004, up from $2.7 billion a decade ago. In 2002, individuals and private insurance firms paid about half of that amount to cover charges for private rooms and other preferred accommodation, care for non-residents, chronic care and uninsured services. (Almost 15 million Canadians aged 12 and over reported that they had insurance that covered all or part of hospital charges for a private or semi-private room in 2003.)[9] Hospitals may also receive payments for some over-the-counter drugs and personal health supplies, ancillary fees (such as parking and food services), donations and investment income.

For More Information

1. Canadian Centre for Analysis of Regionalization and Health, *About Regionalization in Quebec*, last modified 2005, [online], cited July 14, 2005, from <http://www.regionalization.org/Regionalization/Reg_QC.html>.

2. Canadian Centre for Analysis of Regionalization and Health, *About Regionalization in Ontario*, last modified 2005, [online], cited July 14, 2005, from <http://www.regionalization.org/Regionalization/Reg_ON.html>.

3. Ministère de la Santé et Services sociaux du Québec, *Création de 95 centres de santé et de services sociaux (CSSS) au coeur des 95 réseaux locaux de services de santé et de services sociaux (RLS)*, last modified 2005, [online], cited July 14, 2005, from <http://www.msss.gouv.qc.ca/reseau/rls/>.

4. Canadian Centre for Analysis of Regionalization and Health, *About Regionalization in Newfoundland and Labrador*, last modified 2005, [online], cited July 4, 2005, from <http://www.regionalization.org/Regionalization/Reg_NL.html>.

5. Statistics Canada, "Health Care Services—Recent Trends," *Health Reports* 11, 3 (1999): pp. 91–109.

6. Canadian Institute for Health Information, *Inpatient Hospitalizations Continue to Decline, Same-Day Surgery Visits on the Rise* (news release), last modified 2004 [online], cited July 12, 2005, from <http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=media_29oct2004_e>.

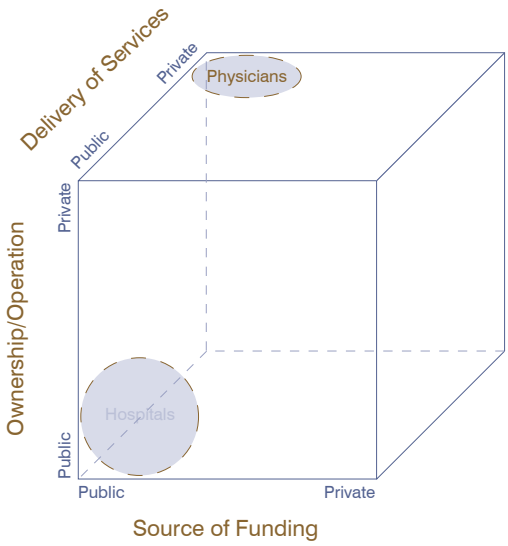
7. Organisation for Economic Co-operation and Development, *OECD Health Data, 2005* (CD-ROM), (OECD, 2005).

8. Canadian Institute for Health Information, *Hospital Financial Management Practices in Canada, 2000—Funding, Reporting and Performance Monitoring* (Ottawa: CIHI, 2000).

9. Statistics Canada, *Data Dictionary*, [online], last modified 2005, cited July 14, 2005, from <http://www.statcan.ca/cgi-bin/imdb/p2SV.pl?Function=getDocumentation&AC_Id=27504&AC_Version=2&ul=ul&lang=en&db=IMDB&dbg=f&adm=8&dis=2>.

10. Statistics Canada, *Satellite Account of Non-Profit Institutions and Volunteering, 1997–1999* (Ottawa: Statistics Canada, 2004).

5 Physician Services



Source: Adapted from I. McKillop, J. Alpenberg, R. G. Evans, et al., *Private Sector Delivery: Scope and Extent in Canada's Health Care System*, (Waterloo: University of Waterloo, 2004).

Quick Facts

Use

- More than 59,000 physicians were practising in Canada in 2003.
- Most Canadians (80%) report visiting a doctor each year. This percentage has remained relatively unchanged since 1994–1995.

Coverage

- The *Canada Health Act* ensures that all medically necessary physician services are funded by public health insurance plans.

Spending

- Since 1994, public funding for physicians in Canada has remained above 98%.
- Average annual payments to physicians from public health insurance plans vary across the country.

A Visit to the Doctor . . .

At the end of 2003, there were more than 59,000 physicians working across the country, with a near fifty-fifty split between family physicians and specialists. These doctors work in a variety of settings, including private practices, walk-in clinics, hospitals, community health centres and emergency rooms. Most Canadians visit a doctor at least once a year.

Patients do not have to pay directly for most of the care they receive from doctors. Physicians bill provincial or territorial health insurance plans for each insured patient service that they provide. Each province or territory establishes a fee schedule for physician services covered under its health care plan. This type of payment practice is referred to as "fee-for-service" billing. The amount that physicians in each province or territory are paid is based primarily on this fee schedule, negotiated between governments and medical associations. However, alternative payment plans have gained popularity in Canada in recent years. These methods of physician payment typically include salaries, benefits and capitation (see *Physician Pay Preferences* on page 54).

Canadians' Use of Physicians

Eight in ten Canadians visit a doctor each year, a rate that has remained relatively unchanged since 1994–1995.

Most (86%) people aged 12 or older reported that they had a regular doctor in 2003. That leaves another 2 million people (9%) who had not looked for a regular doctor, and 1.2 million who could not find one. In the 2001 National Family Physician Workforce Survey, only one-quarter (24%) of family doctors said that they were accepting new patients. Among this group, most said that their practices were conditionally open. This means that they were accepting new patients only under certain circumstances (for example, referrals from other physicians).

Health Spending on Physicians

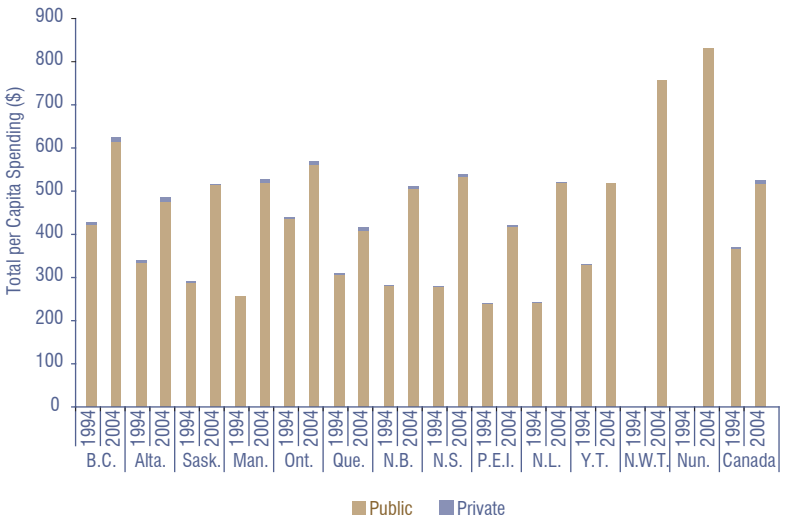
In 2004, Canada spent an estimated $130 billion on health care—about 10% of the economy, or gross domestic product (GDP). This money was used to purchase a variety of goods and services, including millions of physician visits, immunizations and hospital stays.

Three categories—hospitals (30%), drugs (17%) and physician services (13%)—account for the majority (60%) of health care costs. In 2004, physician services made up the third-largest category of total health expenditures. Spending on physician services increased to a forecast $16.8 billion in 2004—up 4.8% from the year before. However, these costs increasingly take up a smaller share of a growing pie. The proportion of total health care dollars going to pay for physician services has decreased over the years, from 15% of total spending on health in 1994 to 13% in 2004. Spending on prescription and over-the-counter drugs and other pharmacy supplies has grown faster than spending for physician services since 1997. As well, the growth in spending on public health and administration, other professional services and capital projects has outpaced spending increases for physician services in recent years.

The public sector plays a larger role in financing health care in Canada than the private sector. In 2002, approximately $7 of every $10 spent on health care came from public sources—mostly from provincial and territorial governments. Since 1975, public-sector payment for physicians has been at above 98% of total physician costs. The private share of physician services was approximately 1.7% in 2002. Households account for almost all private spending on physician services not covered by public plans in some or all jurisdictions. Examples of private physician services not covered by public plans in some or all jurisdictions include over-the-phone prescription refills, employment-related physical examinations and general doctors' notes.

32 Public and Private Spending on Physicians per Capita

The figure below shows fluctuations in public and private per capita spending on physicians' services between 1994 and 2004. Public per capita spending has increased within each province and territory, as well as in the country as a whole.



Notes: Data for 2004 are forecasts. Figures are not adjusted for inflation. Data for 1994 for Nunavut and the Northwest Territories are not available.

Source: National Health Expenditure Database, CIHI.

How Doctors Are Paid

Physicians' incomes are affected by several factors, including province or territory of work and types of services performed. Reimbursement methods used by provinces and territories to pay physicians for their services fall under two main categories: fee-for-service and alternative payments.

Fee-for-Service Payments

The majority of doctors in Canada get most of their income from fee-for-service payments. In 2002–2003, 83% of physician payments (excluding physicians in Nunavut and the Northwest Territories) were in the form of fee-for-service billing. This number varied across the country, ranging from roughly 58% in Newfoundland and Labrador to 92% in the Yukon Territory and Alberta.

Under the fee-for-service system, physicians bill their provincial or territorial health insurance plan for each insured patient service they provide. The amount that they are paid is based on a fee schedule, negotiated between governments and medical associations.

Alternative Payments

Alternative payment plans include a broad range of payment methods, such as salary, capitation, sessional, per diem or hourly, service contracts, incentives and premiums. Blended payments are a combination of fee-for-service payments and one or more alternative payment methods. Although alternative payment plans have gained popularity in Canada in recent years, only 18% of payments to physicians in 2002–2003 were received through alternative payment plans.

Physician Pay Preferences

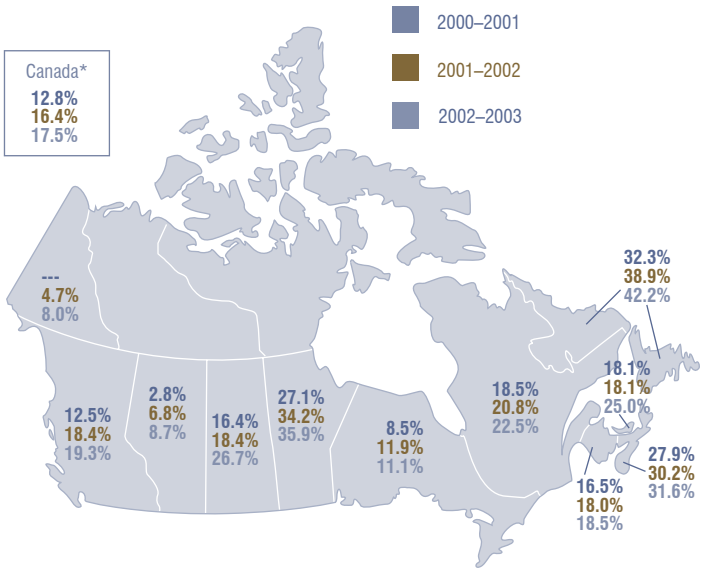
In 2004, 51% of physicians reported receiving 90% or more of their income from fee-for-service billing, a drop from 68% in 1990. As well, only 28% of physicians surveyed in 2004 endorsed fee-for-service as the sole method of payment, a drop from 50% in 1995. At the same time, there was a reported increase in the popularity of blended payments. Almost half (48%) of those surveyed in 2004 endorsed blended payments, up from 27% in 2001.

These results draw on data from two recent surveys. In 2004, the College of Family Physicians of Canada, the Canadian Medical Association (CMA) and the Royal College of Physicians and Surgeons of Canada collaborated for the first time on the National Physician Survey (NPS). The results of the NPS are compared here with those of the CMA-administered Physician Resource Questionnaires of 1990 and 2001, which are part of an ongoing series. All respondents were asked about their current compensation arrangement and preferred methods of remuneration.

Results of the two surveys indicate that the most preferred options for payment are fee-for-service and salary, either individually or as part of a blended plan. On the other hand, specialists and family doctors show little support for payment models based on capitation or on service contracts.[3]

33 Alternative Payments to Physicians, 2000–2003

The popularity of fee-for-service remuneration for doctors has dropped over time. The proportion of all clinical payments coming through alternative payment plans has increased over time, but continues to vary across the country. For example, between 2000–2001 and 2002–2003, this increase ranged from 12% in New Brunswick to 211% in Alberta. The national average increase was 38%.



Source: Canadian Institute for Health Information, *The Status of Alternative Payment Programs for Physicians in Canada 2002–2003* and *Preliminary Information for 2003–2004 (Ottawa: CIHI, 2004)*.
* National percentages exclude Nunavut and the Northwest Territories.

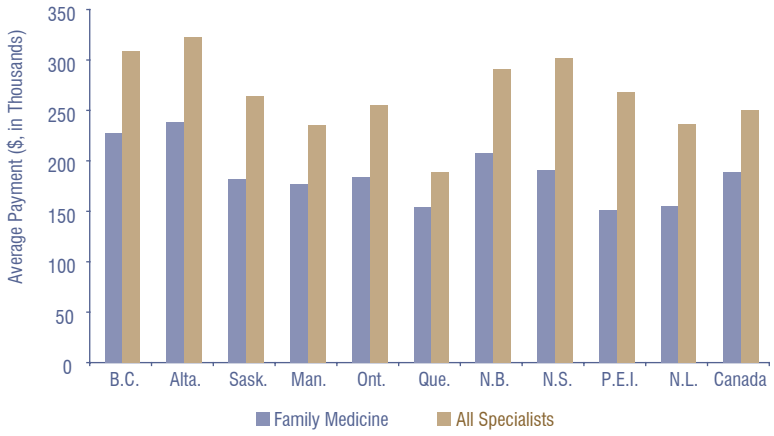
How Much Doctors Get Paid

How much doctors are paid can vary depending on the area of the country they work in. For full-time family doctors, the average amount received from fee-for- service billing ranged from $150,779 in Prince Edward Island to $238,182 in Alberta. Full-time specialists received average payments of $188,737 in Quebec to $322,204 in Alberta. For all physicians in Canada (excluding Nunavut and the Northwest Territories), the amount paid to full-time fee-for-service physicians increased by 3.4% between 2001–2002 and 2002–2003.

The amount that doctors are paid also depends on the type of service they provide. These services are categorized as either procedures or consultations and visits with patients. For example, in 2002–2003, the average amount that a family physician received for all visits and consultations from fee-for-service billings ranged from $200,420 in Alberta to $105,264 in Prince Edward Island. For all procedures performed in the same year, the amounts also ranged considerably—from $32,150 in Alberta to $7,990 in Newfoundland and Labrador. Fee-for-service payments to specialists for all visits and consultations varied from $152,436 per doctor in Alberta to $103,106 in Newfoundland and Labrador. Likewise, the variation in average payments to specialists for all procedures performed in 2002–2003 ranged from $165,347 in New Brunswick to $106,953 in Manitoba.

34 How Much Do Doctors Get Paid?

Full-time† specialists received higher average payments for their services through provincial fee-for-service programs than did family physicians and general practitioners in 2002–2003. In addition, average payments to both specialists and family doctors varied significantly across Canada, depending on where they practise.



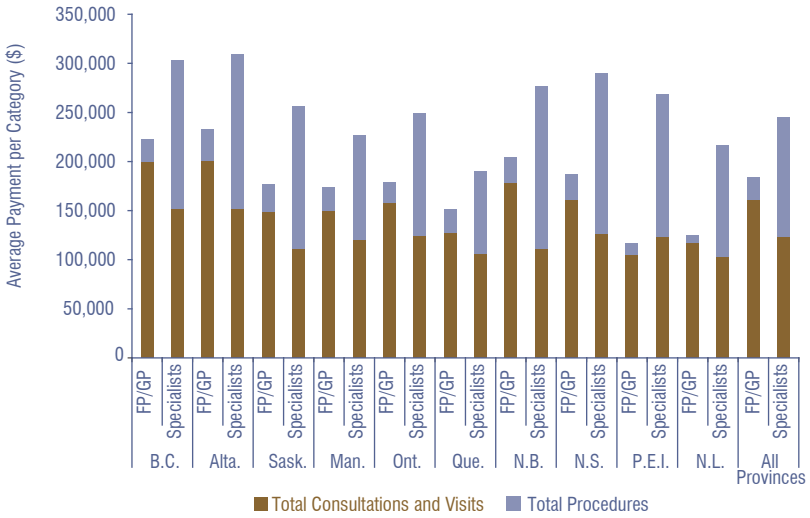
† For the purposes of payment calculations, the term "full-time equivalent" (or "FTE") is used to describe doctors working full-time. For more information, see CIHI's *Average Payment per Physician Report, Canada, 2002–2003* and *Full-Time Equivalent Physicians Report, Canada, 2002–2003*.

Notes: Average *annual* payment figures are total amounts paid to individual physicians (gross amounts) and exclude expenses or overhead costs incurred in their main practice settings. Medical and surgical specialties are combined into one "specialist" category. Also note that the territories are excluded due to lower volumes of reported services.

Source: Canadian Institute for Health Information, *Average Payment per Physician Report, Canada, 2002–2003* (Ottawa: CIHI, 2004).

35 Differences in Cost for Specialists and Family Doctors

Physicians receive payments through government fee-for-service insurance plans for both consultations/visits and procedures. The balance between these two types of payments differs for full-time and part-time FP/GPs and specialists. It also varies across the country, as shown in the graph below.



Note: These figures represent full-time and part-time fee-for-service billing physicians, and are drawn from the National Grouping System (NGS), developed by CIHI to facilitate comparisons among different provinces and territories.

Source: Canadian Institute for Health Information, *National Grouping System Categories Report, Canada, 2002–2003* (Ottawa: CIHI, 2005).

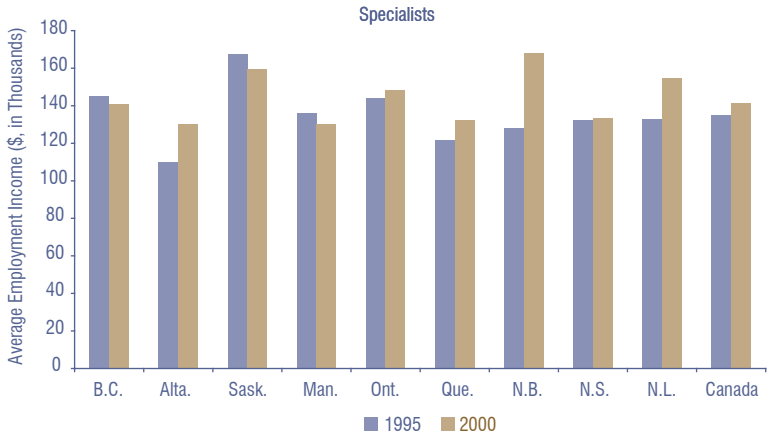
At the same time, as average payments are changing, so too are the number and type of services provided by physicians. For example, the 2004 National Physician Survey found that 17% of physicians reported that they had reduced their weekly work hours in the past two years, and 13% reported that they had reduced their scope of practice over the same time period. Only 4% said that they had expanded their services. Looking ahead, 5% of family physicians and 8% of specialists said that they planned to retire in the coming two years.

Overhead Costs and Physicians' Incomes

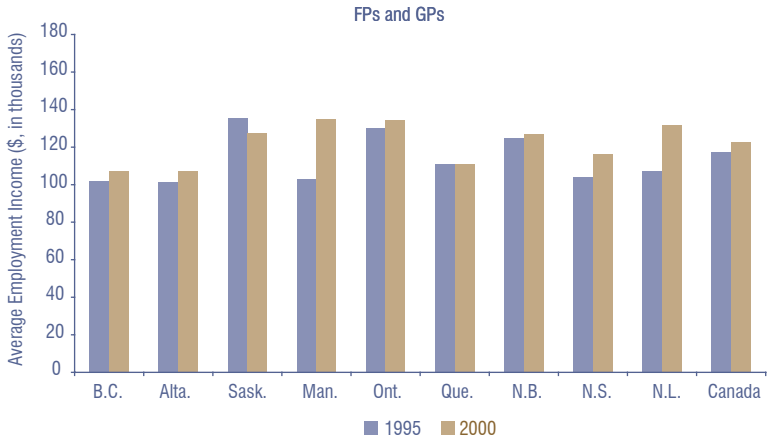
Costs associated with running a practice affect the amount of income a physician or specialist gets to "take home." These overhead costs mean that doctors' overall incomes may vary considerably from the amount they bill for the services they perform. Overhead costs, including investments in office equipment, supplies, rent, professional fees and staff salaries, can be a significant amount. A 2002 survey by the Canadian Medical Association asked physicians (specialists, family doctors and general practitioners) to estimate these costs. Medical specialists reported spending over one-quarter (27%) of their earnings on overhead costs. Surgical specialists spent one-third (33%) of their income on overhead costs and family/general physicians spent 35%.[6] Data from the Census (see Figure 36) provide a perspective on physicians' income (from all sources) after these types of costs are deducted.

36 A Look at Physician Income—FPs and GPs

The graphs below show the variation in annual employment income among specialists, family physicians (FPs) and general practitioners (GPs) in 1995 and 2000. In all provinces except Manitoba, specialists earned more than other physicians in 2000. However, the size of the income gap varied across the country.



A Look at Physician Income—Specialists



Note: Data for Prince Edward Island, Nunavut, the Yukon and the Northwest Territories were not available.

Source: Statistics Canada, Census 1996, 2001.

Private Spending on Physician Services

Payment for physician services comes primarily from the public sector (98% since 1975). Physician services are a core service insured under the *Canada Health Act*. This legislation facilitates "reasonable access" to medically necessary insured services, without direct charges, but also outlines specific criteria and conditions related to publicly insured health care services.

However, services that are not covered by provincial or territorial health insurance plans have to be paid for by individuals out-of-pocket or by their coverage under private health insurance. Services that are not covered by public insurance plans are those that have become de-insured (and are no longer listed on provincial fee-for-service schedules) or others deemed to be not medically necessary. For example, cosmetic and plastic surgery, in general, are not covered under public insurance plans, except for specific procedures involving burns and reconstructive surgery performed in a hospital.

Private Spending—The Rise of Plastic Surgery in Canada

When we think of plastic we often tend to think of common objects like toys and household food containers. However, the term "plastic" actually evolved from the Greek word *plastikos*, which means to reconstruct, form, or create. Not surprisingly then, plastic surgery focuses on "the creation of new tissue, improvement of form and function, and reconstruction following accident or injury."[7]

Plastic surgery has been cited as early as 800 B.C., when physicians in India performed reconstructive work using skin grafts.[8]

Today it is used for both reconstructive and cosmetic purposes. For example, burn victims may require reconstructive skin grafts to treat severe burns, while some individuals may choose cosmetic surgery to change their physical appearance and to improve their sense of well-being. Although some reconstructive surgery is covered by provincial and territorial health insurance plans, cosmetic procedures are generally paid for out-of-pocket.

In Canada, little information is available on cosmetic surgery. In May 2004, Medicard Finance Inc. (a finance company for medical procedures) and researchers from the Rotman School of Business at the University of Toronto surveyed a sample of Canadian surgeons and cosmetic physicians to find out more about these procedures. According to their statistics, liposuction and breast augmentation accounted for 24% and 17% respectively of all cosmetic surgeries performed that year. Surgical facelifts accounted for 2%. Women are the primary recipients of plastic surgery; they accounted for 85% of all cosmetic procedures performed in 2003.

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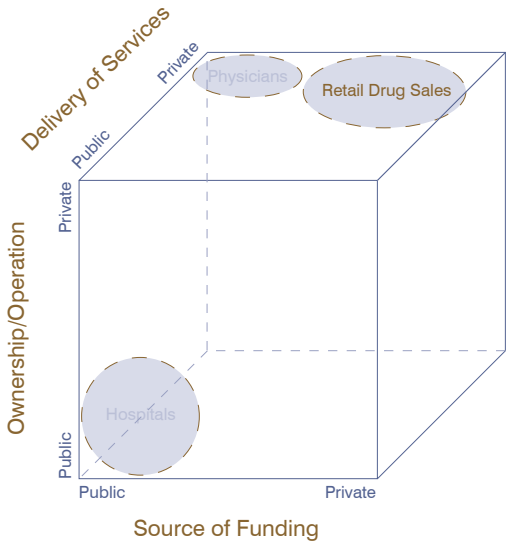
6 Retail Drug Sales



Source: Adapted from I. McKillop, J. Alpenberg, R. G. Evans, et al., *Private Sector Delivery: Scope and Extent in Canada's Health Care System*, (Waterloo: University of Waterloo, 2004).

Quick Facts

Use

- 56% of Canadian adults in 2002–2003 reported taking a prescription medication in the previous month.
- Over 380 million prescriptions were filled in 2004, an increase of 74% over the past 10 years.

Coverage

- $8.5 billion was spent by the public sector on prescribed drugs in 2004 (forecast). The public sector's share of total spending on prescribed drugs has grown from 42% in 1984 to 47% in 2004.
- 79% of Canadians aged 12 or older reported having some public and/or private drug insurance in 2003—up 18% points from 1996–1997. In 2003, rates ranged from 66% in Prince Edward Island to 89% in Quebec.

Spending

- $13.3 billion was spent on retail drugs by the private sector in 2004. Of that total, $9.5 billion was spent on prescriptions. Out-of-pocket expenses for the remaining $3.8 billion paid for over-the-counter drugs and personal health supplies.
- 3% of households reported spending more than 5% of their after-tax income on prescription drugs in 2002.

Taking medication is a part of everyday life for many Canadians. Medicine cabinets include a growing assortment of newer—and often expensive—drugs.[1] How we obtain and pay for drugs, as well as the amount that we pay, varies almost as much as the effects that different drugs can have on our bodies.

Prescription and over-the-counter drugs help Canadians in many ways. They can save lives, reduce the need for surgery and allow us to maintain or improve our quality of life. In some cases new drugs—such as antibiotics and insulin—revolutionize the treatment of a disease. But many medications in use today are "halfway technologies"; they alleviate symptoms but do not cure or prevent the underlying condition.[2]

While many medications offer significant benefits, using drugs inappropriately can lead to health risks and costs. For example, drugs can have serious side effects, and some medications are harmful when combined with other drugs or natural products. In addition, drugs are sometimes prescribed for problems better managed in other ways. In some cases, new and more expensive drugs are used in situations where older, less expensive products would be equally effective. As well, mistakes can occur when drugs are prescribed or taken. Some people also abuse or misuse medications. In a study in Atlantic Canada, for instance, 15% of adolescents who had been prescribed stimulants told researchers that they had given their drugs to others; 7% reported having sold them.[3]

Since 1997, spending on retail drugs has been the second-largest category of health expenditure in Canada. Although government programs help to finance some of these costs, the private sector still pays more than half of the bill. This chapter explores how the utilization and financing of retail drug sales has changed over time and how they compare across Canada and with other countries.

Drug Spending in Hospitals

Retail drug sales account for the bulk of spending in Canada, but hospital budgets also include significant—and growing—drug costs. In 2001–2002, Canadian hospitals spent over $1.3 billion on drugs, or about 4% of their operating budgets—more than a fourfold increase over 20 years (not adjusted for inflation). The proportion of hospital budgets spent on drugs in 2002 ranged from 3.1% in Newfoundland and Labrador to 4.9% in Alberta. Across the country, provincial and territorial health insurance plans typically cover these costs.

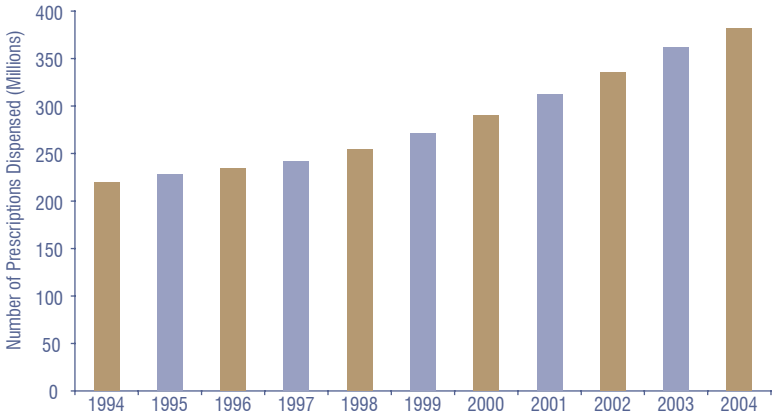
Medicating More

From aspirin to beta-blockers, we are consuming more medication than ever before. In 2002–2003, a joint Canada/United States survey showed that over half of Canadian (56%) and American (58%) adults reported taking a prescription medication in the previous month.[4] In the last 10 years, the volume of prescriptions dispensed to Canadians grew by over 70%.[5]

A recent study suggests that variation in the use of medications partly—but by no means completely—explains why drug spending differs from province to province.[6] Other factors may include differences in the price of drugs, the use of generic drugs, specific treatment choices and the mix of drugs that are prescribed. The study also showed that Quebec had the highest average per capita spending on oral solid prescriptions in 2002 ($406). As well, it found that Quebec residents used more medications on average, consumed a more expensive mix of products and paid more per product unit. This compares with residents of British Columbia ($274) and Saskatchewan ($269), who purchased fewer drugs on average and tended to receive relatively low-cost therapeutic alternatives.

37 Prescriptions Filled in Canada

In 2004, Canadian retail pharmacies filled more than 380 million prescriptions, an increase of 74% from a decade before. The most frequently filled classes of drugs were cardiovasculars (15%), psychotherapeutics (12%), hormones (6%) and antibiotics (6%). On average, Canadians filled 12 prescriptions per person in 2004. However, this amount increased with age—adults aged 80 or older filled the greatest number of prescriptions each, averaging 42 per person.



Source: IMS Health Canada, *Growth in Retail Prescriptions Slows in 2004*, [online], last modified March 7, 2005, accessed July 12, 2005, from <http://www.imshealthcanada.com/htmen/4_2_1_54.htm>.

Who Is Covered?

In Canada, both the public and private sectors pay part of the drug bill. Public-sector payers include governments, Workers' Compensation Boards and other social security schemes. The federal government pays for prescribed drugs for the military, the Royal Canadian Mounted Police, veterans, inmates in federal jails and Status Indians and Inuit. Provincial and territorial governments pay for drugs given to patients in hospitals across the country. They also have a variety of programs that cover parts of the total drug bill.

More than three-quarters of Canadians do not have to pay the full cost of their prescribed drugs out-of-pocket. In 2003, 79% of Canadians aged 12 or older reported that they had some public and/or private drug insurance, according to a Statistics Canada survey. That's up from 61% in 1996–1997.[7] Low-income Canadians, part-time workers and those without jobs are less likely than their counterparts to say that they are insured. In part, this likely reflects the fact that private insurance is often a benefit of employment, covering employees and their dependents.[8]

Statistics Canada measured coverage rates among the provinces and territories and found that they ranged from 67% in Prince Edward Island to 89% in Quebec. Researchers largely attribute this to differences in public drug plans.[9] In some cases, experts suggest that these figures may be underestimates. They believe that respondents may not be aware of coverage available to them or may not interpret public drug coverage as "insurance."[8, 9]

Each province and territory has developed its own publicly funded drug plan(s). As a result, families with similar incomes and medical needs may receive very different government-funded benefits, depending on where they live. Persons receiving social assistance are covered in all provinces and territories, but program benefits vary.[10]

There's More

Want to learn more about what's covered under provincial and territorial drug plans?

Check out CIHI's *Drug Expenditure in Canada 1985 to 2004* report online at www.cihi.ca.

Coverage for MS Drugs

Public drug plans vary significantly across Canada. While there tends to be a common core, plans cover different drugs, include different groups as eligible beneficiaries and require different levels and types of patient cost sharing.[11, 15] For example, some drugs appear on all provincial and territorial "formularies" (lists of drugs eligible for reimbursement). Others are covered only in selected provinces and territories. The conditions under which particular drugs are covered also vary.

Take, for instance, the four drugs (Avonex, Betaseron, Copaxone and Rebif) that have become available for the treatment of multiple sclerosis (MS) in recent years. All provinces and territories provide some coverage for these MS drugs, although the level of coverage differs across the country.

CIHI's National Prescription Drug Utilization Information System reports that eight jurisdictions (British Columbia, Alberta, Saskatchewan, Quebec, New Brunswick, Prince Edward Island, Newfoundland and Labrador and Yukon Territory) list MS drugs as restricted benefit drugs. This means that coverage is offered to patients who meet pre-defined criteria (for example, the diagnosis and/or the prescription is written by a neurologist). In Manitoba, they are listed as exceptional status drugs and appropriateness of coverage must be assessed by an MS clinic.

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Coverage for MS Drugs continued from previous page

In Nova Scotia, the Dalhousie MS Research Unit provides funding assistance based on established clinical criteria when there is no other drug coverage (for example, private insurance).

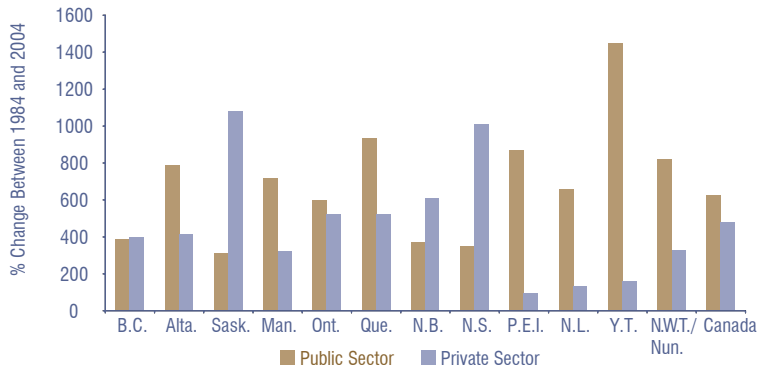
Beyond these parameters, the amount that is covered by provincial and territorial programs can vary, depending on family income. This is the case in British Columbia, Saskatchewan, New Brunswick and Prince Edward Island. In Newfoundland and Labrador and the Yukon, public coverage for drugs is available only for persons on social assistance, seniors and persons registered under the Yukon Territory Chronic Disease Program. Ontario residents may request special coverage if they are 65 years of age or older, reside in a long-term care facility or Home for Special Care, receive social assistance, receive professional services under the Home Care Program, or are Trillium Drug Program recipients.

Most government plans also cover seniors (although coverage is based on income in some provinces). Some government drug plans also cover persons with specific diseases—such as HIV/AIDS, cancer and diabetes—that often require expensive drug therapy. The diseases that qualify for coverage vary across the country.[11, 12]

Most public plans require clients to share part of the cost of their drugs through deductibles and/or copayments. These requirements differ across the country. For example, public drug plans cover all residents of Saskatchewan, British Columbia and Manitoba, but residents must pay relatively high deductibles.[11, 13] Likewise, all residents without private insurance are covered under public plans in Quebec, but most Quebec residents must pay a monthly deductible and a premium based on their monthly income.[11, 13, 14]

38 Rising Drug Bill

Retail drug sales have increased across the country, but the rate of change and distribution between the public and private sectors varies. The figure below shows the percent change in prescribed drug expenditures per person between 1984 and 2004 by province and territory (not adjusted for inflation).



Source: National Health Expenditure Database, CIHI.

Why Is Drug Spending Rising?

In total, Canada spent $21.8 billion on retail drug sales in 2004, 83% of which went to prescribed drugs. Spending first reached $10 billion in 1995; it broke the $20 billion level in 2003. In recent years, spending on prescribed drugs has risen more quickly than on over-the-counter drugs and personal health supplies. Annual growth rates for the former have been between 10%

and 15% in the past five years, compared with 2% to 4% per year for non-prescribed drugs and personal health supplies.

A number of intersecting trends may explain recent increases in drug spending. Changes in the prices of drugs and in retail and wholesale markups and professional fees are some examples.[16] However, the Patented Medicines Prices Review Board recently identified a number of other trends affecting drug spending, including:

- Changes in population size
- Changes in population demographics and health status
- More cases of health problems that can benefit from drug therapy
- Changes in the prescribing patterns of physicians (for example, shifts from older, less expensive medication to newer, relatively more expensive medications to treat the same underlying condition)
- Emergence of new drug therapies to treat previously untreatable conditions
- Greater propensity to use drugs to treat conditions not previously considered problematic.[17]

Which factor matters most? A study of prescriptions dispensed to seniors under British Columbia's Pharmacare Plan looked at reasons for the jump in average drug costs per person.[18] Spending per person rose from $49 to $136 between 1985 and 1999. The study found that three major changes drove increases over this period:

- Drug mix (40%): Different drugs were prescribed within a category (for example, switched drugs within a category, increased doses or additional prescriptions for drugs within a category).

Managing Costs

In Canada and other Organisation for Economic Co-operation and Development (OECD) countries, governments face the difficult task of containing public spending on drugs while ensuring that their residents have access to essential medications regardless of their ability to pay. To accomplish this task, public drug plans use a variety of mechanisms to manage their drug costs. (Private plans also face cost escalation challenges. Some use similar management options as to those employed by public plans.)

In many countries, copayments, deductibles and premiums are widely used cost-sharing mechanisms. Although these mechanisms are intended to promote the appropriate use of medication and/or manage costs, in some cases they may diminish access to needed medications among those who are less able to pay.[19] For example, in 1996, the Quebec government legislated mandatory drug coverage for those without private insurance. To help finance this expanded coverage, it increased the amounts that residents were required to pay through the use of deductibles and premiums. Researchers found that this new policy improved access to medications for uninsured people. However, seniors and those on social assistance used fewer "essential" drugs, experienced more serious adverse events and had more visits to emergency departments.[20, 21] As a result of these findings, the Quebec government revised its drug plan and eliminated payments from social assistance recipients with severe employment constraints and seniors receiving the maximum Guaranteed Income Supplement.[14, 22, 23]

Although controversial, reference-based pricing is another mechanism used to manage costs in some parts of the country. First introduced by British Columbia in 1995, this is a process whereby the public plan generally covers up to the cost of "referenced" drugs among a category of chemically different drugs that have the same therapeutic effect. (A related "low-cost alternative" program ensures that the public plan pays no more than the price of the

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Managing Costs continued from previous page

lowest-cost option among drugs with identical active ingredients.) This program has been implemented for five drug classes in the province.[24] In these cases, experts have judged that two or more drugs can be used to treat the same condition. These drugs may have different chemical properties and are often sold at different prices. British Columbia's Pharmacare program will pay only the cost of the reference drug, unless there are medical reasons why a patient cannot take it (such as allergies). Research suggests that this program saves money without increased hospital admissions or mortality.[25]

Following B.C.'s lead, other jurisdictions have considered similar types of programs, such as Nova Scotia's pricing of non-steroidal anti-inflammatory products (e.g. naproxen, ibuprofen, etc).[26] In early 2005, Ontario began considering reference-based pricing for proton pump inhibitors.[27]

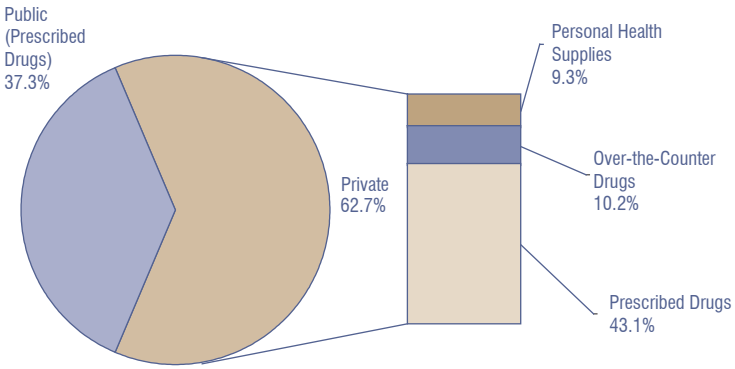
- Exposure across therapeutic categories (38%): Seniors had prescriptions from more categories of drugs (for example, nonsteroidal anti-inflammatory agents or benzodiazepines), on average.
- Drug prices (22%): Higher prices for individual products, partially offset by the substitution of lower-cost generic products for brand name drugs.

Who Pays?

Paying for retail drug sales is a shared responsibility. In 2004, the public sector spent a forecast $8.5 billion on prescribed drugs. This took the public sector share to 47%, up from 42% in 1984. And it's a growing share of a growing pie. Over the past two decades, actual

39 Sharing the Cost

Governments, social security funds, private insurers and individuals share the costs of prescribed drugs. In contrast, individual Canadians bear the bulk of the costs for over-the-counter drugs and personal health supplies (such as diabetic test strips). The figure below shows the share of spending on prescribed and non-prescribed drugs by the public and private sectors in 2002.



Source: National Health Expenditure Database, CIHI.

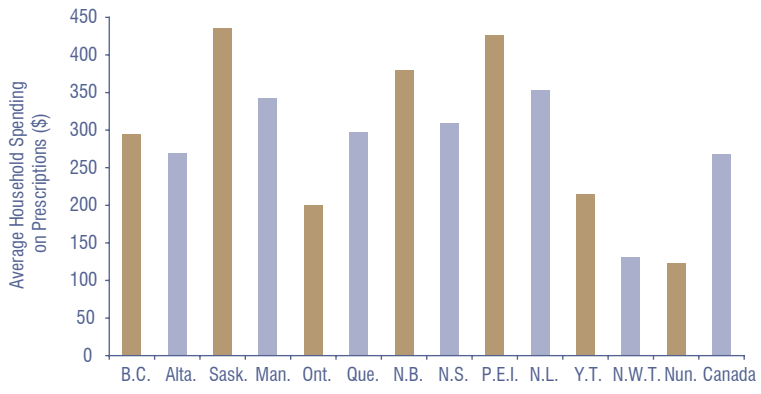
spending on prescribed drugs has increased significantly. In 2004, we spent a forecast $562 per person on prescribed drugs—more than a fivefold increase since 1984 (not adjusted for inflation).

The private sector continues to pay for the majority of retail drug sales—a total of $13.3 billion in 2004. Of that total, $9.5 billion was spent on prescribed drugs. The remaining $3.8 billion was spent on over-the-counter medications and personal health supplies and was paid for out-of-pocket by individual Canadians.

Some households pay more out-of-pocket than others. According to Statistics Canada, 65% of households paid for some or all of the cost of prescriptions in 2002. As well, 3% of households reported spending more than 5% of their after-tax income on prescription drugs provincially. This rate ranged from 1.6% in Ontario* to 8.1% in Saskatchewan.[28]

40 Household Spending on Prescriptions

Canadian households spent an average of $268 out-of-pocket on prescription drugs in 2003. Among the provinces, the average amount spent varied from $200 in Ontario to $427 in Prince Edward Island. Residents in the territories reported the lowest average out-of-pocket costs. The figure below shows the range in average household spending on prescription drugs across the country.



Source: Survey of Household Spending, Statistics Canada, 2003.

* The percentage reported for Ontario has a coefficient of variation of 18.5 and should be interpreted with caution.

An International Perspective

Drugs are an important part of modern medicine and account for a rising share of health budgets around the world. In 2003, the most recent year for which international comparisons are available, Canada spent 17% of total health expenditure on pharmaceuticals. That's almost equivalent to the OECD average.

No single factor explains why some countries allocate a larger share of their health care funds to drugs than do others. However, experts suggest that differences in service delivery—such as the level of public coverage and patient cost sharing—may play an important role.[11, 19] A broad range of other factors may also be important. For example, the portion of health expenditures devoted to drugs tends to be higher in low- or middle-income countries, partly because drug prices are high relative to those of other health goods and services.[11, 19]

Although Canada spends a similar percentage on drugs when compared to the OECD average, we tend to spend more overall than many countries. As a result, in 2003, only the U.S. and France spent more on pharmaceuticals per capita than Canada.

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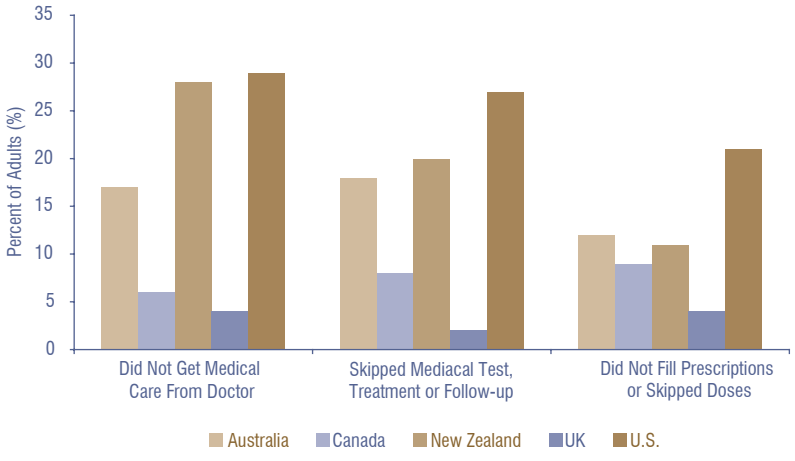
41 When Cost Prevents Access

More money does not necessarily buy better access. Just because a country spends less on drugs per person does not necessarily mean that its citizens will report more cost-related access problems. For example, Canada spent $507 U.S. per person on pharmaceutical products (publicly and privately) in 2003, but 9% of people surveyed in 2004 said that they had not filled a prescription or had skipped doses because of cost in the last year. The U.S. spent considerably more—$728 per person—but 21% reported cost-related access problems. The chart below shows the percentage of adults in five countries in 2004 who reported that, because of cost, they did not get medical care from a doctor; they skipped a medical test, treatment or follow-up; or they did not fill a prescription or skipped doses of their medication at some point in the previous year.



Note: All countries show a statistically significant difference with one or more countries in each of the categories.

Source: C. Schoen et al, "Primary Care and Health System Performance: Adults' Experiences in Five Countries," *Health Affairs Web Exclusive* (October 28, 2004): W4-487–W4-503.

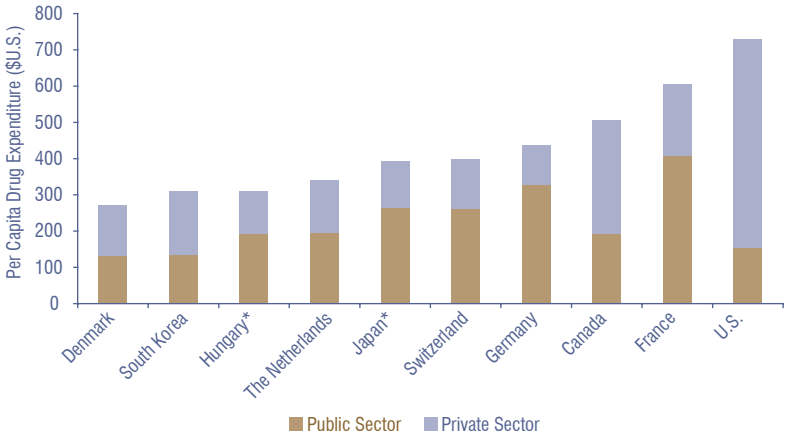
An International Perspective continued from previous page

Interestingly, differences in per capita spending clearly reflect more than simply the price of medications in different countries. The Patented Medicine Prices Review Board (PMPRB) regularly compares the prices of patented medicines in Canada to those of seven other countries.±[17] In the mid-1980s, on average, prices in Canada were below those in the U.S., but higher than those in the other comparator countries. Today, Canada falls in the middle. Compared to Canada, only Italy and France had lower average prices for patented drug products in 2004. On the other hand, the PMPRB found that Canadian prices for generic drugs were 21% to 51% higher than the median for comparator countries as well as Australia and New Zealand in 2003.[29] Just as spending and prices differ across countries, so does who pays for drugs. Canada's public-sector organizations play a smaller role in financing drug expenditures than those in many other OECD countries. Among countries with the most comparable data, the public share in 2003 ranged from 21% in the U.S. to 75% in Germany.

± The comparator countries were France, Germany, Italy, Sweden, Switzerland, the UK and the U.S.

42 Public Spending Across Countries

The public share of drug spending varies considerably across OECD countries, with Canada towards the lower end. On a per capita basis, however, the Canadian public sector spent $193 U.S. per person on drugs in 2003. The figure below shows how public- and private-sector spending per capita compares with that of nine other OECD countries.



Notes: Expenditures are converted to U.S. dollars using purchasing power parities (PPPs) for gross domestic product (GDP), which are designed to eliminate differences in price levels between countries. The OECD asks that member countries report health expenditures according to their system of health accounts. The 12 countries that most closely follow the proposed system of health accounts are Australia, Canada, Denmark, France, Germany, Hungary, Japan, South Korea, the Netherlands, Switzerland, the UK and the U.S.

*Percentages reported for Hungary and Japan are 2002 data. Data for Australia and the UK were not available.

Source: OECD Health Data 2005, OECD.

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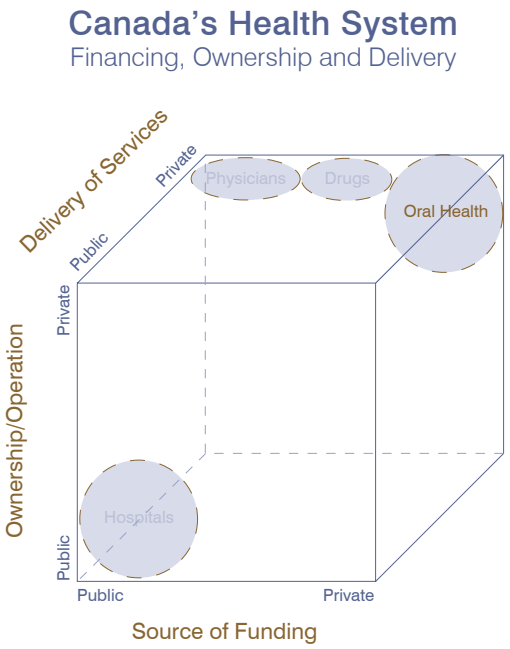
7 Oral Health Care Services



Source: Adapted from I. McKillop, J. Alpenberg, R. G. Evans, et al., *Private Sector Delivery: Scope and Extent in Canada's Health Care System*, (Waterloo: University of Waterloo, 2004).

Quick Facts

Use

- 64% of Canadians aged 12 or older reported consulting a dentist or orthodontist at least once in 2003. This varied across the country from less than half (48%) in Newfoundland and Labrador to 69% in Ontario.
- 26% of Canadian adults reported that they did not seek needed dental care because of cost in 2004.

Coverage

- 61% of teens and adults reported having dental insurance in 2003—up from 53% in 1996–1997.

Spending

- $290 was the average amount spent by Canadian households on dental care in 2002.
- $424 million, or 4.6% of total spending on dental care, came from the public sector in 2004.
- 58% of Canadian employees were offered some dental benefits by their employers in 2002.
- Over the past 20 years, the private sector's share of spending on dental care has risen from 89% in 1984 to 95% in 2004.

"One does not have to travel too far back in the last century to find a time when people in mid-life often lost most, or all, of their adult teeth because of tooth decay and chronic gum infection."[1]

Much has changed over the last century. Fluoridated drinking water, regular oral hygiene and access to professional care have improved the oral health of many Canadians.[1, 2] Oral health care is primarily financed through private insurers (for example, work-related benefits) and out-of-pocket spending. According to recent national survey data, income and insurance status appear to be strong predictors of use of dental services. This chapter explores the use and financing of such care.

Dental Consultations

Daily flossing and brushing have many benefits, but professional help may also be needed to maintain good oral health.[7] In 2003, nearly two-thirds (64%) of Canadians aged 12 or older reported consulting a dentist or orthodontist at least once in the past year, up from 58% in 1996–1997.[8] The consultation rate ranged from 48% in Newfoundland and Labrador to 69% in Ontario. The pattern of use also varied by age, education, income and insurance status.

Some of this care was paid for out-of-pocket, but dental insurance is gradually becoming more common. According to Statistics Canada, 61% of Canadians reported having some public or private insurance in 2003—up from 53% in 1996–1997.[9] Insurance coverage is highest in the territories (81%). Among the provinces, insurance coverage is highest in Alberta (71%). Little is known about the nature of these insurance plans, such as what services are covered and whether enrollees pay small or large copayments and deductibles.

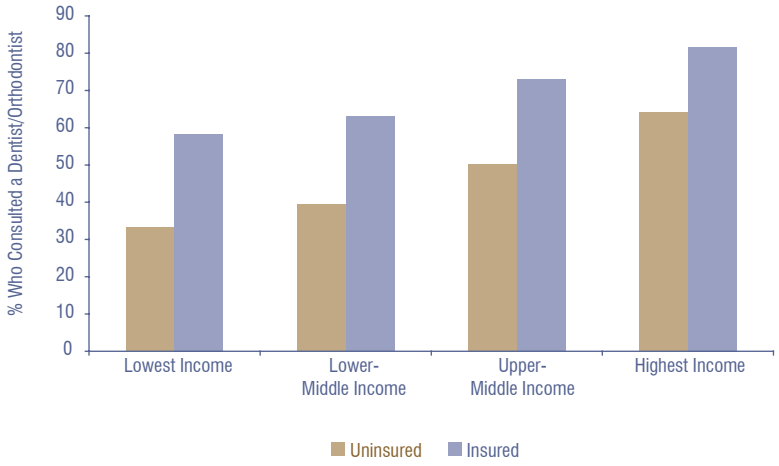
Oral Health of First Nations Children

Although the federal government provides dental coverage for First Nations and Inuit children, the children in this group continue to have poorer average oral health than their non-Aboriginal counterparts. A recent study examined the tooth status of 7- and 13-year-old First Nations children in the District of Manitoulin, Ontario.[3] Researchers found that 96% of children had at least one tooth with active or past decay. The average number of missing or extracted, decayed and filled teeth was 6.2 among 7-year-olds and 4.1 among 13-year-olds. This is much higher than the estimated average of 1.7 missing, decayed or filled teeth among non-Aboriginal 13-year-olds in Ontario.[4]

What explains this difference? A number of theories exist. Some researchers believe that lengthy pre-approval processes to receive dental surgery and orthodontics may deter individuals from seeking treatment.[1] Others suggest that a lack of access to fluoridated drinking water and other prevention and treatment services may be an important factor.[5, 6] In addition, a recent report by federal, provincial and territorial dental directors states that Aboriginal People may not seek dental care because of social/cultural factors. For instance, they may prefer to have dental services provided in their own language or by someone who is familiar with their cultural background.[2]

43 Different Groups, Different Use

There is a strong relationship between income and the chances of consulting a dentist or orthodontist. Teens and adults in higher-income households were more likely to report receiving dental services in 2003, as shown in the figure below. However, at all levels of income, Canadians with some dental insurance were more likely to have consulted a dentist or orthodontist than their uninsured counterparts.

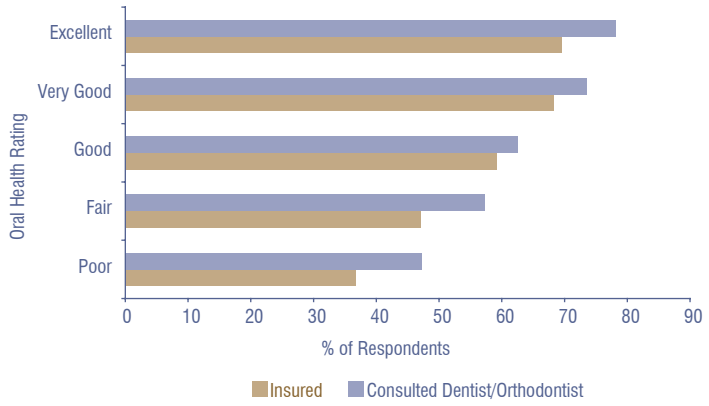


Note: Includes respondents aged 12 or older.

Source: Canadian Community Health Survey, Statistics Canada, 2003.

44 A Glimpse of Oral Health in B.C.

In the 2003 Canadian Community Health Survey, respondents from British Columbia rated the health of their teeth and mouth. Most (84%) rated their dental health as "excellent," "very good" or "good." Those who did so were more likely to have dental insurance or to have sought dental care in the past year than those who reported worse oral health. For example, 70% of respondents who rated their oral health as "excellent" had some dental insurance, and 78% had sought dental care in the past year. Among those who rated their oral health as "poor," only 36% had some dental insurance, and less than half (47%) sought dental care.



Note: Includes respondents aged 12 or older.

Source: Canadian Community Health Survey (Cycle 2.1), Statistics Canada, 2003.

What Predicts Use?

Both income and insurance status appear to be strongly related to use of dental care services.* The two are also entwined. High-income Canadians are much more likely to have private dental insurance. They are also more apt to consult a dentist or orthodontist. Insured Canadians were twice as likely to have consulted a dentist or orthodontist in the past year as the non-insured. High-income earners were three times more likely to do so than the lowest income earners.

* The methodology for this logistic regression analysis is adapted from W. Millar and D. Locker, "Dental Insurance and Use of Dental Services," *Health Reports* 11, 1 (1999): pp. 55-65. The following variables were included in the regression model: age, sex, province, education, income level, insurance status and job status.

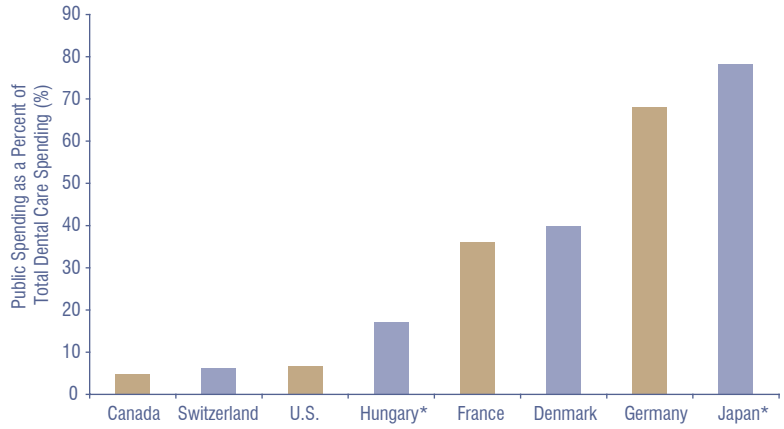
Canadian Spending Compared

The health care financing divide along the 49th parallel is much less pronounced for dental services than for other areas of the health system. In 2004, Canada spent about $9.3 billion, or $290 per person, on dental services. This puts us at the high end of the expenditure range among Organisation for Economic Co-operation and Development (OECD) countries, along with countries like Germany, Switzerland and the United States. Interestingly, rates of dental insurance and visits to dentists are also almost identical on both sides of the Canada/U.S. border, according to a 2002–2003 survey.[14] The proportion of dental costs that are paid by the public sector is also similar in Canada and the U.S.

There is, however, a difference in terms of unmet need. In a 2004 Commonwealth Fund International Health Policy survey, about one-quarter (26%) of Canadian adults reported that they needed dental care but did not see a dentist because of the cost.[15] Even more adults in the U.S. (38%) agreed with this statement. This was the highest level of unmet need reported across the five countries surveyed. The United Kingdom had the lowest rate, with 21% of adults reporting financial cost as a barrier to seeking dental care.

45 Public Spending Across Countries

The extent to which dental care is covered by public funds varies across OECD countries. In 2003, the public share of total dental care spending ranged from less than 10% in Canada, Switzerland and the U.S. to more than half of dental spending in Germany and Japan.



Notes: Comparisons are made against 11 other comparator countries that most closely follow the health care boundary proposed by the OECD.

*Percentages reported for Hungary and Japan are 2002 data. Data for Australia, South Korea, the Netherlands and the UK were not available.

Source: OECD Health Data 2005, OECD.

Aging Teeth?

Canadians are not only living longer, they are also keeping more of their natural teeth.[10] However, seniors are less likely to use dental care services than others.[2] In 2003, fewer than half (46%) said that they had consulted a dentist or orthodontist within the past year. This is significantly less than the overall average for teens and adults (64%).

A variety of potential explanations for this difference have been proposed. Some seniors may, for example, have restricted mobility, transportation challenges, difficulty affording dental care and/or a lack of dental insurance.[11, 12] Although almost two-thirds of teens and adults (61%) reported having some public or private dental insurance, less than a third of seniors (29%) were insured in 2003. Seniors with insurance were twice as likely to have consulted a dentist or orthodontist as the non-insured. Although most provinces and territories cover some oral health care for social assistance recipients, only a few—Alberta, Prince Edward Island and the Northwest Territories—fund some dental care for seniors as part of their public plans.[13]

The Public Sector and Dental Care

In 2004, public-sector spending on dental care in Canada was estimated at $424 million, or less than 5% of dental care spending outside of hospitals. With the exception of hospital-based services, coverage for dental care varies across the country. Where you live matters, but within each province or territory there are also differences by population group, by mix of services and by means of access to the services. For example, dental hygienists and assistants may provide education and fluoride programs for children in schools.[13]

In addition to provincial and territorial programs, some Canadians are eligible for coverage or services paid for by the federal government. As well, some communities provide dental services through public health or other programs.[16] The federal government alone paid $165 million for dental care in 2002–2003, about 39% of the public-sector total. Most of these costs were for services provided through a national health benefit program for about 765,000 eligible registered Indians and recognized Inuit and Innu.[17]

46 A Snapshot of Who's Covered

Most provincial and territorial plans include some dental coverage for children and social assistance recipients. Alberta, Nova Scotia, Prince Edward Island and the Northwest Territories also provide some dental coverage for seniors and/or cleft palate patients. The level of coverage, however, varies, and may be more extensive in some programs than in others. For example, some programs may cover only basic services, such as routine cleaning, x-rays or fillings. More comprehensive programs may include coverage for orthodontic care, root canals or dentures. Although municipal programs for dental care also exist, the table below includes only provincial and territorial programs.

	Children's Program	Social Assistance Program	Cleft Palate Program	Seniors' Program
B.C.	✓	✓		
Alta.	✓	✓	✓	✓
Sask.	✓	✓	✓[1]	
Man.		✓		
Ont.	✓			
Que.	✓	✓		
N.B.		✓		
N.S.	✓	✓	✓	
P.E.I.	✓	✓	✓	✓[2]
N.L.	✓	✓		
Y.T.	✓			
N.W.T.[3]	✓	✓	✓	✓
Nun.	✓			

Notes: 1 Available only for residents under the age of 22.
2 Includes only seniors residing in provincial and private long-term care facilities.
3 The Northwest Territories also provides some public dental care coverage for residents who meet the eligibility requirements for the Métis Health Benefits Policy.

Sources: Canadian Association of Public Health Dentistry, *Public Programs*, cited July 19, 2005, from <http://www.caphd-acsdp.org/index.html>; Ontario Ministry of Health and Long-Term Care, *Children's Health*, [online], cited August 16, 2005, from <http://www.health.gov.on.ca/english/public/program/child/cinot.html>.

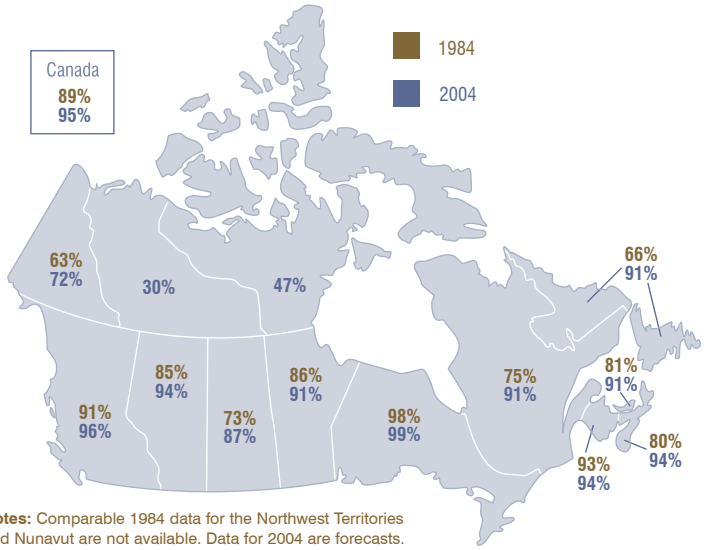
The Primary Payers

The private sector—through out-of-pocket payments and private insurance—dominates dental care financing in Canada. In 2004, the private sector paid $8.8 billion for dental care services, or 95% of total dental care expenditures. Insurers bear just over half of the private sector's share of dental costs. According to the 2002 Survey of Labour and Income Dynamics, 58% of Canadian employees were offered some dental insurance. During that year, private insurance companies paid out $4.4 billion for dental care.

Individual Canadians bear the balance of dental care expenses. Data from Statistics Canada show that Canadian households spent an average of $290 out-of-pocket on dental care in 2002. A closer look reveals that about half (52%) of households paid some amount out-of-pocket for dental care. These households spent an average of $558 on dental care services.

47 Private Share of Dental Care

In 2004, total spending on dental care was forecast at $290 per person. Over the last 20 years, dental care expenditures have doubled, after adjustment for inflation. Over this period, the private-sector share rose from 89% in 1984 to 95% in 2004. The map below shows the private share of spending on dental care per person in 1984 and 2004.

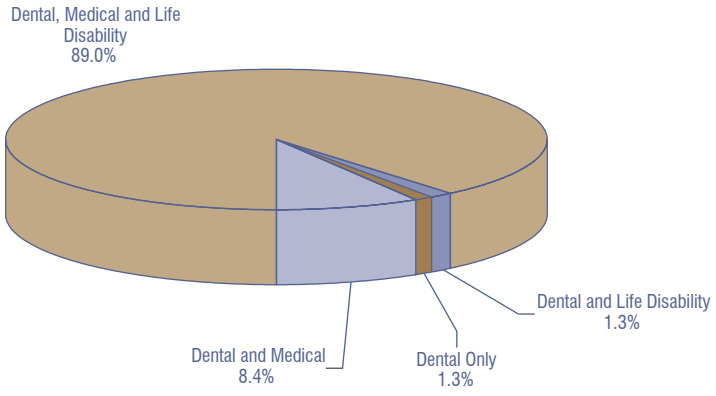


Notes: Comparable 1984 data for the Northwest Territories and Nunavut are not available. Data for 2004 are forecasts.

Source: National Health Expenditure Database, CIHI.

48 Private Dental Insurance

Employer benefits are an important source of coverage for many health services, including dental care. In 2002, about 58% of Canadian employees were offered some dental insurance by their employers. Among these individuals, most (89%) had benefits offered in conjunction with medical and life/disability insurance. The figure below shows the proportion of employees with dental insurance that were offered one, two or all three types of benefits.



Notes: Data include all persons who did some paid work in 2002. Information about non-wage benefit coverage is derived from the respondent's main paid job. The extent of dental coverage varies depending on the type of benefits offered by employers.

Source: Survey of Labour and Income Dynamics, Statistics Canada, 2002.

For More Information

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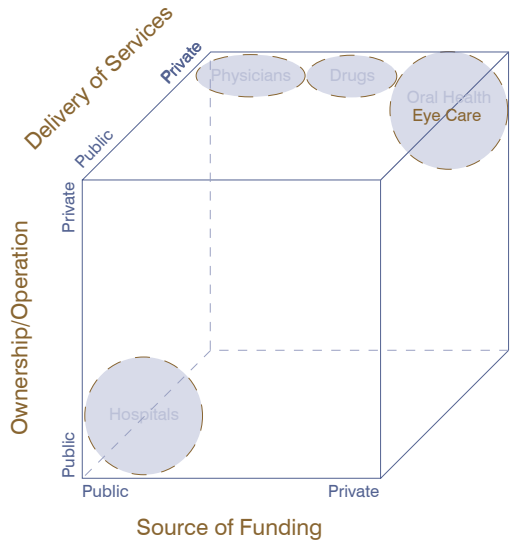
8 Eye Care

Canada's Health System
Financing, Ownership and Delivery



Source: Adapted from I. McKillop, J. Alpenberg, R. G. Evans, et al., *Private Sector Delivery: Scope and Extent in Canada's Health Care System* (Waterloo: University of Waterloo, 2004).

Quick Facts

Use

- 39% of Canadians aged 12 or older reported having consulted an eye care specialist (optometrist or ophthalmologist) within the past year in 2003.
- The rate of consultations varied according to where people lived and by age group.

Coverage

- 55% of Canadians aged 12 or older reported having some supplementary coverage for glasses and contact lenses in 2003—up from 47% in 1996–1997.
- High-income earners are four times more likely than low-income earners to have some coverage. Non-insured Canadians are about as likely to seek care as the average Canadian.

Spending

- $161 was spent, on average, per Canadian household on eye care goods and services in 2003. Average spending ranged from $125 in Nova Scotia to $208 in Alberta.

From contacts to laser eye surgery, a series of innovations has transformed vision care. Options now exist to care for once untreatable conditions, such as glaucoma, cataracts and diabetic retinopathy.[1] Same-day clinics now perform surgery that used to require several days in hospital. Nevertheless, sight disorders continue to cause substantial long-term disability. Health Canada estimated productivity losses at $633 million in 1998.[2]

Individuals and insurance companies finance most optometrist and optician services, as well as eyeglasses and contact lenses. Over the past two decades, total spending on these types of services has doubled (after adjusting for inflation).* The public sector plays a greater role in financing eye care services provided by physicians and hospitals. Public funding also covers the cost of routine eye examinations for some groups, but many provinces and territories have fully or partially delisted these tests.

Seeking Eye Care

In 2003, over one-third (39%) of Canadians aged 12 or older reported having consulted an eye care specialist (optometrist or ophthalmologist) within the last year—up from 35% in 1998–1999. In 2003, rates varied from 34% in Newfoundland and Labrador and British Columbia to 42% in Saskatchewan. Younger people (12 to 24 years of age) and seniors were more likely to have visited an eye care specialist than other adults (40% and 57%, respectively). This may reflect, in part, the fact that public insurance plans cover routine eye examinations for children and seniors in most areas of the country.

Many Providers, Many Services

Many different types of health professionals provide eye care services. For example, Canadians may visit one of the country's 3,800* optometrists to receive a routine eye examination. Optometrists are trained to assess the visual system for dysfunctions and refractive disorders. They may prescribe corrective and preventive eyewear for their patients. One of Canada's 5,900* opticians may fill these prescriptions. They are responsible for supplying, preparing and dispensing eyewear.[3]

- Ophthalmologists are physicians who specialize in the diagnosis and treatment of eye diseases. They provide comprehensive examinations, prescribe corrective lenses, perform surgery and prescribe and administer medication. There were 1,055 ophthalmologists who practised across the country in 2003, down from 1,085 four years earlier.
- Orthoptists evaluate and provide non-surgical treatment for visual disorders caused by an imbalance of the eye muscles. They work with ophthalmologists.
- Ophthalmic medical assistants work under the supervision of ophthalmologists and provide diagnostic and therapeutic procedures.[3]
- Family physicians also play an important role in the prevention and treatment of eye diseases. For instance, they treat common eye infections and refer patients to other eye care professionals as needed.[3]

*The coefficient of variation indicates that these Labour Force Survey estimates may be unreliable.

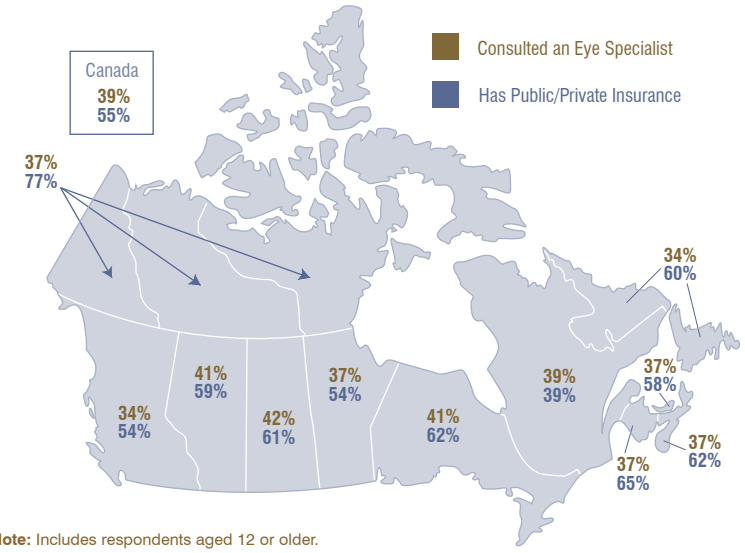
* Expenditures are inflation-adjusted using the consumer price index—Health Care Component.

Public Insurance Coverage

Most public-sector spending on eye care goes towards physician and hospital services. For example, fee-for-service payments to ophthalmologists alone totalled $407 million in 2002–2003. A smaller amount goes towards optometrist and optician services, eyeglasses and contact lenses. In 2004, the public sector spent a forecast $250 million in these areas, less than 10% of all such expenditures. The public share was highest in the territories, with Nunavut leading the way at 64%. Among the provinces, public-sector spending ranged from $1 per person in Newfoundland and Labrador to $11 in Ontario.

49 Insurance and Consultations for Eye Care

In 2003, the rate at which Canadians reported consulting an eye specialist ranged from 34% in Newfoundland and Labrador and British Columbia to 42% in Saskatchewan. The percentage of those with some public and/or private insurance to cover the costs of their eyeglasses and contact lenses also varied—from 39% in Quebec to 77% in the territories.



Note: Includes respondents aged 12 or older.

Source: Canadian Community Health Survey (Cycle 2.1), Statistics Canada, 2003.

The Ophthalmologist's Bill

Provincial governments paid ophthalmologists $407 million through fee-for-service insurance plans in 2002–2003. Almost two-thirds (61%) of this amount was for eye surgery and other procedures. The rest was for consultations and visits. Across the provinces, spending ranged from $9 per capita in Newfoundland and Labrador to $20 in Nova Scotia.

Where is this money going? Many provinces and territories cover routine eye examinations for children, seniors and social assistance recipients. In most cases, eye examinations are covered annually. However, there are some exceptions. For example, Saskatchewan typically pays for social assistance recipients aged 18 to 64 to have an eye examination every two years. The Nova Scotia government has a similar policy for children and seniors, as does the federal Non-Insured Health Benefits program for the adults it insures. New Brunswick, Prince Edward Island and Newfoundland and Labrador do not cover routine eye examinations.

Public plans also cover eye examinations where "medically necessary"—although what falls into this category varies across the country. Many provinces and territories cover eye examinations for persons with diabetes since they are more likely to develop serious eye problems.

About 5% of Canadians aged 12 or older reported having diabetes in 2003. In that same year, almost two-thirds (62%) of these individuals reported having consulted an eye care specialist in the past year, more than the overall national average of 39%. The Canadian Diabetes Association recommends that persons 15 years of age or older with Type I diabetes have annual eye examinations starting five years after onset. They also suggest that persons with Type II diabetes have an eye examination every one or two years.[4]

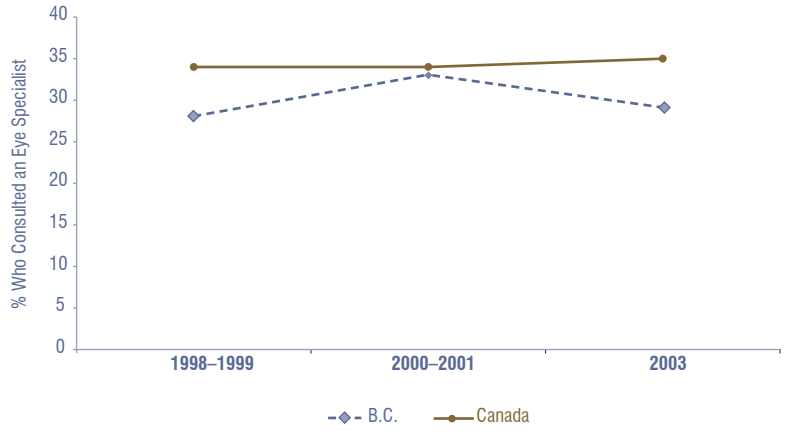
Most Canadians have supplementary insurance to cover part or all of the cost of eyeglasses or contact lenses. In 2003, over one-half (55%) of Canadian teens and adults reported having some supplementary coverage for eyeglasses and contact lenses—up from 47% in 1996–1997.[6]

Delisting of Eye Exams

There's a mix of coverage for routine eye examinations across the country. Some provinces—Prince Edward Island and New Brunswick—never paid for them. Others have reduced coverage over time. For example, Newfoundland and Labrador delisted this service for all residents on April 1, 1991. More recently, routine eye examinations for adults were delisted in British Columbia (November 19, 2001) and Ontario (November 1, 2004). Survey data suggest that adults in British Columbia were more likely to have consulted an eye care specialist in the year prior to delisting, but rates then returned to earlier levels.

Finding variations in the use of eye care services over time does not necessarily mean that delisting *caused* the changes observed. According to a preliminary study by researchers at the University of Toronto, other factors also need to be considered. They suggest that the demand for services can vary significantly across populations, and an individual's use of a service depends on factors such as income, sex, insurance status and use of the service prior to it becoming delisted.[5]

50 Delisting of Eye Exams

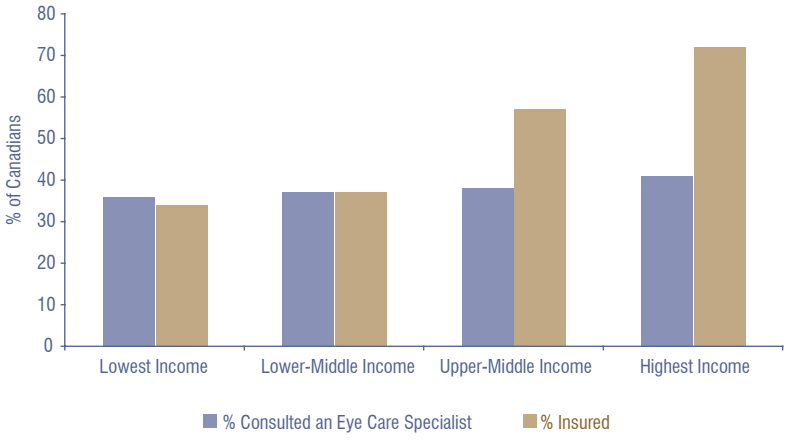


Note: Includes respondents aged 20 to 64 years.

Source: National Population Health Survey (Health File), Statistics Canada, 1998–99; Canadian Community Health Survey (Cycle 1.1), Statistics Canada, 2000–01; Canadian Community Survey (Cycle 2.1), Statistics Canada, 2003.

51 Income and Eye Care

Canadians with higher incomes are more likely to have some public and/or private insurance to fund the cost of eyeglasses and contact lenses. In 2003, 72% of high-income earners reported having some insurance, compared to only 33% of low-income earners. However, those with a lower income were about as likely as those with a high income to have consulted an eye care specialist in the past year.



Note: Includes respondents aged 12 or older.

Source: Canadian Community Health Survey (Cycle 2.1), Statistics Canada, 2003.

Access to Visual Aids and Rehabilitation

The 2001 Participation and Activity Limitation Survey reported that over 500,000 Canadian adults with a visual disability required the use of visual aids or devices.[7] The vast majority (87%) of these individuals reported that their needs for aids and devices were fully met. The remaining 13% said that they had partially or completely unmet needs, largely due to cost issues and a lack of information on where to obtain these products.

Currently, Alberta, Saskatchewan, Ontario and Quebec have public programs offering assistive devices to children, adults and seniors. Other areas of the country offer limited funding for employment-related assistive devices.[1, 8] Additionally, Quebec provides publicly funded rehabilitation after vision loss, including services such as orientation and mobility training. The Canadian National Institute for the Blind typically provides these services for individuals living outside of Quebec.[1]

There are, however, important coverage differences by income. Compared to those with low incomes, high-income Canadians were four times more likely to report having insurance. However, in 2003, those without insurance were about as likely to have consulted an eye care specialist (36%) as Canadians overall (39%).

More Than Pocket Change

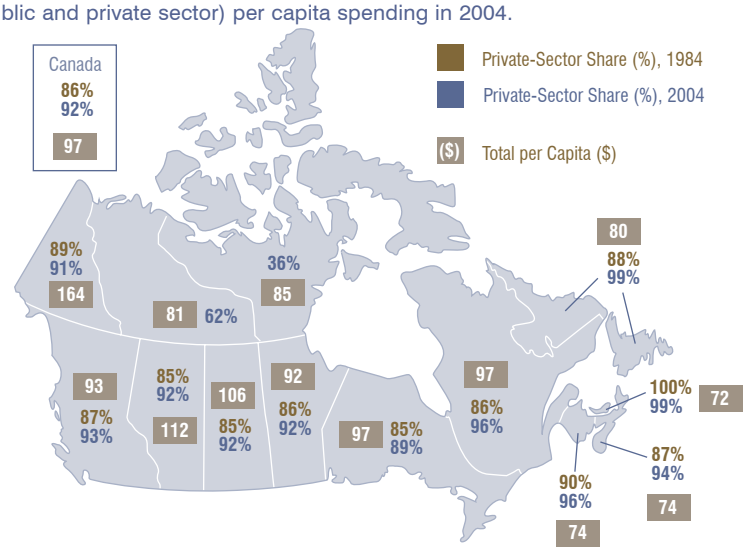
In total, Canada spent $3.1 million on vision care (provided by optometrists and opticians), eyeglasses and contact lenses in 2004. Today's spending levels are twice those in 1984, after adjusting for inflation. Over the past 20 years, the private-sector share of spending on these types of vision care has also continued to rise—from 86% in 1984 to a forecast 92% in 2004.

While most Canadians have some public or private insurance coverage, individuals paid about $2.0 million out-of-pocket in 2002. Although much of this money is spent on prescription eyewear, laser eye surgery is becoming an increasingly popular choice. According to a 2003–2004 poll by BBM RTS Canada, over 280,000 Canadian teens and adults said that they have had laser eye surgery.

Surgery recipients were mostly female (69%) or aged 55 or older (79%).[9] Laser eye surgery is commonly used to treat refractive disorders such as nearsightedness (myopia), farsightedness (hyperopia) and astigmatism (distorted vision from a distance).[10] These are generally considered elective procedures and, therefore, are not covered by public health insurance plans. Although we do not know the exact amount that Canadians are spending out-of-pocket for these services, we do know that the costs can vary significantly, depending on the patient's condition and circumstances and on fees set by each practice.[11]

52 Paying for Vision Care

The private sector paid for 92% of vision care provided by optometrists and opticians, eyeglasses and contact lenses in 2004, up from 86% in 1984. The map below compares the private share of spending on these services in 1984 and in 2004 for each province and territory. It also shows forecast total (public and private sector) per capita spending in 2004.

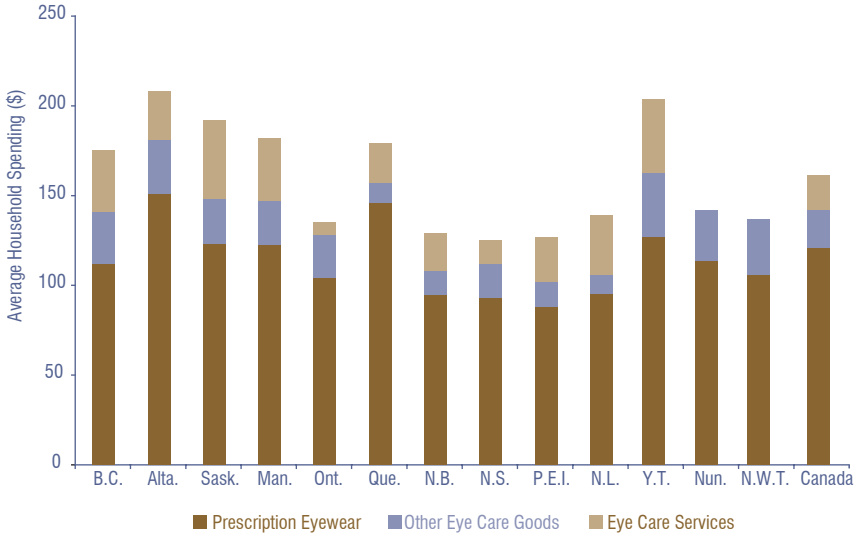


Note: Comparable data for 1984 are not available for the Northwest Territories and Nunavut. Data for 2004 are forecasts.

Source: National Health Expenditure Database, CIHI.

53 Household Eye Care Expenses

In 2003, Canadians spent an average of $161 out-of-pocket per household on eye care goods and services. Average spending ranged from $125 in Nova Scotia to $208 in Alberta. Most dollars spent went towards glasses and contact lenses, with smaller amounts going towards services such as eye examinations and surgery.



Note: Spending data on eye care services in the Northwest Territories and Nunavut are not available due to small sample size.

Source: Survey of Household Spending, Statistics Canada, 2003.

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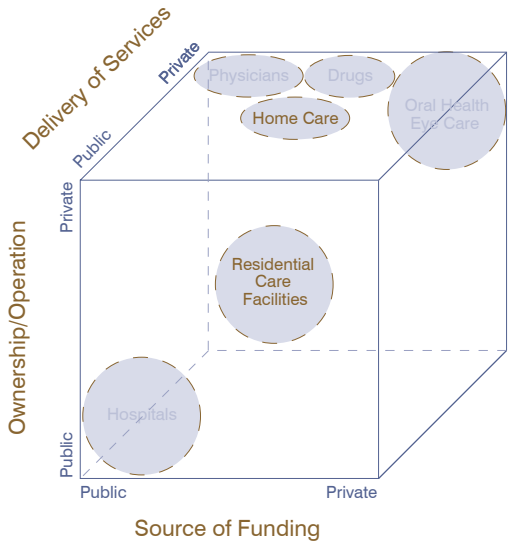
9 Continuing Care



Source: Adapted from I. McKillop, J. Alpenberg, R. G. Evans, et al., *Private Sector Delivery: Scope and Extent in Canada's Health Care System*, (Waterloo: University of Waterloo, 2004).

Quick Facts

Use

- Over 110,000 Canadians lived in the 1,343 residential care facilities that provided 24-hour personal care, medical and/or nursing supervision or institution-based care in the second quarter of 2001–2002.
- 1.2 million Canadian teens and adults reported using home care services in 2003.

Coverage

- 73% of spending on residential care in Canada was funded by the public sector in 2004.

Spending

- $178 to $665 per person was spent by public sources on residential care in 2004.
- $54 to $158 per person was spent by provinces and territories on public-sector home care in 2004.

Canadians are living longer than ever before. Our life expectancy is one of the best in the world—more than 79 years in 2001. That's up from 59 years in the early 1920s and 69 years in the 1950s.[1–3] And, compared with 20 years ago, older adults can, on average, look forward to better quality and longer lives.

However, not all Canadians enjoy good health. Continuing care services are designed to step in when we can no longer live safely at home or when we need support to do so. These services are provided both in the home and in specialized facilities.

The term "continuing care" reflects two complementary concepts: care that *continues* over a long period of time and an integrated program of care that *continues* across different parts of the health system, from community services to geriatric units in hospitals.[4] For example, the Alberta Long Term Care Association divides continuing care services into three streams:[5]

- **Home care** (including home health and home support services) assists individuals so that they can continue living in their homes;
- **Supportive living** options provide individuals with a secure living environment and various levels of assistance with everyday living; and
- **Continuing care** facilities offer a broad range of services, from nursing and personal care to accommodation and meals.

The way in which continuing care is structured, delivered and financed has become a key policy issue in many parts of the country. Population ageing is one factor driving this focus. If current patterns in the use of health services continue, projected average annual growth rates in spending between 2002 and 2026 due purely to ageing would be highest for residential care facilities (2.1% per year), followed by prescribed drugs (1.6%).[6] This chapter focuses on two vital components of continuing care—residential care and home care—and the role of the public and private sectors in paying for these services.

Residential Care Facilities

The 2001 Census counted 327,670 Canadians who made a health care institution their home.[7] However, seniors are less likely to do so than in the past. The proportion of those aged 75 and over living in such institutions fell to 14% in 2001, down from 17% in 1981.[8]

Many lived in residential care facilities approved, funded or licensed by provincial or territorial departments of health and/or social services. Examples include nursing homes and other homes for the aged; facilities for persons with physical disabilities, developmental delays, or psychiatric disabilities; facilities for persons with alcohol and/or drug problems; and facilities for emotionally disturbed children.

Use of Residential Care

Suppose that you could no longer live safely at home. In Newfoundland and Labrador, *nursing homes* provide support for people unable to live independently and/or who require 24-hour care. But you would choose a *residential continuing-care facility* in Yukon Territory, *a manor home* in Prince Edward Island and a *long-term care facility* in Ontario. In Manitoba, *personal care homes* offer facility-based long-term care. In Saskatchewan, however, they offer only non-professional services. The province's *special care homes* provide facility-based long-term care.[10]

Residential Care Quick Facts

- In 2001–2002, residential care facilities had almost 75% of the total number of beds available in the health system. The rest were hospital beds.[9]
- Facilities for the aged account for 77% of all residential care beds.
- Over the last 10 years, the occupancy rate for these beds has been between 97% and 98%.[9]

Not only do the names of facilities differ, but so do the types of services that they provide. In this section, we focus on facilities that provide residential care to clients needing 24-hour personal care, as well as medical and/or nursing supervision (type II care or higher). In 2001–2002, over 110,000 Canadians lived in the 1,343 facilities that met these criteria.

Starting in 1994–1995, Statistics Canada followed 2,300 people who were living in health care institutions across the country.[11] Most (68% of seniors) reported at least one chronic condition, such as incontinence, Alzheimer's disease or other dementia and the effects of stroke. By 1998–1999, about half were deceased.

The bad news is that two out of three residents had more chronic health problems than four years before. The most common new conditions were osteoporosis, heart disease and Alzheimer's disease and other forms of dementia. This trend is expected given that this population tends to be in poorer health and aged over the course of the study.

In spite of this, the good news for the others was that three out of five reported that their health in 1998–1999 was as good as, or better than, four years before. Additionally, a large proportion of residents had a social life that was at least as active as previously. For example, almost four in five of those with close family had contact at least as often with one family member as they did before they moved into a residential facility.

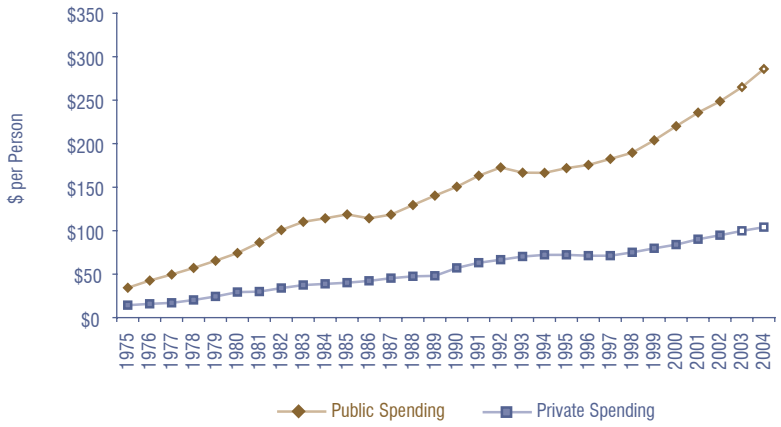
Spending on Residential Care

In 2004, Canadians paid $12 billion, or about $390 per person, for residential care. Private sources, mostly out-of-pocket payments, accounted for about 27% of this amount, with the remaining 73% coming from the public sector.

Residential care facilities are a unique part of Canada's health system. Canada's hospitals are largely funded by public monies; they tend to be owned publicly or by not-for-profit institutions. Doctors' offices are typically privately owned and operated, although most services are paid for from public funds. Residential care facilities, on the other hand, have a complex mix of public and private ownership and funding.

54 Rising Spending on Residential Care

Spending per person on residential care has increased significantly over time. Overall, it's up almost 63% since 1994. Growth in public-sector spending (up 72%) outpaced that in the private sector (up 44%) over this period.

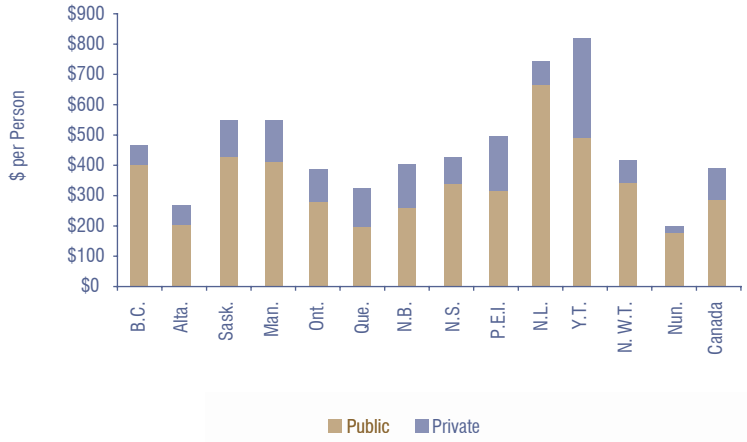


Note: Data for 2003 and 2004 are forecast.

Source: National Health Expenditure Database, CIHI.

55 Spending on Residential Care Across Canada

Some parts of the country spend much more per person on residential care than others. The mix of public and private financing also differs. In 2004, for example, Newfoundland and Labrador's public sector spent over $665 per person (roughly 90% of spending in this category) on residential care. In comparison, this figure was $178 (also approximately 90% of spending) Nunavut. Private-sector spending varied from just over $20 per person in Nunavut to $328 in the Yukon. Differences in spending may reflect variations in the age distribution coverage or co-insurance across the provinces and territories.



Note: Data for 2004 are forecast.

Source: National Health Expenditure Database, CIHI.

56 Out-of-Pocket Spending on Residential Care

Often, provincial and territorial governments and residents share the cost of residential care. In general, governments cover the costs of nursing and personal care, up to a daily limit. The resident is responsible for the cost of accommodation. Governments typically set accommodation rates, which apply to all residential care facilities in their jurisdiction. Daily charges vary across the country, as shown in the table below

	Daily Charge for Standard Accommodation	
	Minimum (per Day)	**Maximum (per Day)**
B.C.	$27/day[4]	$65/day[4]
Alta.	$40/day[1]	$40/day[1]
Sask.	$29/day[4]	$54/day[4]
Man.	$26/day[4]	$62/day[4]
Ont.	$49/day[1]	$49/day[1]
Que.	$30/day[3]	$49/day[3]
N.B.	$118/day*	$174/day*
N.S.	$110/day*	$199/day*
P.E.I.	$45/day[2]	$153/day[2]
N.L.	$93/day[1]	$93/day[1]
Y.T.	$18/day[2]	$21/day[2]
N.W.T	$10/day[5]	$24/day[5]
Nun.	Under consideration	Under consideration

Notes:
1 One charge for all residents.
2 Charge varies with level of care provided to residents.
3 Charge varies with number of beds per room.
4 Range of charges geared to income.
5 Charge varies with age.

*Charges for upgraded accommodation (for example, private rooms) may factor into these averages, since room rates are set differently than in other provinces.

Source: Canadian Health Care Association, 2004.

More than half of the residential care facilities in Canada are publicly owned and operated. But the picture varies across the country. For example, 95% of residential care facilities in Saskatchewan are publicly owned and operated. This compares to just under one-half (43%) in Ontario. Publicly owned residential care facilities tend to be similar to their privately owned counterparts. They average 84 beds each, compared with 86 beds in privately owned and operated facilities.[12]

Home Care Services

Home care is an increasingly important part of the health system. For some clients, it substitutes for care in hospital or long-term care facilities. For other clients, the goal is to remain independent in their own homes and communities or to provide preventive services with a view to reducing long-term care needs. Services may include home support (such as housekeeping) and clinical care (such as the administration of intravenous medication).[13] The importance of home care was highlighted in the Ten-Year Plan to Strengthen Health Care signed by first ministers in September 2004.

The role of home care has expanded in recent years. Experts suggest that a number of factors are driving this growth. For example, new technology makes it possible for people to receive certain forms of specialized care at home rather than in a hospital.[14] In addition, many suggest that it may be more appropriate and inexpensive to provide some services at home rather than in an acute care environment.[15]

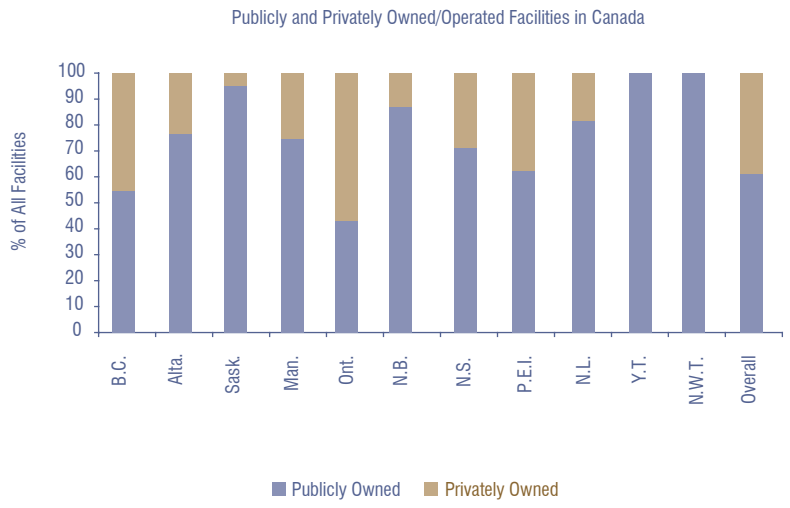
Use of Home Care Services

Home care programs served almost 1.2 million Canadians in 2003.[16] The use of home care services varies across the provinces and territories. In Nova Scotia, an estimated 5.9% of the population aged 12 or older received some form of home care service in 2004, compared to 3.7% in Newfoundland and Labrador.[16]

The services covered under public programs vary across the country. Provinces and territories tend to cover services such as assessment and case management, nursing care and home support for eligible clients. But only some include prescription drugs and various types of therapy in publicly funded home care programs. If home care clients would like to have services beyond those covered, they typically have to pay for them themselves, either out-of-pocket or through insurance plans. Some clients receive publicly funded services but also pay out-of-pocket for other home care services.

57 The Public/Private Mix

Ownership of residential care facilities varies widely across Canada. In 2001–2002, almost 60% of facilities in Ontario were privately owned, compared with 5% in Saskatchewan.



Note: Because of differences in reporting, these data do not include Quebec.

Source: Residential Care Facilities Survey, Statistics Canada.

Coverage of Home Care Services

A mix of federal, provincial and territorial programs, private insurance, user fees and other out-of-pocket payments funds home care services. In 2003, over 641,000 Canadians said that they had received home care services partially or fully covered by public funds in the past 12 months.

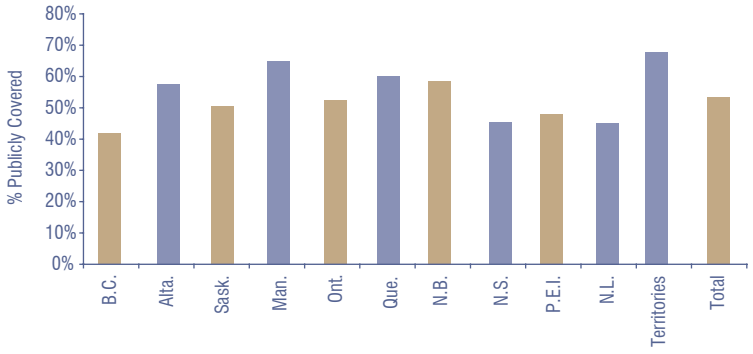
Roughly 726,000 home care recipients also paid out-of-pocket for their services. Currently, very little information is available about the amount spent by these individuals.

The Romanow Commission summarized the situation as follows:

> In most parts of Canada, medical and nursing services are usually delivered without charge to people at home, although the time professionals spend with care receivers is quite restricted. Care receivers often have to pay fees, however, for personal care and homemaking services, and there may be direct charges or partial payments based on income for prescription drugs, medical supplies or adaptive equipment.[17]

58 A Look at Public Home Care

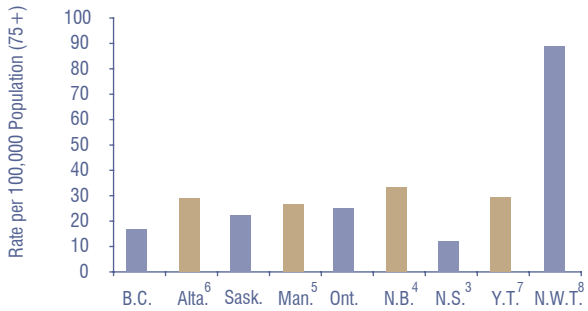
The proportion of residents across the country who received publicly funded home care depends on the programs available in their region and other factors. About 65% of home care recipients in Manitoba in 2003 reported that some or all of their care was covered by public funding, compared to 42% in British Columbia.



Source: Canadian Community Health Survey 2004 (Cycle 2.2), Statistics Canada.

59 Home Care Clients

Utilization of publicly funded home care services varies across Canada. For 2002–2003, provinces and territories counted the number of individuals aged 65 or older who received publicly funded home care services delivered in a home or community setting. These health and support services included home nursing care, rehabilitation therapy and home support services (which provide personal assistance with daily activities such as bathing, dressing and grooming). Rates per 100,000 population aged 75 or older ranged from 11,870 in Nova Scotia to 88,980 in the Northwest Territories.



Source: Performance Reporting Technical Working Group, 2004.

Notes:

1 Comparisons of N.L. to other jurisdictions are not recommended, since only home support is included. Data represent clients age 65 and over. Information for age 75 and over is not available.

2 It is possible that a small number of clients in N.L. were counted more than once.

3 Data are based on the distinct number of clients that required home care for the week ending November 6, 2004.

4 It is estimated that 35% of clients were counted more than once.

5 Excludes home care data for clients living in First Nations communities.

6 Results for 2003–2004 are available in the Alberta Health and Wellness Annual Report, 2003–2004.

7 May be underestimated because some clients who had received nursing services only may not have been counted in the region. Also excludes home care data for First Nations clients.

8 All numbers are estimates based on quarterly or monthly occupancy reports.

.. Not available: P.E.I. Nunavut, Quebec.

Spending on Home Care Services

In total, the provinces and territories spent about $3 billion on publicly funded home care services in 2000–2001.[20] That's over three times the amount they paid in 1990–1991. Looking even further back, the Romanow Commission estimated that provincial and territorial government spending on home care grew by an average of 14% per year between 1980–1981 and 2000–2001. That's much higher than the 6% growth in hospital spending and the 7% for all provincial and territorial health expenditures over the same period.[21]

Home care programs and spending vary from coast to coast. In 2000–2001, provincial government home care spending per person ranged from $54 in Prince Edward Island to $158 in New Brunswick.[20] The Romanow Commission estimated that, on average, provinces and territories spend 4% to 5% of their health budgets on home care. However, New Brunswick, home to the "hospital without walls" extramural program, allocates close to 10% of its health care budget to home care.[21]

There is also considerable variation internationally in the extent of public support for home care services. A recent OECD report shows that, relative to many other countries, Canada's publicly funded continuing care programs emphasize long-term care in institutions, rather than home care.

Most countries spend less than 1.5% of GDP on long-term care, with a range of 0.2% to 3% in 2000. Canada spent 1.1% that year. Norway and Sweden spent the most. They also have older populations with the highest proportion of those aged 80 and over. As well, the OECD indicates that they offer relatively comprehensive publicly funded services. Both factors may be important in explaining spending differences; the OECD points out that the relationship between long-term care spending and the proportion of elderly in the population is weak.

Assistive Devices

Many home care clients also need assistive devices. These devices aim to ease the strain of daily activities at home, at work or for leisure. They include medical equipment, mobility aids, information technologies, practical daily aids and various devices designed to cater to individual tastes and needs.[18]

To find out the average cost of assistive devices and supports, Human Resources Development Canada conducted a survey in 2003.[19] Sample findings based on the survey results include the following:

Homecare beds	$2,223
Physiotherapy—assessment	$48 per assessment
Physiotherapy—therapy session	$39 per hour
Registered nurse	$37 per hour
Registered nurse—special tasks	$40 per hour
Registered nursing assistant	$27 per hour
Orderly	$17 per hour

Government programs to support assistive devices differ across Canada. These programs vary both in the types of devices covered and the level of coverage available.

Beyond the Health Care System: Informal Support From Family and Friends

Although formal home care is key for many Canadians, so is informal support and care provided by family members, friends, neighbours or others. In 2002, about 1 million seniors living at home reported receiving such care due to a long-term health problem. More than a third (39% of women and 46% of men) received all of their care from informal sources.[22] That's about the same as in 1996, but women were less likely to receive formal care only. Rates dropped from 31% to 25% between 1996 and 2002.[22]

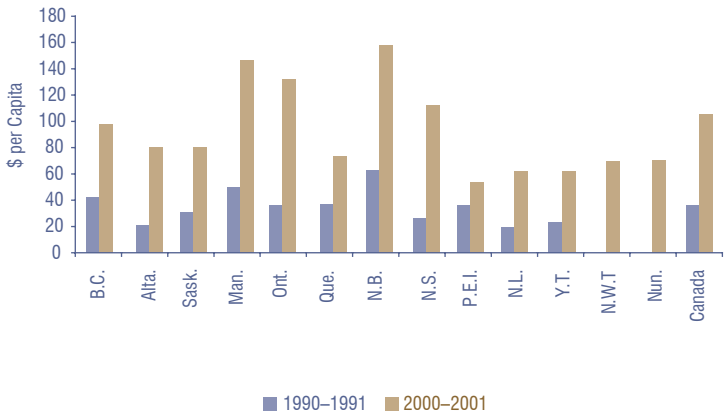
The type of care people seek differs by age. Younger seniors are more likely to receive all of their care from family and other informal sources. About half (47% of women and 52% of men) did so in 2002. By age 75, especially for women, care by home care programs and other formal sources tends to supplement or replace care by family and friends.

The Sandwich Generation

Informal caregivers—family members, friends and community networks—play an important role in providing voluntary home-care support services.[13] For the "sandwich generation," this can mean raising children and caring for aging parents or other dependent relatives at the same time.[24] According to a 2002 survey, roughly 30% of Canadians aged 45 to 64 with unmarried children under the age of 25 living at home were also caring for a senior. This translates to about 712,000 individuals.

60 Public-Sector Home Care Spending Across Canada

Home care spending per person increased significantly between 1990–1991 and 2000–2001, but varied across the country.



Note: These expenditure estimates have been compiled for the purpose of the home care feasibility study and should be used with caution. CIHI will continue to refine home care estimates.

Source: National Health Expenditure Database, CIHI.

A recent Statistics Canada study found that 1.7 million Canadians aged 45 to 64 provided informal care to 2.3 million seniors with a long-term disability or physical limitation in 2002.[23] Although men and women are equally likely to act as informal caregivers, there are differences in the amount of time spent providing support, as well as the activities that they perform. Women dedicated an average of 30 hours per month to their caregiving responsibilities, compared to 16 hours for men. Most of the care provided by women (67%) took the form of "inside activities," such as housekeeping. Among male caregivers, only 40% of their time was spent on inside activities.[23]

While most caregivers reported benefits from their role, caregiving also had consequences. More than one-third of caregivers aged 45 to 64 said that they incurred extra expenses due to their caregiving duties (42% of women and 38% of men). So did 27% of female caregivers 65 years of age or older and 30% of senior men. Caregiving may also affect work patterns and income. Half (51%) of these caregivers indicated that occasional relief through respite care would help allow them to continue providing care.

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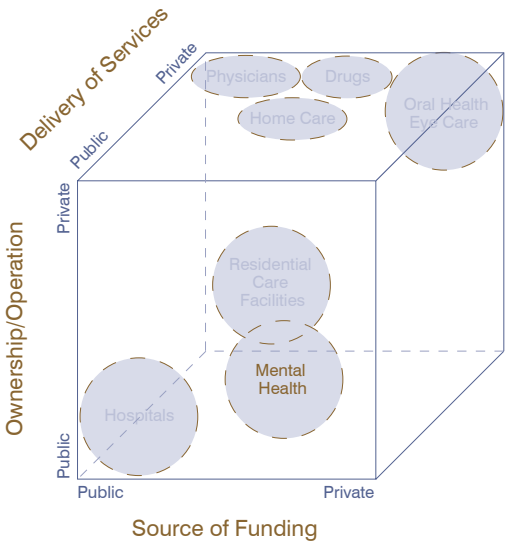
10 Mental Health Services



Source: Adapted from I. McKillop, J. Alpenberg, R. G. Evans, et al., *Private Sector Delivery: Scope and Extent in Canada's Health Care System*, 2004 (Waterloo: University of Waterloo, 2004).

Quick Facts

Use

- Roughly 7% of all psychiatric and general hospital admissions in Canada were primarily due to mental illness and/or addiction in 2002–2003.
- Only 32% of Canadians with symptoms suggesting one of the surveyed mental disorders or substance dependencies consulted a health professional for their mental health or addiction problems in 2001.

Coverage

- 47% to 72% (depending on the type of professional consulted) of Canadians aged 20 or older who consulted a mental health professional in 2001 reported having some form of government or private insurance coverage.

Spending

- Mental illnesses were the second-highest source of direct health care costs in Canada in 1998, after cardiovascular diseases (based on attributable disease categories).
- The economic cost (direct and indirect) of mental illnesses in Canada was approximately $14 billion in 1998.
- Average acute care and psychiatric hospital costs per patient were highest for patients with bipolar disorder ($7,980), schizophrenia ($6,972) and depression ($5,568) in 2002–2003.

Health Canada estimates that about one in five Canadians suffer from a mental illness at some point in their life.[1] The *Global Burden of Disease* study conducted by the World Health Organization, the World Bank and Harvard University reported that mental illness, including suicide, accounted for 11% of the total burden of disease worldwide in 1990. The study estimates that this number will increase to approximately 15% by 2020 in established market economies, such as Canada.*

In 1998, based on costs attributable to a disease category, mental disorders were the second-largest source of direct health care costs in Canada after cardiovascular diseases.[2] Added to this are indirect costs of approximately $3 billion that reflect mortality and short- and long-term disability. Other factors, such as under-performance within the workplace or at school, as well as social consequences, such as stigmatization and social exclusion, may also be important but are rarely included in economic analyses.

Thanks to a recent Statistics Canada survey, we have better information than ever before on how often some mental illnesses occur. However, we still have a limited understanding of the total costs of care and sources of payment. This is particularly true for care that occurs through formal or informal support networks and community-based services, as well as care that occurs in conjunction with treatment for other health conditions. This chapter focuses on what we *do* know about utilization, coverage and spending on mental health services, with particular emphasis on services received in hospitals.

Who Is and Isn't Using Mental Health Services

Mental illness is common. Some 2.6 million Canadians aged 15 or older reported symptoms or feelings associated with major depression, mania disorder, one of three types of anxiety disorders, or dependence on alcohol or illicit drugs in the year prior to a 2002 Statistics Canada survey.[3] That's more than 10% of all respondents.

Most of those reporting symptoms consistent with the mental disorders or addictions surveyed said that they had not sought or received professional help. Only about a third (32%) said that they had consulted a health professional (for example, a psychiatrist, family physician, medical specialist, psychologist or nurse) about problems concerning emotions, mental health or use of alcohol and drugs in the previous year.

* The World Health Organization expresses "disease burden" in disability-adjusted life-years (DALY), which is the sum of years of potential life lost due to premature mortality and the years of productive life lost due to disability.

On the other hand, about one in five (21%) individuals with any of the surveyed mental disorders or substance dependencies said that they had needed help in the past year, but did not receive it. Respondents reported several reasons for not seeking treatment. Many (34%) of those aged 20 or older stated that they preferred to manage the problem themselves. About one in five (20%) also reported that they did not get around to getting help. Only 12% said that the cost of these services prevented them from getting help.

Was Cost a Factor?

In 2002, Statistics Canada asked Canadians aged 20 or older who had stopped consulting a health professional about their mental health and/or addiction problems in the previous year why they stopped. Many (29% to 53%, depending on the type of professional consulted) reported that they had stopped seeing the health professional because they felt better. The extent to which cost was a factor in their stopping treatment varied by the type of professional consulted, as shown in the table below.

Type of Health Professional Consulted	% of Respondents Who Said They Stopped Because They Couldn't Afford the Service
Family physician/GP	2
Psychiatrist	6
Psychologist	6
Nurse	0
Social worker/counsellor	4
Spiritual/religious advisor	0
Other MD*	6
Other professionals**	16

Notes: * "Other MD" refers to cardiologists, gynaecologists, urologists and allergists, among others.

** "Other professionals" refers to acupuncturists, chiropractors, herbalists, hypnotists and other complementary and alternative professionals.

Source: Canadian Community Health Survey (Cycle 1.2) Mental Health and Well-Being, Statistics Canada, 2002.

Individuals who did receive treatment for their mental health and/or substance dependence problem used a wide variety of services. For most Canadians living with mental illness, their first—and often only—contact with the health system is with a family physician.[1] Today's doctors tend to provide a different mix of services than in the past. In 2001, 85% of family doctors were providing mental health counselling in their offices—up from 82% in 1992.[4]

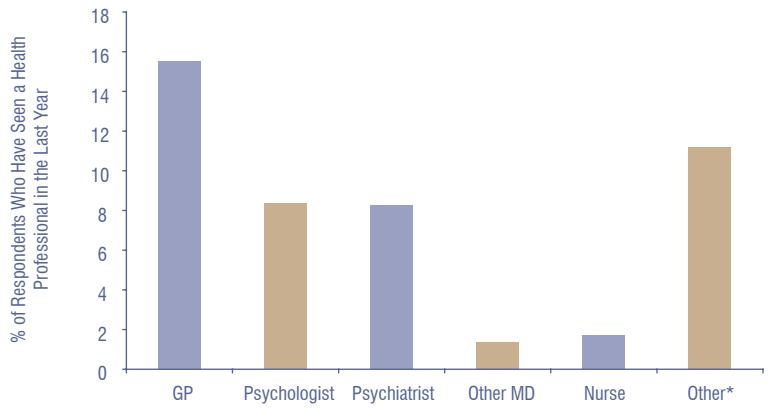
The extent to which Canadians use mental health services varies by age and other factors. For example, although mental health or substance problems are more common among those 15 to 24 years of age than among older adults, fewer 15-to-24-year-olds reported having used mental health services in the 2002 survey. Only one-quarter of people in this age group reporting symptoms consulted with a health professional or used some type of resources, compared to 32% overall.[3]

According to Statistics Canada, men and women are equally likely to report symptoms of selected mental health problems or substance dependence. However, there are differences in the types of mental health problems they report. Across all age groups, over 22% of women reported that they needed help for their mental health and substance use problems, but did not receive it, while less than 20% of men reported unmet needs. Only 9% of seniors aged 65 or older reported having unmet needs for mental health resources. This is lower than the 21% reported overall.

Although most care for mental illness is provided in the community, some Canadians require overnight care. In 2002–2003, about 7% of all psychiatric and general hospital admissions were cases with a primary diagnosis of mental illness and/or addiction.[6] This translated to a rate of about 600 hospital stays per 100,000 population. Across the country, rates varied between 606 per 100,000 in Quebec to 1,274 per 100,000 in Prince Edward Island in 2002–2003. Several factors may contribute to these variations, including demographic differences, population health, how care is organized and delivered as well as the availability and accessibility of resources in the community and in hospital.

61 Who Do Canadians Consult About Their Mental Health Problems?

In 2003, one-quarter (25%) of Canadians with selected mental health problems reported that they had spoken with a physician (that is a GP, psychiatrist or other MD) in the previous year about the problem. Consultations with other types of professionals were less common.



Note: *"Other" refers to acupuncturists, chiropractors, herbalists, hypnotists and other complementary and alternative professionals.

Source: Canadian Community Health Survey (Cycle 1.2), Mental Health and Well-Being, Statistics Canada, 2003.

A Focus on Manitoba

Researchers in Manitoba[5] found that people living with mental illness used more than twice as many health services as the rest of the Manitoba population between 1997–1998 and 2001–2002. Most of this care was not primarily for their mental illness. Only about 1 in 5 physician visits and 1 in 10 hospital visits were primarily for mental illness.

The researchers also showed that, while those living in lower-income areas had the highest treatment rate for mental illness, those in higher-income areas were more likely to receive treatment from psychiatrists. While the most frequent users of psychiatric services were people aged 35 to 55, those over 60 were the most frequently diagnosed with mental illness.

The rates of admission, as well as the number of hospital days due primarily to mental illness and/or addiction, are falling. The 2002–2003 admission rate of 606 per 100,000 population is significantly less than the 1973 rate of 894 per 100,000. In total, overnight stays primarily for mental illness and/or addiction accounted for about 7.8 million days of care in general and psychiatric hospitals in 2002–2003, versus 8.2 million in 2001–2002.

Most admissions for mental illness occur in general hospitals. In 2002–2003, there were 525 admissions primarily due to mental illness and/or addiction to general hospitals for every 100,000 people, compared to only 81 admissions to psychiatric hospitals (about 13% of the total). However, those admitted to psychiatric hospitals tended to have much longer stays. Patients in these hospitals stayed an average of 140 days, compared to 26 days for general hospitals.

Who's Paying for Mental Health Care?

The *Canada Health Act* covers "medically necessary" inpatient and outpatient mental health services, including those provided by physicians (including psychiatrists). For example, in 2002–2003, fee-for-service payments to physicians for psychotherapy or counselling services amounted to roughly $733 million.[7] That represents 8% of total physician fee-for-service payments.**

The *Canada Health Act* does not mandate public coverage of mental health services outside of hospitals, but all the provinces and territories have elected to cover them to varying degrees. Across the country, health insurance plans do not tend to cover services by allied health professionals such as psychologists and social workers, but a province or territory may pay for some care through other programs (for example, social assistance and child welfare).[8]

As a result, some services are paid for by public funds, while others are not. In 2002, Statistics Canada asked individuals who had had contact with a health professional about problems with their emotions, mental health or use of alcohol or drugs whether these services were covered through private, government or employee-paid insurance plans. The extent of coverage depended on the type of health professional consulted. More than half of those who consulted a psychologist, nurse, social worker or counsellor (61% to 72%) said that their care was fully or partly covered. Fewer of those who consulted other professionals (47%) had at least some coverage.

** Fee-for-service payments include all billings from any location (such as a hospital, private office or nursing home), but do not include services provided by salaried physicians.

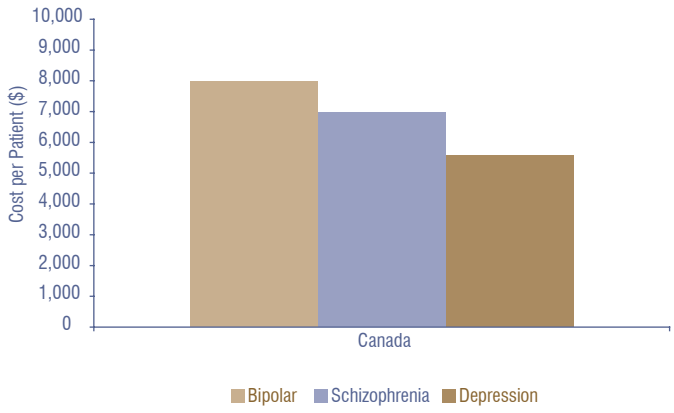
The Cost of Mental Health Care

Health Canada estimates that about $4.7 billion of Canada's direct health care costs in 1998 went towards care for mental disorders.[2] Although most care for mental illness occurs in the community, hospitals accounted for $2.7 billion of this total. Drugs ($1.1 billion) and physician care ($0.9 billion) accounted for the majority of the remaining direct costs.

Another study calculated cost estimates for non-medical mental health services and lost productivity due to short-term disability, and estimated the total to be $14.4 billion.[9] This study incorporated data from the 1996–1997 National Population Health Survey on depressed and distressed persons aged 12 or older who made publicly and non-publicly insured visits to social workers and psychologists. Direct costs for treating diagnosed mental disorders were roughly $6.3 billion, and indirect costs related to lost productivity and premature death totalled $8.1 billion. The vast majority (96%) of direct costs included in this study were for publicly insured services. The remaining 4% of direct costs (or $278 million) were for the non-publicly insured 3 million visits to psychologists and social workers that took place on a fee-for-service basis outside institutions. This amount may reflect the out-of-pocket spending by patients for these visits, but little data exists about the extent of private insurance coverage. These figures may also underestimate spending, because only selected mental disorders were studied, and spending on over-the-counter medications and for other community services were not included.

62 How Much Are Hospitals Spending for Mental Health Illnesses?

Some mental health problems are more expensive to treat than others. Among patients of all ages hospitalized in acute, sub-acute and psychiatric facilities primarily for mental illness and/or addiction, the average cost of an admission in 2002–2003 was highest for bipolar patients ($7,980). Next most expensive was treatment for patients with schizophrenia ($6,972) or depression ($5,568). Of note is that in all cases, these costs are averages for typical patients and do not include cases where patients died, were transferred, signed out against medical advice or had unusually long hospital stays.



Notes: Includes all patients admitted in acute, sub-acute and psychiatric care hospitals and for whom the most responsible diagnosis was a mental illness. Does not include data from Quebec and the territories.

Source: Canadian MIS Database and Discharge Abstract Database, CIHI.

The 2002 Canadian Community Health Survey (CCHS) found that roughly 92% of Canadians aged 20 or older reported no out-of-pocket spending for services or products to help them with their mental health or addiction problems over the 12 months prior to the survey. About 8% said that they had spent less than $5,000 out-of-pocket, while 0.1% had spent $5,000 or more.

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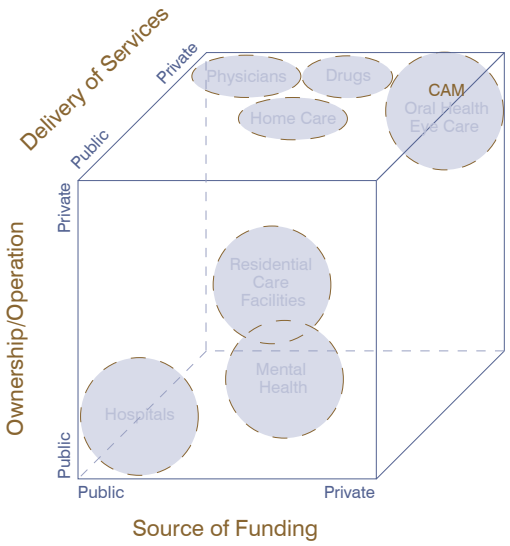
11 Complementary and Alternative Medicine



Source: Adapted from I. McKillop, J. Alpenberg, R. G. Evans, et al., *Private Sector Delivery: Scope and Extent in Canada's Health Care System*, (Waterloo: University of Waterloo, 2004).

Quick Facts

Use

- 3.3 million Canadians aged 12 or older reported having consulted with a complementary and alternative medicine practitioner in the year prior to the 2003 Survey.
- 75% of Canadians aged 15 or older reported using one or more natural health products in 2001.

Coverage

- Public health insurance plans in Manitoba, Saskatchewan and Alberta partially cover chiropractic services.
- British Columbia's public health insurance partially covers naturopathy provided by naturopathic physicians.
- Private health insurance coverage for these and other services varies across the country.

Spending

- Researchers estimate that $3.8 billion was spent on complementary and alternative therapies in 1997.

For centuries, echinacea was used by Native Americans to fight off infections; women in Ancient Greece used Queen Anne's lace as a contraceptive; and people in China took ginkgo to prevent deterioration of the mind.[1]

People have used natural remedies for treating ailments and diseases for thousands of years, well before the first hospital walls were built. Today, Canadians rely on both traditional and new therapies. Massage therapy, traditional Aboriginal and Chinese medicine, homeopathy and herbal products are examples of healing practices and products that are used along with (*complementary to*) or instead of (*alternatives for*) conventional medical treatment.[2] Currently, a growing number of people use natural health products or consult with providers of complementary and alternative therapies.

Canadians pay out-of-pocket for most of these services and products, since public and private health insurance plans tend to provide only limited coverage.[3] However, despite the growing popularity of these services, little is known about rates of utilization or related costs and spending.

Seeking Care Outside the Doctor's Office

Many Canadians substitute or supplement the array of services provided by hospitals and doctors.

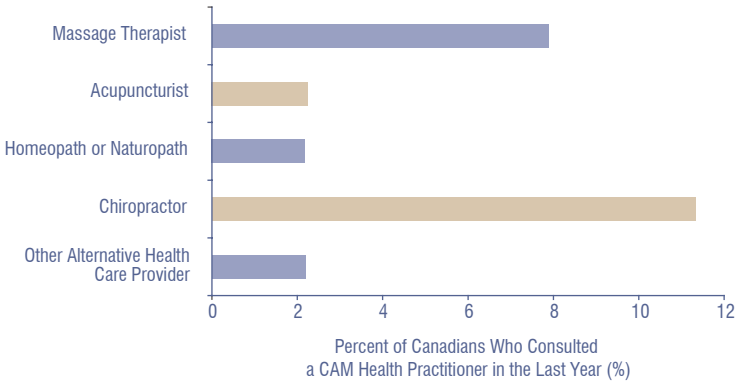
A 2003 Statistics Canada survey estimated that 3.3 million Canadians (12% of the population) aged 12 or older had used the services of complementary and alternative (CAM) care providers in the year prior to the survey, up from 5% in 1994-1995.[4] Massage therapists were most often consulted (8%), followed by acupuncturists (2%) and homeopaths or naturopaths (2%).[5] In a separate survey question, 11% of CAM users reported consulting a chiropractor.

The use of complementary and alternative therapists is highest in Western Canada.[5] Other groups who are more likely to visit a chiropractor or other complementary and alternative care provider include:

- Females (almost twice as likely as males)
- People who are middle-aged
- People with higher incomes and more education
- People with chronic health conditions, such as cancer or heart disease[6]

63 What Type of Services Are Canadians Using?

A 2003 Statistics Canada survey estimated that 3.3 million Canadians (12% of the population) aged 12 or older had used the services of complementary and alternative (CAM) care providers in the year prior to the survey, up from 5% in 1994–1995.[4] Massage therapists were most often consulted (8%), followed by acupuncturists (2%) and homeopaths or naturopaths (2%).[5] In a separate survey question, 11% of CAM users reported consulting a chiropractor.



Notes: "Other alternative health care provider" includes Feldenkrais or Alexander teachers, relaxation therapists, biofeedback teachers, Rolfers, herbalists, reflexologists, spiritual or religious healers and other alternative health care providers.

Source: Canadian Community Health Survey (Cycle 2.1), Statistics Canada, 2003.

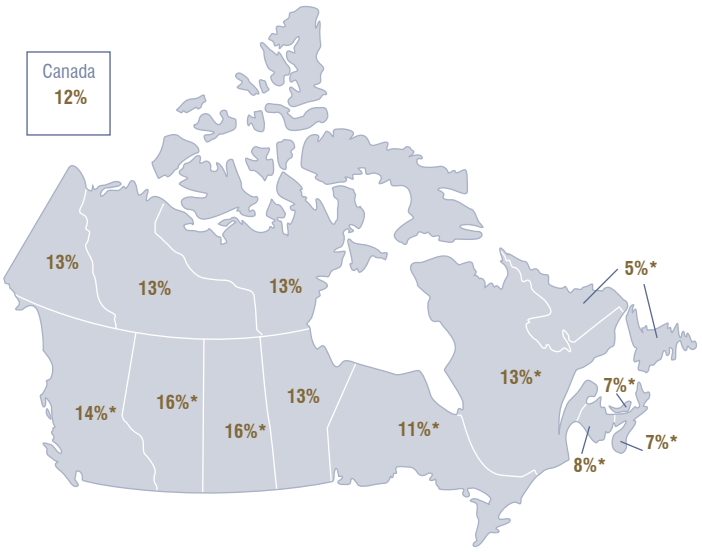
The use of natural health products—such as herbal remedies, homeopathic medicines, vitamins, minerals and much more—is also common. For example, Statistics Canada found that over one-third (38%) of Canadians who treated their cold or flu symptoms themselves in 1998–1999 reported that they used herbal or vitamin supplements. Another quarter (26%) reported using home remedies.

Similar to findings about the use of complementary and alternative care providers, the use of natural health products is also more common in Western Canada. According to the 2001 Berger Population Health Monitor survey, British Columbia had the highest use: 41% of respondents reported using three or more natural health products in the previous six months.[7] Those living in the Atlantic provinces reported the lowest use (15%). The average for Canada as a whole was 31%.

Over the years, more Canadians are reporting that they take natural health products instead of a drug prescribed by a physician. In the 2001 Berger Population Health Monitor Survey, roughly 7% said that they did so, up from 2% in 1999. Additionally, the number of Canadians who reported substituting a natural health product for over-the-counter medication doubled from 15% in 1998 to 30% in 2000.[7]

64 Who Uses the Most CAM Services?

Overall, 13% percent of Canadian adults aged 20 or older reported visiting some type of complementary of alternative health care provider in the year prior to the 2003 Canadian Community Health Survey. Those living in Western Canada reported the highest rates of CAM use.

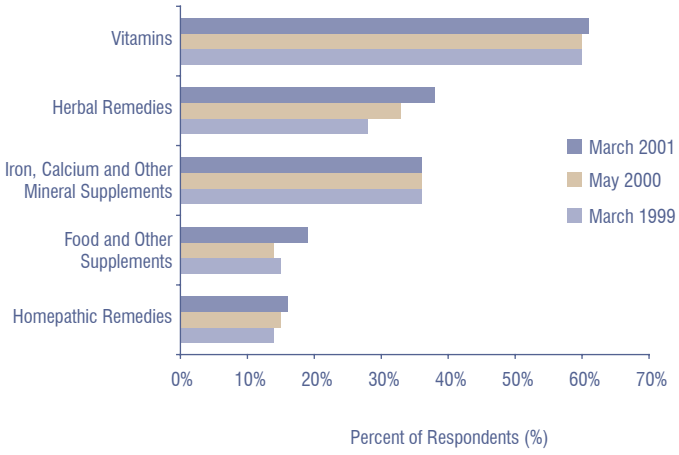


Note: *Statistically significantly different from the Canadian rate (p = 0.05).

Source: Canadian Community Health Survey (Cycle 2.1), Statistics Canada, 2003.

65 Use of Natural Health Products

In March 2001, more than 7 in 10 Canadians aged 15 or older reported using one or more natural health products six months prior to survey. For example, almost 40% reported using herbal remedies in 2001, up from 30% in 1999.



Notes: The rates for selected types of products (shown above) are estimated to be correct within 2 percentage points, 19 times out of 20.

Source: E. Berger, The Berger Population Health Monitor (Toronto, 2001).

Coverage for CAM

Most Canadians pay out-of-pocket for many complementary and alternative medical services and therapeutic products. Chiropractic and naturopathic services are the two services most likely to be covered under public health insurance. In 2004, Ontario delisted chiropractic services, but Manitoba, Saskatchewan and Alberta continue to partially insure them.[8, 9] British Columbia also partially covers naturopathy provided by physicians.[10] In some cases, private health insurance offers partial or full coverage for chiropractic services, naturopathy, acupuncture, homeopathy and/or massage therapy. In general, such coverage tends to be limited and varies considerably across insurance plans.

Spending

Very little information is available about spending on complementary and alternative therapies and natural health products. A 1997 study estimated that Canadians spent $3.8 billion on complementary and alternative care.[3] This money paid for fees to service providers ($1.8 billion) and other resources, such as books, medical equipment, herbs, vitamins and special diet programs.

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National Health Expenditure Trends Data Tables

Source: Adapted from *National Health Expenditure Trends 1975 to 2004*, by the Canadian Institute for Health Information, Ottawa, 2004.

Table A.2.1

Total Health Expenditure by Source of Finance, Canada, 1975 to 2004—Current Dollars

	Provincial Government	Federal Direct	Municipal Government	Social Security Funds	Total of Public Sector	Private Sector	Total
	A	B	C	D	A+B+C+D	F	E+F
Year			($' 000,000)		E		G
1975	8,709.3	398.3	71.6	121.1	9,300.3	2,899.2	12,199.4
1976	10,129.9	439.7	105.8	141.9	10,817.2	3,232.6	14,049.8
1977	11,102.0	475.2	114.2	153.1	11,844.6	3,605.4	15,450.0
1978	12,269.4	485.6	111.7	173.8	13,040.5	4,066.3	17,106.8
1979	13,696.6	512.8	156.0	186.8	14,552.3	4,617.4	19,169.7
1980	15,794.0	582.1	234.0	231.7	16,841.8	5,456.5	22,298.4
1981	18,655.5	692.7	275.4	319.0	19,942.6	6,334.1	26,276.7
1982	22,002.1	854.8	250.8	339.1	23,446.8	7,312.3	30,759.1
1983	24,510.1	994.9	222.2	352.7	26,080.0	7,958.6	34,038.6
1984	26,243.9	1,106.1	214.5	392.3	27,956.9	8,786.3	36,743.1
1985	28,202.8	1,157.7	273.1	461.3	30,094.9	9,746.9	39,841.7
1986	30,501.5	1,260.8	310.2	456.2	32,528.6	10,808.7	43,337.3
1987	32,821.9	1,349.7	404.6	478.5	35,054.7	11,733.5	46,788.2
1988	35,806.2	1,522.8	303.5	530.3	38,162.8	12,796.4	50,959.2
1989	39,332.1	1,686.6	326.4	566.0	41,911.1	14,184.3	56,095.5
1990	42,469.7	1,970.4	364.6	640.8	45,445.5	15,577.1	61,022.6
1991	46,176.8	2,110.0	374.7	720.8	49,382.2	16,906.9	66,289.1
1992	48,337.8	2,199.9	396.9	759.1	51,693.8	18,112.0	69,805.7
1993	48,572.6	2,280.9	383.7	742.5	51,979.7	19,578.1	71,557.7
1994	48,885.6	2,519.8	446.1	747.2	52,598.7	20,486.8	73,085.4
1995	48,936.4	2,667.0	394.9	792.4	52,790.6	21,285.3	74,075.9
1996	49,095.6	2,606.3	348.1	827.1	52,877.1	21,819.7	74,696.8
1997	50,904.3	2,827.2	318.7	951.4	55,001.5	23,433.8	78,435.3
1998	54,193.6	3,026.7	765.4	1,047.0	59,032.8	24,706.8	83,739.6
1999	58,374.6	3,152.8	582.6	1,174.8	63,284.8	26,621.9	89,906.6
2000	63,284.3	3,614.5	688.3	1,370.7	68,957.9	28,945.5	97,903.4
2001	68,047.3	4,258.7	803.1	1,480.5	74,589.7	31,721.1	106,310.8
2002	72,828.3	4,279.5	873.5	1,557.8	79,539.1	34,502.5	114,041.6
2003 f	78,804.9	4,508.6	981.6	1,738.6	86,033.7	36,970.0	123,003.7
2004 f	83,427.6	4,737.5	1,035.5	1,853.2	91,053.7	39,221.5	130,275.2

f = forecast
CIHI 2004

Table A.2.3

Total Health Expenditure by Source of Finance, Canada, 1975 to 2004—Current Dollars

	Provincial Government	Federal Direct	Municipal Government	Social Security Funds	Total of Public Sector	Private Sector	Total
	A	B	C	D	A+B+C+D	F	E+F
Year			($' per Capita)		E		G
1975	376.32	17.21	3.10	5.23	401.86	125.27	527.13
1976	431.98	18.75	4.51	6.05	461.29	137.85	599.14
1977	467.93	20.03	4.81	6.45	499.22	151.96	651.19
1978	512.01	20.26	4.66	7.25	544.19	169.69	713.87
1979	565.93	21.19	6.45	7.72	601.29	190.79	792.08
1980	644.23	23.74	9.54	9.45	686.97	222.57	909.54
1981	751.62	27.91	11.10	12.85	803.48	255.20	1,058.67
1982	875.97	34.03	9.99	13.50	933.49	291.12	1,224.61
1983	966.22	39.22	8.76	13.90	1,028.11	313.74	1,341.85
1984	1,024.85	43.20	8.38	15.32	1,091.74	343.11	1,434.85
1985	1,091.32	44.80	10.57	17.85	1,164.54	377.16	1,541.70
1986	1,168.59	48.30	11.88	17.48	1,246.25	414.11	1,660.36
1987	1,240.96	51.03	15.30	18.09	1,325.38	443.63	1,769.01
1988	1,336.28	56.83	11.33	19.79	1,424.23	477.56	1,901.79
1989	1,441.70	61.82	11.97	20.75	1,536.23	519.92	2,056.15
1990	1,533.34	71.14	13.16	23.13	1,640.78	562.40	2,203.18
1991	1,647.32	75.27	13.37	25.71	1,761.68	603.14	2,364.82
1992	1,704.03	77.55	13.99	26.76	1,822.33	638.49	2,460.82
1993	1,693.50	79.52	13.38	25.89	1,812.29	682.59	2,494.88
1994	1,685.76	86.89	15.38	25.76	1,813.80	706.46	2,520.26
1995	1,670.06	91.02	13.48	27.04	1,801.59	726.40	2,527.99
1996	1,658.03	88.02	11.75	27.93	1,785.73	736.88	2,522.61
1997	1,702.06	94.53	10.66	31.81	1,839.06	783.55	2,622.61
1998	1,797.02	100.36	25.38	34.72	1,957.48	819.26	2,776.74
1999	1,919.97	103.70	19.16	38.64	2,081.47	875.61	2,957.08
2000	2,062.12	17.78	22.43	44.67	2,246.99	943.19	3,190.17
2001	2,193.57	137.28	25.89	47.73	2,404.47	1,022.56	3,427.03
2002	2,321.40	136.41	27.84	49.65	2,535.30	1,099.77	3,635.07
2003 f	2,489.06	142.41	31.00	54.92	2,717.39	1,167.70	3,885.09
2004 f	2,611.49	148.30	32.41	58.01	2,850.21	1,227.73	4,077.94

f = forecast
CIHI 2004

Table A.3.1.1

Total Health Expenditure by Use of Funds, Canada, 1975 to 2004—Current Dollars

	Hospitals	Other Institutions	Physicians	Other Professionals			
				Dental Services	Vision Care Services	Other	Sub-Total
Year	A	B	C				D
			($' 000, 000)				
1975	5,454.9	1,125.0	1,839.9	741.7	226.1	128.4	1,096.2
1976	6,357.3	1,368.6	2,071.0	869.1	260.1	145.5	1,274.7
1977	6,792.8	1,577.0	2,284.4	1,034.6	295.8	162.6	1,493.0
1978	7,382.0	1,851.8	2,566.7	1,191.3	336.0	186.3	1,713.5
1979	8,114.1	2,171.7	2,857.1	1,374.5	365.8	219.2	1,959.5
1980	9,334.4	2,539.6	3,287.5	1,592.0	414.4	255.4	2,261.7
1981	11,030.7	2,889.9	3,824.8	1,811.8	513.6	303.7	2,629.1
1982	13,092.8	3,384.8	4,420.8	2,072.7	609.8	357.3	3,039.8
1983	14,417.6	3,741.6	5,052.7	2,225.7	715.0	411.6	3,352.4
1984	15,344.8	3,915.5	5,525.9	2,402.3	829.4	452.2	3,683.8
1985	16,260.3	4,105.9	6,045.7	2,711.3	925.9	496.4	4,133.6
1986	17,637.2	4,087.3	6,674.8	2,959.6	1,002.2	562.0	4,523.8
1987	18,951.1	4,329.2	7,342.8	3,203.6	1,075.6	634.3	4,913.5
1988	20,400.3	4,738.7	7,942.1	3,494.0	1,184.2	715.6	5,393.8
1989	22,270.1	5,141.3	8,506.7	3,820.7	1,302.3	833.8	5,956.7
1990	23,866.4	5,748.2	9,245.1	4,139.0	1,402.7	956.6	6,498.3
1991	25,714.9	6,344.9	10,205.5	4,467.5	1,484.8	1,082.7	7,035.0
1992	26,667.2	6,787.8	10,448.5	4,690.2	1,535.0	1,171.6	7,396.8
1993	26,739.5	6,796.3	10,498.9	4,926.9	1,587.0	1,220.4	7,734.3
1994	26,165.6	6,921.6	10,731.6	5,217.1	1,683.0	1,253.7	8,153.8
1995	25,499.8	7,152.8	10,638.0	5,485.2	1,774.4	1,295.7	8,555.3
1996	25,206.4	7,305.2	10,758.8	5,663.4	1,830.1	1,336.7	8,830.2
1997	25,759.9	7,591.0	11,176.6	5,895.8	2,188.3	1,543.1	9,627.3
1998	27,082.1	7,983.2	11,715.7	6,278.4	2,275.3	1,528.0	10,081.7
1999	28,207.9	8,622.9	12,223.5	6,774.6	2,346.3	1,725.3	10,846.1
2000	30,554.5	9,331.3	12,977.0	7,205.5	2,574.2	1,806.9	11,586.6
2001	32,199.0	10,104.7	13,978.0	7,803.1	2,751.2	2,022.4	12,576.7
2002	34,375.1	10,776.5	15,050.7	8,279.7	2,794.2	2,042.9	13,116.8
2003 f	36,808.7	11,547.6	16,012.6	8,784.3	2,945.4	2,161.4	13,891.0
2004 f	38,896.8	12,456.1	16,785.2	9,267.5	3,089.2	2,278.9	14,635.6

f = forecast
CIHI 2004

Drugs					Other Health Spending				
Prescribed Drugs	Non-Prescribed Drugs	**Sub-Total**	Capital	Public Health and Administration	Pre-payment Administration	Health Research	Other	**Sub-Total**	**Grand Total**
		E	F	G				H	A+B+C+D+E+F+G+H
				($' 000, 000)					
771.7	305.6	1,077.3	536.1	551.1	172.1	93.7	253.2	519.0	12,199.4
883.4	316.0	1,199.4	544.1	638.2	200.4	105.4	290.6	596.4	14,049.8
987.9	324.5	1,312.4	563.7	727.4	234.3	129.4	335.4	699.1	15,450.0
1,052.7	392.8	1,445.5	672.2	726.7	237.0	150.4	360.9	748.3	17,106.8
1,162.9	495.5	1,658.4	725.1	817.8	268.0	173.7	424.2	865.9	19,169.7
1,298.4	586.3	1,884.6	990.7	963.8	294.7	202.5	538.7	1,035.9	22,298.4
1,677.1	655.0	2,332.1	1,111.2	1,133.8	383.9	231.2	710.1	1,325.2	26,276.7
1,924.1	715.0	2,639.1	1,394.8	1,333.0	369.1	258.0	826.9	1,454.0	30,759.1
2,107.1	845.9	2,953.0	1,436.6	1,444.7	396.9	297.3	945.8	1,640.0	34,038.6
2,255.6	1,058.6	3,314.2	1,504.1	1,604.6	482.4	336.9	1,030.8	1,850.1	36,743.1
2,566.5	1,235.9	3,802.3	1,651.2	1,788.6	503.6	381.2	1,169.4	2,054.2	39,841.7
3,018.0	1,399.0	4,417.1	1,801.4	1,835.6	570.4	452.8	1,336.8	2,360.1	43,337.3
3,293.1	1,621.7	4,914.9	1,871.8	1,942.3	576.5	452.0	1,494.2	2,522.7	46,788.2
3,736.8	1,784.9	5,521.7	1,901.7	2,055.3	738.3	507.1	1,760.2	3,005.6	50,959.2
4,262.9	1,975.6	6,238.5	2,092.8	2,258.3	987.7	588.4	2,055.0	3,631.0	56,095.5
4,871.8	2,058.7	6,930.5	2,123.7	2,541.4	1,002.5	667.7	2,398.8	4,069.1	61,022.6
5,468.7	2,236.6	7,705.3	2,027.5	2,753.4	1,092.5	698.6	2,711.6	4,502.7	66,289.1
6,100.7	2,418.1	8,518.8	2,058.0	3,049.7	1,161.2	806.5	2,911.1	4,878.9	69,805.7
6,603.5	2,576.0	9,179.6	2,016.9	3,238.0	1,408.9	793.5	3,151.9	5,354.2	71,557.7
6,760.9	2,676.6	9,437.5	2,272.8	3,610.8	1,566.3	804.2	3,421.1	5,791.7	73,085.4
7,399.0	2,703.6	10,102.6	2,263.1	3,882.7	1,613.0	808.2	3,560.5	5,981.7	74,075.9
7,602.1	2,756.0	10,358.1	2,160.0	4,049.1	1,645.4	819.9	3,563.9	6,029.1	74,696.8
8,540.8	2,877.5	11,418.3	2,122.0	4,208.1	1,626.1	1,091.7	3,814.3	6,532.2	78,435.3
9,469.2	3,067.0	12,536.2	2,298.3	5,217.4	1,471.0	1,194.3	4,159.8	6,825.1	83,739.6
10,267.3	3,252.3	13,519.5	3,441.5	5,600.1	1,717.3	1,179.1	4,548.6	7,445.0	89,906.6
11,764.6	3,321.2	15,085.8	3,888.0	6,264.5	1,924.4	1,433.5	4,857.9	8,215.8	97,903.4
13,218.1	3,442.7	16,660.8	4,467.8	7,081.4	2,439.4	1,926.4	4,876.7	9,242.6	106,310.8
14,813.3	3,595.4	18,408.7	4,913.6	7,471.4	2,786.4	1,953.7	5,188.7	9,928.9	114,041.6
16,298.7	3,704.2	20,002.9	5,844.8	8,367.8	3,030.8	2,056.9	5,440.7	10,528.4	123,003.7
17,955.3	3,803.1	21,758.4	5,873.2	8,693.8	3,349.5	2,236.5	5,590.1	11,176.1	130,275.2

Table A.3.2.1

Private-Sector Health Expenditure by Use of Funds, Canada, 1975 to 2004—Current Dollars

	Hospitals	Other Institutions	Physicians	Other Professionals			
				Dental Services	Vision Care Services	Other	Sub-Total
Year	A	B	C				D
			($' 000, 000)				
1975	318.1	328.4	26.8	685.3	190.3	81.7	957.2
1976	379.6	369.5	29.5	799.3	219.4	91.6	1,110.3
1977	420.1	401.8	32.3	950.9	251.0	102.0	1,303.9
1978	520.1	484.3	38.3	1,087.3	284.0	110.8	1,482.1
1979	626.5	590.3	52.6	1,230.7	307.8	130.3	1,668.8
1980	749.2	718.2	51.5	1,397.0	347.1	150.5	1,894.6
1981	903.4	743.2	49.7	1,533.4	434.9	177.0	2,145.2
1982	1,090.8	853.4	67.7	1,802.7	518.6	214.3	2,535.7
1983	1,243.1	947.2	79.4	1,965.1	609.3	247.7	2,822.1
1984	1,408.5	992.3	81.3	2,135.5	711.7	271.2	3,118.4
1985	1,522.6	1,039.4	83.6	2,435.8	795.5	281.8	3,513.0
1986	1,700.1	1,104.9	76.9	2,672.5	856.2	301.3	3,829.9
1987	1,796.9	1,197.1	76.6	2,917.3	918.3	358.0	4,193.6
1988	1,903.1	1,270.4	79.6	3,182.6	1,003.4	419.6	4,605.6
1989	2,001.1	1,312.8	84.0	3,470.4	1,096.7	492.2	5,059.3
1990	2,240.3	1,581.4	87.9	3,756.8	1,177.3	562.1	5,496.2
1991	2,421.4	1,768.3	90.9	4,061.8	1,237.1	619.7	5,918.6
1992	2,537.8	1,889.9	93.8	4,272.8	1,295.4	679.0	6,247.2
1993	2,670.0	2,012.9	97.3	4,500.9	1,376.0	732.6	6,609.5
1994	2,660.6	2,092.0	102.2	4,781.2	1,479.0	797.4	7,057.6
1995	2,382.0	2,112.6	109.1	5,060.2	1,581.3	838.9	7,480.5
1996	2,248.1	2,105.4	119.5	5,274.1	1,634.9	884.0	7,793.0
1997	2,327.8	2,132.1	121.3	5,514.8	1,974.7	1,068.8	8,558.2
1998	2,335.7	2,261.9	143.3	5,909.1	2,073.5	1,028.1	9,010.7
1999	2,476.9	2,422.1	153.0	6,378.9	2,130.0	1,184.1	9,692.9
2000	2,664.6	2,574.0	175.3	6,783.6	2,346.1	1,217.2	10,346.9
2001	2,643.0	2,793.5	148.5	7,361.2	2,513.3	1,450.8	11,325.2
2002	2,826.5	2,973.4	259.8	7,830.5	2,559.2	1,503.5	11,893.2
2003 f	2,950.5	3,156.4	234.6	8,351.0	2,703.3	1,619.1	12,673.4
2004 f	3,082.7	3,323.1	255.5	8,843.2	2,840.9	1,727.0	13,411.1

f = forecast
CIHI 2004

Drugs					Other Health Spending				
Prescribed Drugs	Non-Prescribed Drugs	**Sub-Total**	Capital	Public Health and Administration	Pre-payment Administration	Health Research	Other	**Sub-Total**	**Grand Total**
		E	F	G				H	A+B+C+D+E+F+G+H
				($' 000, 000)					
613.1	305.6	918.7	159.6	—	72.2	23.4	94.7	190.4	2,899.2
667.6	316.0	983.6	177.1	—	62.0	29.5	91.4	182.9	3,232.6
721.4	324.5	1,045.9	178.3	—	90.2	36.4	96.6	223.1	3,605.4
724.7	392.8	1,117.6	217.4	—	86.2	43.2	77.1	206.4	4,066.3
776.5	495.5	1,272.0	177.3	—	100.1	50.3	79.5	229.9	4,617.4
833.3	586.3	1,419.6	355.4	—	117.1	63.0	87.8	267.9	5,456.5
1,110.2	655.0	1,765.2	379.3	—	186.5	66.4	95.2	348.1	6,334.1
1,240.5	715.0	1,955.5	489.1	—	146.6	73.8	99.7	320.1	7,312.3
1,289.8	845.9	2,135.6	371.4	—	172.7	82.1	105.0	359.9	7,958.6
1,312.7	1,058.6	2,371.3	364.3	—	250.3	91.2	108.6	450.2	8,786.3
1,447.7	1,235.9	2,683.6	414.4	—	269.2	102.8	118.2	490.3	9,746.9
1,698.8	1,399.0	3,097.9	449.9	—	296.4	119.7	133.0	549.1	10,808.7
1,800.4	1,621.7	3,422.2	480.7	—	280.4	136.1	149.9	566.5	11,733.5
2,034.0	1,784.9	3,818.9	351.0	—	426.3	164.1	177.4	767.8	12,796.4
2,292.0	1,975.6	4,267.7	390.4	—	660.2	196.1	212.9	1,069.1	14,184.3
2,593.9	2,058.7	4,652.5	383.4	—	665.4	226.2	243.8	1,135.4	15,577.1
2,861.9	2,236.6	5,098.5	341.7	—	746.8	249.8	270.9	1,267.5	16,906.9
3,192.3	2,418.1	5,610.4	363.1	—	805.0	265.5	299.3	1,369.8	18,112.0
3,558.7	2,576.0	6,134.7	366.7	—	1,060.0	275.6	351.4	1,687.0	19,578.1
3,673.3	2,676.6	6,349.9	329.6	—	1,226.4	293.2	375.3	1,894.8	20,486.8
4,033.8	2,703.6	6,737.3	439.1	—	1,274.1	319.4	431.2	2,024.7	21,285.3
4,273.3	2,756.0	7,029.3	474.0	—	1,309.1	332.1	409.4	2,050.5	21,819.7
4,933.2	2,877.5	7,810.7	364.3	—	1,291.4	358.9	469.0	2,119.3	23,433.8
5,443.5	3,067.0	8,510.5	418.8	—	1,110.3	427.8	487.8	2,025.9	24,706.8
5,689.0	3,252.3	8,941.3	585.6	—	1,333.2	449.2	567.6	2,350.0	26,621.9
6,429.3	3,321.2	9,750.5	790.6	—	1,514.4	532.0	597.0	2,643.4	28,945.5
7,102.5	3,442.7	10,545.2	1,051.7	—	1,990.1	650.7	573.2	3,214.0	31,721.1
7,938.2	3,595.4	11,533.6	1,216.1	—	2,305.0	754.4	740.6	3,800.0	34,502.5
8,683.3	3,704.2	12,387.5	1,532.7	—	2,510.6	810.2	713.9	4,034.8	36,970.0
9,466.0	3,803.1	13,269.0	1,356.9	—	2,837.3	909.4	776.4	4,523.1	39,221.5

Table A.3.3.1

Public-Sector Health Expenditure by Use of Funds, Canada, 1975 to 2004—Current Dollars

		Other		Other Professionals			
	Hospitals	Institutions	Physicians	Dental Services	Vision Care Services	Other	Sub-Total
Year	A	B	C				D
			($' 000, 000)				
1975	5,136.8	796.6	1,813.2	56.4	35.9	46.7	139.0
1976	5,977.7	999.1	2,041.5	69.8	40.6	53.9	164.4
1977	6,372.7	1,175.2	2,252.1	83.7	44.9	60.5	189.1
1978	6,861.9	1,367.5	2,528.3	104.0	51.9	75.5	231.4
1979	7,487.6	1,581.4	2,804.5	143.8	58.0	88.9	290.7
1980	8,585.2	1,821.5	3,236.0	194.9	67.2	104.9	367.1
1981	10,127.4	2,146.7	3,775.1	278.4	78.7	126.7	483.9
1982	12,001.9	2,531.4	4,353.1	270.0	91.1	143.0	504.2
1983	13,174.5	2,794.4	4,973.3	260.7	105.7	164.0	530.3
1984	13,936.3	2,923.3	5,444.6	266.7	117.7	181.0	565.4
1985	14,737.7	3,066.5	5,962.1	275.5	130.4	214.6	620.5
1986	15,937.1	2,982.4	6,597.9	287.2	146.1	260.7	693.9
1987	17,154.2	3,132.1	7,266.2	286.3	157.3	276.4	719.9
1988	18,497.2	3,468.3	7,862.5	311.3	180.8	296.0	788.2
1989	20,269.0	3,828.5	8,422.7	350.3	205.6	341.5	897.4
1990	21,626.1	4,166.8	9,157.3	382.2	225.4	394.5	1,002.1
1991	23,293.5	4,576.6	10,114.5	405.7	247.7	463.0	1,116.4
1992	24,129.5	4,897.9	10,354.7	417.4	239.6	492.6	1,149.6
1993	24,069.5	4,783.5	10,401.6	426.1	211.0	487.7	1,124.8
1994	23,505.0	4,829.6	10,629.4	435.9	204.1	456.2	1,096.2
1995	23,117.8	5,040.2	10,528.9	425.0	193.1	456.7	1,074.9
1996	22,958.3	5,199.8	10,639.3	389.3	195.3	452.7	1,037.2
1997	23,432.2	5,458.8	11,055.3	381.0	213.6	474.4	1,069.0
1998	24,746.4	5,721.2	11,572.4	369.3	201.8	499.9	1,071.0
1999	25,731.0	6,200.8	12,070.6	395.7	216.3	541.1	1,153.1
2000	27,889.8	6,757.3	12,801.7	421.9	228.1	589.7	1,239.6
2001	29,556.0	7,311.1	13,829.5	441.9	237.9	571.6	1,251.5
2002	31,548.6	7,803.1	14,790.9	449.2	235.1	539.3	1,223.6
2003 f	33,858.2	8,391.2	15,778.0	433.3	242.1	542.2	1,217.6
2004 f	35,814.0	9,133.1	16,529.7	424.3	248.3	551.9	1,224.5

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Drugs					Other Health Spending				
Prescribed Drugs	Non-Prescribed Drugs	**Sub-Total**	Capital	Public Health and Administration	Pre-payment Administration	Health Research	Other	**Sub-Total**	**Grand Total**
		E	F	G				H	A+B+C+D+E+F+G+H
				($' 000, 000)					
158.6	—	158.6	376.4	551.1	99.9	70.3	158.4	328.6	9,300.3
215.8	—	215.8	367.0	638.2	138.4	75.9	199.2	413.5	10,817.2
266.6	—	266.6	385.4	727.4	144.1	93.1	238.8	476.0	11,844.6
327.9	—	327.9	454.8	726.7	150.8	107.2	283.8	541.9	13,040.5
386.4	—	386.4	547.8	817.8	167.9	123.4	344.7	636.0	14,552.3
465.0	—	465.0	635.3	963.8	177.6	139.5	450.9	768.0	16,841.8
566.9	—	566.9	731.9	1,133.8	197.5	164.7	614.9	977.1	19,942.6
683.6	—	683.6	905.7	1,333.0	222.4	184.2	727.3	1,133.9	23,446.8
817.4	—	817.4	1,065.2	1,444.7	224.2	215.1	840.8	1,280.1	26,080.0
942.8	—	942.8	1,139.9	1,604.6	232.1	245.7	922.2	1,400.0	27,956.9
1,118.7	—	1,118.7	1,236.9	1,788.6	234.4	278.4	1,051.2	1,563.9	30,094.9
1,319.2	—	1,319.2	1,351.5	1,835.6	274.0	333.2	1,203.8	1,811.0	32,528.6
1,492.7	—	1,492.7	1,391.1	1,942.3	296.1	315.9	1,344.2	1,956.2	35,054.7
1,702.8	—	1,702.8	1,550.7	2,055.3	312.1	343.0	1,582.8	2,237.9	38,162.8
1,970.9	—	1,970.9	1,702.4	2,258.3	327.5	392.3	1,842.1	2,561.9	41,911.1
2,278.0	—	2,278.0	1,740.3	2,541.4	337.2	441.5	2,155.0	2,933.6	45,445.5
2,606.7	—	2,606.7	1,685.8	2,753.4	345.7	448.9	2,440.7	3,235.3	49,382.2
2,908.5	—	2,908.5	1,694.9	3,049.7	356.2	541.0	2,611.8	3,509.1	51,693.8
3,044.9	—	3,044.9	1,650.2	3,238.0	348.8	517.9	2,800.5	3,667.2	51,979.7
3,087.6	—	3,087.6	1,943.2	3,610.8	340.0	511.1	3,045.8	3,896.9	52,598.7
3,365.3	—	3,365.3	1,824.0	3,882.7	338.9	488.8	3,129.3	3,957.0	52,790.6
3,328.8	—	3,328.8	1,685.9	4,049.1	336.3	487.7	3,154.6	3,978.6	52,877.1
3,607.6	—	3,607.6	1,757.6	4,208.1	334.7	732.8	3,345.4	4,412.9	55,001.5
4,025.7	—	4,025.7	1,879.5	5,217.4	360.8	766.4	3,672.0	4,799.2	59,032.8
4,578.2	—	4,578.2	2,855.9	5,600.1	384.1	729.9	3,981.0	5,095.0	63,284.8
5,335.3	—	5,335.3	3,097.4	6,264.5	410.0	901.5	4,260.9	5,572.4	68,957.9
6,115.6	—	6,115.6	3,416.1	7,081.4	449.3	1,275.7	4,303.6	6,028.6	74,589.7
6,875.1	—	6,875.1	3,697.5	7,471.4	481.5	1,199.3	4,448.1	6,128.9	79,539.1
7,615.3	—	7,615.3	4,312.1	8,367.8	520.2	1,246.7	4,726.8	6,493.6	86,033.7
8,489.3	—	8,489.3	4,516.3	8,693.8	512.2	1,327.1	4,813.7	6,653.0	91,053.7

Table B.1.1

Total Health Expenditure, by Province/Territory and Canada, 1975 to 2004—Current Dollars

	B.C.	Alta.	Sask.	Man.	Ont.	Que.	N.B.	N.S.	P.E.I.	N.L.	Y.T.	N.W.T.	Nun.	Canada
Year						**($' 000, 000)**								
1975	1,383.4	992.3	441.2	546.3	4,422.8	3,378.8	277.5	382.5	59.2	264.5	15.9	35.1	---	12,199.4
1976	1,628.3	1,158.9	520.3	629.4	5,040.8	3,875.2	321.9	442.2	62.9	312.8	18.1	39.0	---	14,049.8
1977	1,831.8	1,272.1	587.4	706.0	5,524.6	4,200.7	358.9	469.1	68.7	362.9	18.5	49.3	---	15,450.0
1978	2,044.4	1,465.4	622.4	749.0	6,071.9	4,666.6	404.7	512.5	79.5	412.7	21.3	56.5	---	17,106.8
1979	2,288.6	1,781.0	703.5	823.3	6,728.0	5,149.6	470.0	573.0	96.6	473.3	23.9	59.0	---	19,169.7
1980	2,880.0	2,153.1	815.7	971.4	7,634.1	5,886.5	562.5	657.2	122.3	528.4	26.1	61.1	---	22,298.4
1981	3,430.4	2,623.7	949.0	1,153.2	8,903.0	6,887.8	681.2	788.8	136.4	621.3	28.2	73.8	---	26,276.7
1982	3,870.2	3,351.7	1,130.0	1,332.1	10,445.2	7,890.5	819.3	919.1	152.4	701.2	37.1	110.4	---	30,759.1
1983	4,155.7	3,622.1	1,257.6	1,478.6	11,850.0	8,675.3	894.6	1,004.8	164.5	773.7	38.0	123.5	---	34,038.6
1984	4,428.9	3,764.2	1,371.3	1,592.0	13,086.0	9,313.7	975.1	1,125.3	171.0	751.7	37.9	125.8	---	36,743.1
1985	4,637.3	4,070.4	1,528.8	1,726.5	14,442.8	10,031.9	1,026.2	1,232.5	181.2	785.8	39.7	138.5	---	39,841.7
1986	4,983.3	4,448.5	1,703.6	1,889.7	16,097.2	10,537.4	1,091.1	1,376.9	187.6	812.5	42.6	166.9	---	43,337.3
1987	5,340.3	4,499.9	1,767.8	1,980.2	17,866.4	11,268.6	1,194.0	1,560.6	202.9	881.6	44.7	181.3	---	46,788.2
1988	5,838.3	4,830.6	1,837.6	2,069.6	19,819.8	12,279.2	1,291.5	1,585.2	219.5	930.9	45.8	211.2	---	50,959.2
1989	6,509.0	5,349.8	2,052.9	2,257.4	21,970.8	13,290.3	1,400.1	1,751.8	239.3	991.6	49.5	232.9	---	56,095.5
1990	7,372.6	5,749.4	2,252.2	2,484.3	23,799.1	14,311.5	1,533.5	1,866.9	256.2	1,096.4	53.6	246.8	---	61,022.6
1991	8,126.7	6,062.5	2,319.8	2,576.0	26,194.3	15,634.6	1,629.3	1,970.0	280.6	1,153.2	62.6	279.5	---	66,289.1
1992	8,769.1	6,430.7	2,325.4	2,701.9	27,631.7	16,376.1	1,699.8	2,031.6	295.0	1,197.4	67.5	279.6	---	69,805.7
1993	9,296.8	6,520.4	2,301.9	2,749.1	28,133.7	16,904.2	1,739.1	2,025.0	311.7	1,209.1	79.6	287.1	---	71,557.7
1994	9,756.5	6,305.7	2,382.4	2,802.0	28,773.5	17,311.6	1,791.6	2,021.4	313.3	1,247.9	93.2	286.2	---	73,085.4
1995	10,099.0	6,085.0	2,439.5	2,912.7	29,320.6	17,356.7	1,818.0	2,059.4	327.1	1,268.2	94.8	294.8	---	74,075.9
1996	10,364.2	6,312.9	2,487.3	2,968.9	29,705.7	16,966.6	1,812.4	2,086.9	338.8	1,251.9	109.4	291.9	---	74,696.8
1997	10,817.8	7,073.1	2,653.1	3,097.4	30,780.0	17,744.1	1,854.8	2,361.6	340.0	1,303.8	102.6	307.1	---	78,435.3
1998	11,386.7	7,592.9	2,774.1	3,288.5	33,097.0	18,894.1	1,917.6	2,541.5	358.4	1,433.5	103.5	351.6	---	83,739.6
1999	12,253.7	8,659.3	2,967.2	3,686.1	35,352.2	19,814.7	2,072.3	2,661.5	377.4	1,578.7	108.4	233.5	141.7	89,906.6
2000	13,331.4	9,589.9	3,145.7	4,050.9	38,903.7	21,262.6	2,217.5	2,810.6	401.3	1,682.6	123.5	215.4	168.2	97,903.4
2001	14,620.0	10,927.5	3,442.6	4,290.9	41,600.3	23,136.9	2,449.5	2,991.3	455.9	1,806.6	142.3	263.3	183.8	106,310.8
2002	15,585.7	11,860.5	3,592.5	4,550.7	44,955.7	24,525.0	2,586.3	3,290.8	514.8	1,943.2	154.7	269.4	212.1	114,041.6
2003 f	16,287.9	12,789.3	3,780.0	4,890.7	49,425.5	26,210.7	2,720.0	3,548.4	531.5	2,110.1	159.0	284.1	266.5	123,003.7
2004 f	16,660.4	13,686.8	4,016.5	5,156.7	52,963.2	27,657.0	2,904.2	3,767.7	541.2	2,199.0	170.7	292.5	259.4	130,275.2

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Table B.1.2

Total Health Expenditure, by Province/Territory and Canada, 1975 to 2004—Current Dollars

Year	B.C.	Alta.	Sask.	Man.	Ont.	Que.	N.B.	N.S.	P.E.I.	N.L.	Y.T.	N.W.T.	Nun.	Canada
	($' per Capita)													
1975	553.44	548.65	480.92	533.03	531.61	533.75	409.87	462.74	502.62	475.29	726.48	818.67	---	527.13
1976	642.64	619.96	558.53	610.01	599.11	605.80	466.84	529.45	529.82	555.99	804.44	880.95	---	599.14
1977	712.85	653.15	621.68	680.14	649.52	653.12	515.80	558.65	572.56	641.93	810.18	1,103.96	---	651.19
1978	782.10	724.79	653.82	719.36	706.71	724.60	578.47	606.81	653.05	726.96	899.00	1,248.03	---	713.87
1979	859.40	849.06	733.14	793.65	776.66	796.36	668.42	674.68	785.24	830.23	998.00	1,289.33	---	792.08
1980	1,049.86	982.07	843.21	938.89	872.94	904.64	796.61	770.61	988.59	922.34	1,073.08	1,319.09	---	909.54
1981	1,214.75	1,143.63	972.49	1,112.70	1,010.40	1,051.94	964.41	923.01	1,102.17	1,080.88	1,177.79	1,552.38	---	1,058.67
1982	1,347.15	1,415.24	1,144.53	1,272.56	1,170.69	1,199.29	1,156.84	1,068.71	1,230.17	1,220.41	1,517.96	2,228.99	---	1,224.61
1983	1,430.31	1,515.28	1,255.25	1,393.48	1,310.60	1,313.98	1,250.58	1,156.08	1,311.30	1,334.99	1,611.11	2,420.07	---	1,341.85
1984	1,503.55	1,574.92	1,350.41	1,485.31	1,426.75	1,404.53	1,352.42	1,282.93	1,350.90	1,295.66	1,585.31	2,392.39	---	1,434.85
1985	1,559.13	1,693.92	1,490.78	1,595.25	1,553.40	1,505.01	1,418.05	1,392.54	1,419.40	1,356.50	1,630.07	2,546.73	---	1,541.70
1986	1,658.82	1,829.95	1,655.19	1,731.01	1,705.55	1,570.76	1,504.71	1,548.24	1,460.70	1,409.34	1,739.80	3,052.14	---	1,660.36
1987	1,750.82	1,847.76	1,711.73	1,803.40	1,852.54	1,661.41	1,640.40	1,746.68	1,578.34	1,532.79	1,741.02	3,293.37	---	1,769.01
1988	1,874.03	1,968.11	1,787.57	1,878.01	2,013.75	1,795.46	1,768.26	1,766.48	1,698.12	1,618.95	1,720.95	3,792.49	---	1,901.79
1989	2,035.41	2,143.98	2,014.15	2,045.59	2,173.70	1,918.16	1,904.32	1,938.19	1,840.01	1,720.39	1,826.71	4,084.51	---	2,056.15
1990	2,240.37	2,257.18	2,236.27	2,246.92	2,311.07	2,043.36	2,071.96	2,052.39	1,962.74	1,896.84	1,928.76	4,190.00	---	2,203.18
1991	2,409.00	2,338.38	2,313.60	2,321.53	2,511.89	2,213.09	2,185.39	2,152.81	2,153.50	1,989.99	2,164.74	4,586.61	---	2,364.82
1992	2,528.24	2,442.42	2,316.20	2,428.27	2,614.22	2,303.89	2,272.21	2,209.26	2,255.45	2,064.37	2,242.01	4,480.52	---	2,460.82
1993	2,606.03	2,444.45	2,286.26	2,459.81	2,632.17	2,362.48	2,322.46	2,191.52	2,358.94	2,084.83	2,622.42	4,517.40	---	2,494.88
1994	2,654.34	2,334.87	2,359.92	2,494.62	2,659.72	2,407.10	2,388.13	2,180.72	2,348.55	2,172.27	3,137.34	4,391.79	---	2,520.26
1995	2,673.80	2,225.27	2,405.56	2,579.55	2,677.68	2,404.16	2,420.84	2,218.76	2,433.70	2,234.86	3,115.33	4,428.49	---	2,527.99
1996	2,675.13	2,274.78	2,440.67	2,617.66	2,680.28	2,341.22	2,409.10	2,240.52	2,495.61	2,236.23	3,486.14	4,320.58	---	2,522.61
1997	2,739.69	2,499.26	2,605.98	2,726.27	2,741.29	2,439.18	2,464.73	2,532.60	2,498.00	2,366.14	3,227.26	4,533.25	---	2,622.61
1998	2,858.78	2,618.75	2,726.39	2,890.95	2,911.67	2,589.67	2,554.91	2,727.20	2,639.15	2,655.04	3,322.87	5,201.86	---	2,776.74
1999	3,054.75	2,932.11	2,924.15	3,226.40	3,072.40	2,705.71	2,760.86	2,850.00	2,769.33	2,959.70	3,522.44	5,742.54	5,282.14	2,957.08
2000	3,300.51	3,191.37	3,121.43	3,530.58	3,329.26	2,890.11	2,954.69	3,009.60	2,940.42	3,186.53	4,059.13	5,317.49	6,116.91	3,190.17
2001	3,584.70	3,574.87	3,442.11	3,727.04	3,496.52	3,127.89	3,266.52	3,208.23	3,335.60	3,460.98	4,721.67	6,449.09	6,535.18	3,427.03
2002	3,787.16	3,805.93	3,607.30	3,937.98	3,714.72	3,293.83	3,446.89	3,521.45	3,759.63	3,740.98	5,134.41	6,494.05	7,381.38	3,635.07
2003 f	3,922.62	4,049.00	3,801.21	4,210.50	4,032.55	3,498.34	3,622.28	3,790.38	3,872.22	4,070.82	5,202.59	6,732.40	9,143.86	3,885.09
2004 f	3,970.18	4,274.58	4,035.13	4,406.43	4,273.73	3,666.69	3,865.09	4,021.16	3,925.56	4,253.07	5,469.49	6,833.25	8,751.41	4,077.94

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Use of figures	❑ Excellent	❑ Good	❑ Fair	❑ Poor
Quality of analysis	❑ Excellent	❑ Good	❑ Fair	❑ Poor
Level of detail presented	❑ Excellent	❑ Good	❑ Fair	❑ Poor
Length of the report	❑ Excellent	❑ Good	❑ Fair	❑ Poor

Usefulness of the Report

4. Please indicate how useful you found each of the following sections of the report:

Health Financing	❑ Very Useful	❑ Somewhat Useful	❑ Not Useful	❑ Did Not Read
The Canadian Reality	❑ Very Useful	❑ Somewhat Useful	❑ Not Useful	❑ Did Not Read
What It Costs	❑ Very Useful	❑ Somewhat Useful	❑ Not Useful	❑ Did Not Read
Hospital Services	❑ Very Useful	❑ Somewhat Useful	❑ Not Useful	❑ Did Not Read
Physician Services	❑ Very Useful	❑ Somewhat Useful	❑ Not Useful	❑ Did Not Read
Retail Drug Sales	❑ Very Useful	❑ Somewhat Useful	❑ Not Useful	❑ Did Not Read
Oral Health Care Services	❑ Very Useful	❑ Somewhat Useful	❑ Not Useful	❑ Did Not Read
Eye Care	❑ Very Useful	❑ Somewhat Useful	❑ Not Useful	❑ Did Not Read
Continuing Care	❑ Very Useful	❑ Somewhat Useful	❑ Not Useful	❑ Did Not Read
Mental Health Services	❑ Very Useful	❑ Somewhat Useful	❑ Not Useful	❑ Did Not Read
Complementary and Alternative Services	❑ Very Useful	❑ Somewhat Useful	❑ Not Useful	❑ Did Not Read

5. How do you plan on using the information presented in this report?

6. What did you find most useful about this report?

7. Do you think you will refer to CIHI's health reports during the year?

❑ Yes ❑ No ❑ Maybe

8. How would you improve this report? Do you have any suggestions for future reports?

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Reader Information

9. Where do you live?

- ❑ Newfoundland and Labrador
- ❑ Nova Scotia
- ❑ New Brunswick
- ❑ Prince Edward Island
- ❑ Quebec
- ❑ Ontario
- ❑ Manitoba
- ❑ Saskatchewan
- ❑ Alberta
- ❑ British Columbia
- ❑ Northwest Territories
- ❑ Yukon Territory
- ❑ Nunavut
- ❑ Outside Canada (please specify country)_____

10. What is your main position or role?

- ❑ Health services manager or administrator
- ❑ Board member
- ❑ Health care provider
- ❑ Educator
- ❑ Researcher
- ❑ Policy analyst
- ❑ Elected official
- ❑ Student
- ❑ Clinician
- ❑ Other (please specify)_____

Thank you for your feedback.