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Canada's Health System

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Aim. To examine the Canadian health system, in particular as it relates to health care, and to assess the functions of the provincial and federal governments in relation to health care, spending, funding, and reform.

Methods. Description and analysis of the Canadian health care system, including the overall structure, funding and spending, history, necessary reforms, and future of the system.

Results. Canada's health care system, through funding from both the federal and provincial/territorial governments, provides insured hospital and medical care services to all eligible Canadian residents. In order for the provinces to receive funding from the federal government, five criteria as stated in the Canada Health Act, must be met, namely: public administration, comprehensiveness, universality, accessibility, and portability. Funding is provided primarily through taxation, with some provinces also utilizing ancillary funding methods, such as health care premiums. In the latest review of Canada's health care system, the National Forum on Health reported in 1997 that the system must become more efficient, effective, and reflective of contemporary practices in health care delivery.

Conclusions. The benefits of our system can be seen in the favorable health status of Canadians. Canada has been successful in its efforts to contain health expenditures and begin the process of reallocating resources. Health care is recognized as only one element of a larger health system, encompassing a broader range of services, providers, and delivery sites.

Key words: Canada; health care; health expenditures; health insurance; health plan implementation; hospital costs; insurance, health; planning, health and welfare; resource allocation reform

Canada's Health System

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

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

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

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

How the System Works

Canada's health care system relies extensively on primary care physicians (e.g., family physicians and general practitioners), who account for approximately 51% of all active physicians in Canada (1). They are usually the initial contact with the formal health care system and control access to most specialists, many allied providers, hospital admissions, diagnostic testing, and prescription drug therapy.

Canada does not have a system of "socialized medicine", with doctors employed by the government. Most doctors are private practitioners who work in independent or group practices and enjoy a high degree of autonomy. Some doctors work in community health centres, hospital-based group practices, or work in affiliation with hospital out-patient departments. Private practitioners are

generally paid on a fee-for-service basis and submit their service claims directly to the provincial health insurance plan for payment. Physicians in other practice settings may also be paid on a fee-for-service basis, but are more likely to be salaried or remunerated through an alternative payment scheme.

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

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

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

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

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

Milestones in the Evolution of Universal Health Insurance

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

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

For the first twenty years, the federal government's financial contribution in support of Medicare was determined as a percentage – about half – of provincial expenditures on specified insured health services. In 1977, these cost sharing arrangements were replaced by per capita transfers to the provinces and territories, known as block funding. For the period 1977 to 1996, the federal contribution was based on a uniform per capita entitlement and took the form of a tax transfer (taxing power) and cash payments. With this respect, a tax transfer rate refers to the transfer of a given number of income and corporate tax points from the federal government to the provinces; in other words, the federal government agrees to lower its personal and corporate income tax so that the provinces can step in and raise their own taxes by the same percentage points as the corresponding federal tax reduction.

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

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

In response to these concerns, the federal government reaffirmed its commitment to a universal, accessible, comprehensive, portable, publicly administered health insurance system when the Parliament of Canada passed the Canada Health Act in 1984 (Table 1). To discourage provincial user charges and extra-billing, the Act provides for mandatory dollar-for-dollar penalty, deducted from federal transfer payments, if any province permits user charges or extra-billing for insured health services.

The federal government continues to remain firmly committed to the principles of the Canada Health Act.

[Table 1.](#) Principles of Medicare

Funding

Health care in Canada is financed primarily through taxation, in the form of provincial and federal personal and corporate income taxes. Some provinces use ancillary funding methods which are nominally targeted for health care, such as sales taxes, payroll levies, and lottery proceeds. These funds, however, are not earmarked specifically for health and are added to the central revenues of the province. They play a relatively minor role in health care financing.

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

For the period 1977 to 1996, the federal contribution for insured health services was combined with that for post-secondary education and provided through a block funding transfer. The federal contribution was based on an equal per capita entitlement which was adjusted annually according to changes in Gross National Product and calculated independently of provincial costs. Beginning in the fiscal year 1996-97, the federal government's contribution to provincial health and social programs was consolidated in a new single block transfer, the Canada Health and Social Transfer. Federal funding is transferred to the provinces as a combination of cash contributions and tax points. As with the previous transfer arrangement, provincial health insurance plans must adhere to the principles of the Canada Health Act in order to be eligible for the full federal transfer payments.

The schematic diagram of the funding structure of the health system in Canada (Fig. 1) indicates that the flow of funds from individuals in the form of payment of taxes and premiums to governments, employers, and private insurers, finance the health care delivery system and providers.

[Figure 1.](#) The funding structure of the health system in Canada.

[Figure 2.](#) Percentage distribution of health expenditures by category of expenditure in Canada, 1996

[Figure 3.](#) Percentage distribution of health expenditures by sector of finance in Canada, 1996.

Health Spending

In 1996, total health expenditures in Canada (in current dollars) was \$75.2 billion (Cdn) or \$2,511 (Cdn) per capita (approximately \$US1,800). Health expenditures accounted for 9.5% of Gross Domestic Product (GDP) in 1996, down from the 1992 peak level of 10.2% of GDP (Fig. 2) (2). Health care spending accounts for around one-third of provincial program expenditures.

Public sector funding represents about 70% of total health expenditures (Fig. 3). The remaining 30% is financed privately through supplementary insurance, employer sponsored benefits or directly out-of-pocket (2). The controls inherent in the single-payer approach to health care are recognized as a major contributor to Canada's recent cost containment success.

The single-payer attribute of public insurance has enabled the provinces and territories to better control the growth of health expenditures in the public sector than has been the case in the private sector. While public sector spending has been brought under control, private sector spending is continuing to grow. In 1996, total public health expenditures declined by almost 1% while private expenditures increased by 5.5%.

Provinces and territories have considerable power to manage health care spending. For example, a hospital's operating costs are paid out of the annual budget it negotiates with the provincial ministry of health, or with a regional authority given the devolution of many health planning and delivery functions to communities since the early 1990's. In most cases, proposals for the expansion of programs, services, and health facilities must be approved by community and provincial authorities. The acquisition and distribution of expensive high-tech equipment among region's hospitals is also subject to approval to avoid unnecessary duplication of services or their under-utilization.

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

The 1993 World Development Report by the World Bank noted the cost-effectiveness and control functions of public sector involvement in health (3): "In general, the OECD countries that have contained costs better have greater government control of health spending and a larger public sector share of total expenditures".

The OECD review of health reform and development in Canada also recognized the advantage of a significant public sector involvement in health (4): "The structure of Canada's single-payer health system lends itself to effective supply management and control".

Benefits of Medicare

Health Status

One of the most important indicators of the system's success is the favourable health status of Canadians. The life expectancy for Canadian children born in 1994 is 78.2 years, among the highest in industrialized countries, while the 1993 infant mortality rate of 6.3 per 1,000 live births is one of the lowest in the world (5). Canada's health care system is regarded as a major contributor to the Canada's number one world ranking on the United Nations human development index. The United Nations has ranked Canada number one in both 1992 and 1994 and number two in 1993 (6).

Economic Benefits

Medicare provides a variety of economic benefits, which arise from efficiency and cost-savings associated with public financing and competitive advantages it provides to Canadian business. Public financing spreads the cost of providing health services and equitably across society. In addition to the benefits derived from the single-payer attributes of the Canadian health system, financing health insurance through the taxation system is efficient since it does not require the creation of a separate collection process. Canadian business supports the health insurance program, not only because its efficiency has been proven, but also because it provides competitive advantages to the business sector. These advantages include lower employee benefit costs and the promotion of a healthy and mobile workforce. While universal access to quality health care services helps ensure a healthy population and, therefore, a healthy and productive labour force, the national character of Canada's health insurance system enhances labour force mobility, which can be very important in responding to changing business requirements and opportunities. Public health insurance coverage in Canada is based solely on residency. The portability principle of the Canada Health Act ensures that people are covered when they move or while they are temporarily absent from their province. Workers, therefore, need not fear losing health insurance coverage for themselves and their families because they change jobs or move to another province in search of employment.

Renewing Canada's Health System

Since the sweeping reform that created national hospital and medical insurance three decades ago, there has been no major structural change in Canadian health care. Reform efforts that have been undertaken have been incremental in nature and in response to shifting priorities and pressures, including fiscal realities and the changing health care needs of the population.

Starting in the early 1980s, health care spending began to require larger portions of total provincial resources, to the point where they now represent between 28% and 36% of provincial program expenditures. Accounting for such a large proportion of provincial expenditures, health care has been targeted by most provinces for restraint. A consensus among the provinces has emerged that suggests that prevailing levels of health care expenditure are sufficient, and that initiatives are required to limit growth and manage the system more efficiently. Provinces have been able to undertake much of this cost-control by using the power of a single-payer structure.

While the need for cost-containment and increased efficiency is recognized, there is also a growing comprehension of a change in future population health needs, and an understanding of the actual impact of health care on the population general health status. This is evident in the general policy shift away from discussion of the health care system to a focus on the health system, which recognizes that health is more than health care. The overall orientation of new provincial policy directions is the continuance of the shift away from an emphasis on health care towards a more comprehensive and integrated view of health.

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

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

National Forum on Health

The National Forum on Health, the first in-depth national review of Canada's health system since the early 1980's was launched in 1994. The Forum's mandate was to engage the public and health stakeholders in a dialogue, the results of which, along with their own research and study, would guide it in charting a course for the future of health and health care in Canada. In addition to the Prime Minister (Chair) and the Minister of Health (Vice-Chair), 24 members were appointed to the Forum from across Canada, each of whom contributed unique expertise and knowledge of health and the health system.

The Forum submitted its two-volume Final Report, *Canada Health Action: Building on the Legacy*, to the Prime Minister on February 4, 1997. The report was welcomed as a creative and common sense view of how governments can work together to address the long-term health care challenge in Canada (7).

The Forum's diagnosis is that, while Canada does not face an immediate health care crisis, the health system is under enormous pressure. The overall prescription for sustaining Canada's health system for the future is a balance of actions on non-medical determinants and within the health care system itself.

The Forum's report reflects the fact that Canadians cherish Medicare for what it is, and for the values it represents. On economic grounds, the Forum says that the single-payer model of public health insurance (Medicare) is the best approach to controlling overall spending on health. While the report concludes that Medicare is not underfunded, it says a range of concerted actions, based on informed decisions, is needed now to make the system more efficient, effective and more reflective of contemporary practice in health care delivery.

The Forum says that, taken alone, spending money more wisely on health care is not the key to the future sustainability of the health care system. Of all the things that we now know contribute to lifelong health, health care is far less important than many other factors (including positive childhood development, employment and social support to name a few).

In the February 1997 Budget, the Government of Canada provided some early responses to several Forum recommendations in announcing \$300 million over the next three years for: a new Health Transition Fund; a national strategy for an integrated Canadian Health Information System; and restored funding levels for the Community Action Program for Children and the Canada Prenatal Nutrition Program.

Conclusion

Canada has been successful in its efforts to contain national health expenditures. In the mid 1990s health expenditures have levelled off and are expected to decline somewhat further. Cost containment within specific sectors remains a priority in order to provide for the reallocation of resources, but the pragmatic concerns of containing overall costs have been largely addressed.

Canada is now turning its attention toward longer-term considerations about the future of the national health system.

These longer-term considerations are focusing on ensuring that the health care system remains appropriate for achieving good health outcomes and health status. There are a number of converging factors influencing policy development in this area, including changes in our understanding of the role of health care in population health, changes in the fiscal and political environment, and changes in the health needs of the population.

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

Acknowledgement

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