

## **Background Briefing: The Canadian Health Care System**

By Benedict Irvine and Shannon Ferguson.

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Health care in Canada has long been a source of national pride. Known as ‘medicare’, the system is publicly financed but privately run, it provides universal coverage and care is free at the point of use. The system is based on five founding principles. Care must be universal, portable, comprehensive, accessible, and publicly administered. But does medicare adhere to these principles? Many think not.

### **Ten Systems and Five Founding Principles: The Development of Medicare**

Canada’s version of national public health insurance is characterised by local control, doctor autonomy and consumer choice – patients theoretically have a free choice of physician and hospital. (Kraker, 2002). The ten provincial governments are the key providers of health care, having the constitutional responsibility for planning, financing, and evaluating the provision of hospital care, negotiating salaries of health professionals and negotiating fees for physician services. The result is that each provincial insurance plan differs slightly – mostly in how far each extends public insurance coverage beyond medically necessary hospital and physician services (Kraker, 2002). Additional services may include optometric services, dental services, chiropractic services and prescription drug benefits.

### ***Fiscal Federalism***

Canada has a long history of universal health coverage. In 1944, Saskatchewan led the way, being the first of the provinces to introduce universal hospital insurance. In 1956, the federal government offered an open-ended 50-50 cost sharing arrangement with the provinces (WHO, 1996), and by 1958 all provinces had introduced universal hospital coverage. In 1962, despite physician strikes, Saskatchewan introduced full-blown universal medical coverage. In 1965 the federal government followed suit, offering another 50-50 cost sharing arrangement if provinces met four criteria of comprehensiveness, portability, public administration, and universality. In this way, the federal government can exercise “fiscal federalism” over the provinces, by withholding funds if the principles are not met. Implementation of this policy began in 1968.

By 1971, all Canadians were guaranteed access to essential medical services, regardless of employment, income, or health (Kraker, 2002). Amid rising costs for health care, accompanied by low fees to doctors (which caused most to simply increase their daily caseload), many doctors opted out of the system and billed patients themselves. By the late 1970s and early 1980s there were calls to ban such extra billing and user fees – some Canadians could hardly find “opted-in” providers.

### ***Health Care Without Hindrance***

The Canadian Health Act of 1984, which was drafted in response to these protests, denies federal support to provinces that allow extra-billing within their insurance schemes and effectively forbids private or opted-out practitioners from billing beyond provincially mandated fee schedules. The 1984 Act also defines and solidifies the principles of medicare, including: *comprehensiveness* (provinces must provide medically necessary hospital and physician services), *universality* (100 per cent of provincial residents are entitled to the plan), *accessibility* (there should be reasonable access to services, not impeded by user charges or extra billing), *portability* (protection for Canadians travelling outside of their home province), and *public administration* (provinces must administer and operate health plan on a non-profit basis) (Klatt, 2002). These principles aim to provide a one-tiered service.

Since 1977, cost sharing has been transformed through several negotiated legislative steps from the 50-50 split between the federal and provincial governments to a reduced single block fund called the Health and Social Transfer (WHO, 1996).

### ***Healthcare Expenditure***

The Canadian healthcare system is funded primarily by tax dollars. The federal government makes cash transfers to the provinces, but the provinces may levy their own taxes to help defray the costs. Alberta and British Columbia require a health insurance premium, and other provinces have instituted employer payroll taxes (Klatt, 2002). In 2000, 71.1% of total health expenditures were through public expenditure, compared to the 83.3% spent by the U.K. (OECD, 2001). In terms of total health expenditure Canada spent 9.1% GDP in 2000, equivalent to US\$ 2587 PPP. As such, Canada is in a group of high-earning OECD countries where expenditure per capita is between US\$1500 and US\$ 2900. This high-spending group also includes, France, Germany, Japan, Austria, Belgium, Luxembourg, the Netherlands and Switzerland (Hurst, 2000).

Federal government's contributions have decreased significantly in 1998; federal payments make up only slightly more than 20 percent of provincial medical care costs (Kraker, 2002). The provincial government share of total health spending declined from 71.4% in 1975 to 64.4% in 1998, while each of the other sectors' shares increased. The largest share increase occurred in the private sector; its spending increased from 23.8% of all health spending in 1975 to 30.4 per cent in 1999 (Gratzer, 2002, pg 138). Private expenditure, which goes towards the cost of services (such as clinics for eye laser surgery or in-vitro fertilisation) not covered by provincial health insurance programmes, is divided between out-of-pocket expenditure and insurance.

### ***Healthcare Providers***

Healthcare providers are predominantly private, but are funded by public monies via provincial budgets. Hospital systems are largely private non-profit organizations with their own governance structures (usually supervised by a community board or trustees) (WHO, 1996) that receive an annual global operating budget from the provinces (Klatt, 2002). Physicians are mostly in private practice and remunerated on a fee-for-service basis (with an imposed cap to prevent excessive utilization and costs) by the provincial health plan (WHO, 1996). However, physicians that choose to opt out of the system cannot procure any public monies, and are forbidden from billing above negotiated "Schedule of Benefits" pricing which the "opted in" physicians are subject to. In other words, private physicians cannot bill above the fee schedules for medicare physicians. Therefore, opting out is risky for physicians and uptake is low.

### ***Rationing : "Everything is Free but Nothing is Readily Available" (Frogué et al, 2001)***

Like other nations experiencing limitless demand, an ageing population and the costly advance of medical technology, Canada has faced pressure to control health expenditure. It has done so through explicit rationing.

Set up in 1989, the Canadian Co-ordinating Office for Health Technology Assessment is the Canadian predecessor to our NICE, charged with exactly the same brief and, it seems, carrying out its function in the same way. For example, in the case of new cancer treatment, the latest pharmaceuticals (such as visudyne for macular degeneration), and high-tech diagnostic tests, Canadian governments simply reduce their expenses by limiting the service. Such a method of rationing is only possible in a single-payer monopoly. Medicare also shares other defining characteristics of monopolies: limited information, little transparency and poor accountability.

Canada has faced increased pressure to reform hospital structures to accommodate the changing pattern of care from an institutional to a community-based model. Reforms have attempted to limit growth and manage the system more effectively. Provinces have proven their ability to manage cost control by the use of their monopsonistic power associated with the single payer structure (WHO, 1996). Hospitals are paid through the imposition of

annual global budgets by provincial governments. The downside of this cost controlling efficiency is evident by the problem of waiting lists and dilapidated technology and equipment.

For example, in its 2001 annual survey involving more than 2,500 doctors in twelve different specialties, the Canadian think tank, the Fraser Institute, found that, for patients requiring surgery, the total average waiting time from the initial visit to the family doctor through to surgery was sixteen weeks, a significant increase over the last year of the study. In every category, physicians felt waiting times had exceeded “clinically reasonable” delays (Gratzer, 2002, pg 20). Canadians wait an average of 5 months for a cranial MRI scan; Americans just 3 days (Bell, et al, 1998). Indeed, Canada has fewer MRIs per capita than Iceland, Hungary, South Korea, and the Czech Republic (Gratzer, 2002, pg 53). Unsurprisingly, many choose to fly south to the US for diagnosis and treatment.

A key factor behind these statistics is the inability of the Canadian system to provide even equipment deemed basic, let alone new technology. Dozens of diagnostic and therapeutic products developed decades ago, in widespread use in other countries, are relatively unavailable to Canadians. One example is the SynchroMed implantable drug infusion pump, a therapeutic device that, when combined with an antispasmodic drug, can be used in patients with severe spasticity resulting from injury (spinal cord trauma, brain injury) or disease (multiple sclerosis, cerebral palsy) to regain their mobility and independence, and to control their pain. Patients use SynchroMed, in Yugoslavia and Russia, saving their respective health care systems upwards of \$100,000 per year in treatment costs. Canadian hospitals, however, refuse to provide patients with the \$8,000 device (Gratzer, 2002, pg 83).

An assessment in 2000 by the Canadian Medical Association (CMA) argued that shortages have led to an “unconscionable” delay in the diagnosis and treatment of diseases such as cancer, heart disease, and debilitating bone and joint ailments (Gratzer, 2002, pg 88). “We’re not talking about Ferraris and Lamborghinis here,” according to Dr Hugh Scully, the head of the CMA. “We’re talking about the Chevrolets and the Fords that are necessary to make it [diagnosis] accessible and reasonable for everybody<sup>1</sup>. To use Dr Phil Malpass’ phrase, medicare is “functionally obsolete”<sup>2</sup>.

### ***Public Best, Private Bad?***

We have seen that provincial governments are responsible for funding certain services – all those deemed medically necessary – for which every Canadian resident is, in theory, provided with insurance by the public sector. The term “core services” has been used to describe those services covered by the provincial health plans. “Non-core services” are those that fall outside the legislative framework. The Canada Health Act explicitly forbids any Canadian from buying from the private sector a medical service that is already covered under the public health system. Private insurance plans are not allowed to cover “core services” and may only cover “non-core services.” As a result, the role of private medical insurance in Canada is limited to supplemental care. The role of the private sector is further discouraged by the regulation of private physician practice and private insurance plans.

However, despite the provisions of the 1984 Act, private medicine still survived – indeed, in recent years it has flourished and the amounts spent on it have risen dramatically – but only on fringe, alternative, and unlisted services. Thus, private insurance remains a small industry, contributing only 11.2 per cent of total health expenditures (OECD). Of the plans purchased, over 85 per cent are purchased on a group basis by an employer, a union, or an association (Klatt).

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<sup>1</sup> National Post, 22 May 2000

<sup>2</sup> Vancouver Sun, 12 October 2000

### **Creeping Privatisation: The Changing Role of the Private Sector**

Although, the Health Act was designed to prevent the development of a two-tiered system, nothing is ever that straightforward. Given the preponderance of long waiting times, some analysts have argued that the Act does not apply: surgery performed without waiting is simply not the same treatment as surgery for which one is required to wait months. The distinction has never been tested in the courts, but it has led to a growing private sector in areas once thought to be off-limits.

The core requirement of the 1984 Act is that hospital and physician services be 100 per cent publicly financed. But as health care becomes less focused on hospital and physician care (together they comprise less than half of total health care expenditure in Canada) and more focused on community care and drugs (the latter now exceed physician costs), less and less healthcare treatment service is covered by medicare. Dental insurance, eye-care insurance, insurance for prescription drugs, ambulance services, medical devices, private health insurance covering the upgrading of hospital rooms and out of country insurance are all outside the scope of medicare.

For-profit clinics have sprung up across the country. Some are entirely private, some contract with the local health authority. New forms of privatisation have evolved which creatively (and sometimes subversively) attempt to stay within the confines of the Health Act principles. Some private providers have “cherry picked” lucrative, high volume, and low risk services such as MRI scanning, bone densitometry, cataract and corrective eye surgery, rehabilitation (particularly physiotherapy) and arthroscopic surgery. Another “privatisation by stealth” practice is to combine provision of an insured service with non-insured additions. This may lead to queue jumping, where the patient who books fast access to a non-insured service simultaneously gains access to the insured service, for which others would have to wait longer. These practices erode the principles of the Canada Health Act, and suggest a move towards the creation of a two-tiered service (Lewis *et al*).

The issue of privatisation is sensitive in Canada, owing to several recent changes that have shaped public opinion. Massive government reinvestments in health care have not brought stability to, or restored confidence in, public care. This is why the recently appointed federal health minister, Anne McLellan, in similar vein to Alan Milburn, has gone out of her way to suggest that she has a far more open minded to private provision than her predecessor, Alan Rock. Ms McLellan has said that she does not think that the expansion of the private sector’s role in the healthcare system would undermine the key principles of Medicare.

The public seem ready for such an expansion. Last year, the Canadian Medical Association sponsored a poll on user fees. Its results were far from expected; 57 per cent supported user fees (Gratzer, 2002, pg 19). A further Michael poll in August 2001 found that a clear majority of Canadians support both user fees and a private insurance option. (A first, similar poll in 1991 found only a small percentage of the public accepting such ideas.) (Gratzer, 2002)

### **Lessons for Britain:**

The five principles of Canada’s Health Act aim to provide a fair system to Canadians based on the model of public funding. The legislative structures highly regulate all aspects of the private sector to prevent a two-tiered system. However, enterprising private clinics have found ways to provide better quality of care to patients by successfully circumventing the five principles of the Health Act, so Canadian’s die-hard opposition to the private sector as a way of alternative financing may be to its detriment. Meanwhile, the federal government has withdrawn much of its funding and leaves the provinces to foot most of the bill. This tide may be changing, with recent public opinion polls showing more acceptance and support of user fees and private insurance options. Future reforms may show Canadians are more open to other options for funding their healthcare system.

- The Canadian system has many fans, and not just within Canada. Like the NHS to Britons, medicare is a quasi-religion to Canadians. Both systems are regularly subject to the claim that they are the best in the world. And just as the main argument in defence of the NHS is that it is free at the point of use, and as such theoretically the most equitable system possible, so the argument goes that, in comparison with the market model of the US, the Canadian system places a justified premium on fairness.
- Canadians have traditionally mistrusted the involvement of the market in health care. Comparison with the US is geographically and ideologically understandable, but unfortunate. Firstly because opinion of US health care is largely based on myth (many Americans believe these myths too), and secondly, because Canadian system performance should be assessed by looking at other publicly funded systems.
- Unfortunately – as with the NHS – the practice leaves much to be desired. Both the NHS and medicare have founding and guiding principles which they systematically fail to meet or abide by. Hence the charge in Canada that “everything is free but nothing is accessible”.
- Gratzner (2001) highlights three problems within the Canadian single-payer (government) healthcare model. First, accountability is poor and aggravated by the Federal structure. Second, decision-making is politicised. Third, single-payer government control leads to a lack of innovation. These three lead to a lack of responsiveness to patient needs or wants.
- Aba *et al* (2002) argue that Canadian health care is inefficient in that financing (lack of direct payment) does not encourage users and providers of health care to be accountable for the economic benefits and costs of services.
- Single-payer tax financed healthcare lends itself to rationing. Waiting times (owing to rationing by queuing) are a serious concern to Canadians. These are often caused by the lack of availability to medical technology. Again, this is reminiscent of the UK: A recently released report from the UK Audit Commission (2002) reveals “there are relatively short waits for general X-rays but waiting times for some other examinations are excessive. For example, the average wait for general ultrasound is eight weeks and 20 weeks for MRI scans, with a quarter million people waiting for these examinations alone. Tellingly, usage of different items of equipment varies by a factor of two or more across similar departments. For example, some MRI scanners are used for 4,000 examinations a year, but others are used for fewer than 2,000 examinations”. Such scenarios can be found with ease in the Canadian press.
- Despite poor availability in Canada of advanced medical technology, international comparison reveals pretty good healthcare outcomes – generally better than those in the USA and the UK and more akin to those associated with high spending European social insurance systems such as France and Switzerland (OECD). Life expectancy is high, cancer survival rates are good and deaths from IHD and stroke are average.
- So yes, it ‘works’, in that on many measures it delivers a broadly acceptable level of healthcare. But so much depends on what one wants from a health system. On most objective measures the Canadian system at best disappoints, and at worst is simply unacceptable in a wealthy, modern nation, particularly when expenditure is considered. The Dutch with their highly regulated system have recently begun to feel this more strongly and look set to embrace markets with renewed vigour in order to get more for their money and to enable healthcare supply more closely to reflect demand.

- So why does Canada perform relatively well? Studies have shown that a number of non-health system related factors affect health outcomes. Perhaps the high level of expenditure is important. Canada also benefits from lower levels of income inequality than the US and UK. Tobacco consumption is low in comparison to OECD member countries.
- On an ideological level some might consider the Canadian system attractive, however, the reality is that the Canadian tax-funded single-payer model restricts expenditure to such an extent that healthcare supply far from matches demand. Though private expenditure has increased significantly to plug some of this gap, other healthcare funding systems have done so much more successfully.

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