

## Canada: variations on a common theme

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### Abstract

Canada faces health care challenges common to all industrialized countries – how to ensure timely access to high quality care, close to home, at an affordable cost. Addressing these challenges is complicated by inter-jurisdictional variation in both how health care is managed and delivered, and in health outcomes. Canada can be described as a non-system of 10 provincial and three territorial health insurance plans which mandate publicly-funded coverage for medically necessary hospital and physician services, based upon common principles and shaped by a federal governance structure that affords substantial power and autonomy to the provinces/territories over matters of health and health care. This article first examines the structural context of the health care system in Canada, including the range of services publicly funded, the public-private mix, and the complexities of current governance arrangements. It then discusses several issues affecting health policy reform: costs versus access; questions of sustainability, quality, and performance; human resources capacity; and the provision of public and population health services.

*Key words: Canada, health care, federalism, primary health care, public health*

### Introduction

Canada faces health care challenges common to all industrialized countries – how to ensure timely access to high quality care, close to home, at an affordable cost. Its performance is also comparable to its peers, with both Canadian health outcomes and costs (10.1% of GDP in 2009) reasonably equivalent to the Organization for Economic Co-operation and Development (OECD) average. [1, 2]

These challenges are heightened by Canada's proximity to the United States. Health reformers in the US have often looked north for a feasible model; those trying to block reform thus emphasize the perceived failings of the 'Canadian model'. Health care is a source of pride to Canadians, yet they are perpetually worried about its sustainability. [3]

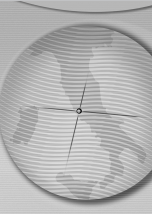
Because the Canadian constitution has placed responsibility for health care at the provincial/territorial level, there is no Canadian health care system per se. Substantial variation exists within and between jurisdictions in how services are managed and delivered, and in health outcomes. [4] About 70% of health expenditure is financed publicly, including almost all physician and hospital services. This publicly-financed insurance

is commonly referred to as Medicare. This leaves a substantial and growing role for private financing, particularly for certain categories of services. However, virtually no services are publicly delivered and Canada uses what the OECD calls a public contract model for its publicly-insured services, [5] under which public money is coupled with largely private delivery. [6] In consequence, generalizations about "the Canadian health care system" are hazardous, although there is a common core. [7-9]

Understanding how challenges can (or cannot) be dealt with in turn requires an examination of the structure of health care across Canada.

### Structure: financing and delivery

Health care systems vary in terms of how care is paid for (financing), how it is delivered (delivery), and how the money flows, which includes the incentives inherent in various payment systems (allocation). Analyzing the 'public-private' mix further requires distinguishing among levels of public and private. [6] Private includes corporate for-profit companies with a fiduciary responsibility to maximize return to their shareholders, for-profit provider-owned practices, not-for-profit organizations, and individuals and their families.



Public includes various levels of government. Quasi-public, although nominally private, is heavily regulated by government and expected to pursue public objectives. In Canada, most health care delivery is private, both not-for-profit (e.g., hospitals), and provider-owned (e.g., physician practices, rehabilitation); both public and corporate for-profit delivery play minor roles, although the corporate role is growing. [6, 10]

### Roles and responsibilities

Canada has a small population on a large land area with at least four levels of government: national (federal government), provincial/territorial (10 provinces and 3 sparsely populated northern territories), regional, and local. The 1867 law establishing Canada included specific language enumerating the division of powers between the federal and provincial/territorial levels. [11] Regional/local governments within provinces/territories are deemed to fall under provincial jurisdiction and have only those responsibilities delegated to them; these can be changed unilaterally. Those powers not specifically mentioned as federal fall, by default, to the provinces/territories. [12] Health is considered a provincial/territorial responsibility, in part due to a mention of “the Establishment, Maintenance, and Management of Hospitals, Asylums, Charities, and Eleemosynary Institutions in and for the Province, other than Marine Hospitals” as a provincial power. Financing and delivery thus vary by both jurisdiction and sub-sector.

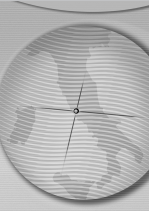
Some provincial/territorial governments have chosen to delegate some activities under their jurisdiction to regional authorities and/or local government. For example, although responsibility for traditional public health activities (e.g., health promotion programs, immunization programs, food and water testing) often rests at the provincial/territorial level, many provinces have delegated various degrees of responsibility for these activities to regions/municipalities. [13–15] In addition, although health delivery is private, most Canadian provinces have replaced their formerly independent hospital boards (plus an array of other services, depending upon the province) by quasi-public regional authorities. These bodies receive funds from the provincial government and deliver those services placed within the regional structure, either directly, or through contracting to other providers. [16] This too varies by jurisdiction.

Although health care is largely a provincial/territorial responsibility, the federal government nonetheless has a combination of explicit and

implicit roles. The federal government is directly responsible for service financing and delivery to several defined populations (including the serving military, federal prisoners, and the First Nations and Inuit populations), although it has increasingly moved away from models in which they directly deliver care, to a public contracting model. The federal government also has explicit power over “quarantine” (interpreted as referring only to migration at national borders, but not to outbreaks within Canada), and for drug approvals (to ensure safety of commercial products sold across provincial boundaries), and a less well-defined mandate for matters of “national concern”, generally understood within the context of federal criminal justice powers. The federal government can also, if it chooses, provide leadership to federal/provincial/territorial efforts to develop and coordinate policies in such areas as disease prevention, health promotion, or regulations. [7]

However, the major federal role is fiscal; to compensate for differences in fiscal capacity across the country, the national government has transferred funds to the provinces for various defined purposes. These transfers have differed over time and are bound up in the complexities of fiscal federalism. [7, 17] Initially, Ottawa agreed to share about half the costs for any province willing to set up insurance plans for hospital services, and subsequently for physician care; all provinces had done so by 1971. Subsequently, the governments moved to a system whereby federal money went directly into provincial general revenues, in a combination of cash contributions and ‘tax points’ (where the federal government reduced its tax rate, allowing provinces to increase theirs without affecting total tax burden). To receive federal money (currently transferred via the *Canada Health Transfer*), each provincial/territorial government must ensure that its publicly-financed insurance plan complies with a set of national principles, currently specified in the *Canada Health Act, 1984 (CHA)*. [18] These are:

- *Public administration*: This condition is the most frequently misunderstood. It does not deal with delivery (which can be, and is, private), but with the operation of the provincial/territorial insurance plans (which must be “administered and operated on a non-profit basis by a public authority”). This condition sets up a single payer for Medicare services, and reduces the scope for private insurers to cover insured services (although they are still able to cover non-insured services, and/or non-insured persons).
- *Comprehensiveness*: All “insured health



services” must be fully covered. However, the definition of insured services, heavily influenced by the previous cost-shared programs, is based both on medical necessity, and on where care is given (hospitals) or by whom (“practitioners”, usually defined as physicians). The definition is a floor rather than a ceiling; provinces are allowed, but not required, to insure beyond these limits. Care falling outside the CHA requirements includes: home care; public health; mental health services; dental care; vision care; prescription drugs; services for other health professionals (e.g., midwifery); and assistive devices (e.g., health appliances and equipment). Depending on the jurisdiction, provinces/territories may nonetheless cover some of these items, either universally, or (more usually), for specific groups (e.g., the elderly, disabled, children, low income, those with particular diagnoses, etc.). With the economic downturn and the erosion of private benefit plans, access to such services for Canadians falling outside of these programs is becoming increasingly problematic. [19]

- **Universality:** All insured persons must be covered for insured health services “on uniform terms and conditions.” The single payer cannot exclude people likely to be high cost, although it can exclude those already covered by other federal or provincial legislation (e.g., serving members of the Canadian Forces).
- **Portability:** Because plans are organized on a provincial basis, the CHA includes provisions for handling people requiring care in a province other than the one in which they are insured. To separate temporary from more permanent absences, provinces were allowed to establish waiting periods, of not more than three months, before covering new residents; the “home” province would retain responsibility for coverage during that waiting period. (This has proven problematic for immigrants to some provinces, since they do not have a ‘home’ province, and hence may not be covered immediately.) The portability provisions are subject to inter-provincial agreements. In addition, the CHA allows provinces to restrict coverage to ‘emergency’ situations (to avoid having people travel to receive services covered in some but not all jurisdictions). There is, accordingly, variation in what is considered emergency, in the extent to which the portability provisions cover out-of-country care, in how absences exceeding 3 months are dealt with (e.g., students studying in another province), whether the care will be paid for at home province or host province rates, and so on.

- **Accessibility:** Finally, the insurance plan must provide for “reasonable access” to insured services by insured persons; user charges are not permitted. This section also provides for “reasonable compensation for ... services rendered by medical practitioners or dentists” and for payments to hospitals to cover the cost of the health services they provide. Note that neither reasonable access nor reasonable compensation are defined by the CHA, although there is a presupposition that certain processes (e.g., negotiations between the provincial governments and organizations representing the providers) satisfy the condition. The CHA allows for dollar-for-dollar withholding of federal contributions from any provinces allowing user charges or extra-billing to insured persons for insured services.

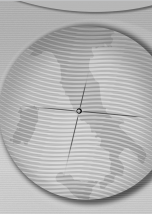
Within the framework of the CHA, provinces/territories vary considerably in terms of how they have chosen to finance and manage care. What gets covered by public funds is becoming increasingly more problematic as care is shifted from the hospital to the home and community; a change in the site of care can potentially result in a shift of who pays for services. [20] For example, medically necessary pharmaceuticals must be publicly insured only if given to hospital inpatients. Similarly, rehabilitation services delivered outside of the hospital setting may require recipients of care to pay for these services, either out-of-pocket or through private insurers.

### The current challenges

In 2002, two major national investigations on the future of Canadian health care generated reports and commissioned scholarly papers. [21–25] Other reports and analysis are regularly generated, including ones by the Canadian Institute for Health Information (CIHI). [4, 26, 27] The ongoing dialogue has led to considerable discussion, but remarkably little change. [28] We next focus on several issues identified by these reports; the goals to be pursued (specifically, cost vs. access, and the role of appropriateness); improving the efficiency of care delivery (including reforming primary health care); health human resources; greater emphasis on health promotion and the determinants of health; and the roles and responsibilities of different levels of government, particularly how these affect public health.

### Goals: costs vs. access

In the 1990s, Canada identified cost containment as a major issue; the resulting cost control measures



did manage to contain costs. Publicly paid per capita expenditures in inflation adjusted dollars actually decreased. [27, 29, 30] Hospital beds were reduced, and growth in the ratio of health providers to population shrank. In turn, this led to perceptions of waiting lists and shortages, and rising public dissatisfaction. [31, 32] The pendulum thus swung to a focus on access issues, with policy emphasis heavily focused on alleviating waiting times, and addressing perceived shortages of health providers. Considerable resources were re-invested. Although the public share of health expenditures has remained relatively stable at approximately 70%, over the past decade, total health care expenditures in Canada have been rising (e.g., from \$ 78.7 billion in current dollars in 1997 to a forecasted \$ 183.1 billion dollars in 2008). [26, 27] More recently, the economic slowdown has allowed cost concerns to re-emerge, and the current dialogue is again placing increasing emphasis on sustainability and cost containment. [33] To a striking extent, this dialogue has relied upon questionable extrapolations of health expenditures resulting from the “aging tsunami,” which, although superficially compelling, are not justified by the data. [34–37]

One set of arguments suggests that health costs are not sustainable, and that the solution is to privatize and shift costs from public to private payers. Others note that sustainability should be seen at the societal level, and that increasing total costs (and the burden on payroll) while decreasing access hardly seems optimal. At its core, this is an ethical debate, relating to the extent to which costs should be borne collectively, and whether access should be based on need, or ability to pay. [34, 38]

### Improving efficiency, quality and performance

Another set of reforms speaks of encouraging more efficient care delivery. It too has a number of dimensions. One perceived ‘win-win’ is to emphasize quality and patient safety. [39] Efforts to improve efficiency through reforming health care delivery (including greater focus on prevention and on primary health care) are also common themes, although the policy successes have been varied. Fortunately those needing care have been relatively satisfied, and health outcomes are and have remained relatively good, although improvements are always possible.

One widely-endorsed approach would attempt to move care from hospitals to home and community, often interpreted as placing greater stress on primary health care and care integration. The goals of such proposed reforms are many and varied, including: management

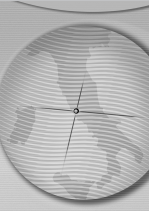
of health care utilization and costs (e.g., reduce costly hospitalization and specialist care, provide better health promotion and disease prevention, improve chronic disease management); improvement of access and reduction of wait times; improvement of quality (e.g., integration of best practices) and improvement of care continuity. Reformed primary care models include combinations of encouraging health teams rather than solo practitioners, rostering patients, ensuring continuity of care (with some provision for making sure that individuals can access care 24 hours/day, 7 days/week), and placing increased emphasis on health promotion and disease prevention. [7, 40–42]

One dispute is whether the emphasis should be placed on primary care (defined in terms of physician services), or on a broader view of primary health care, which would incorporate a wider spectrum of services, but potentially represent an expansion of which services would be publicly paid for. The general sense is that progress has been made, but there is still considerable room for improvement. [43, 44]

An associated set of reforms note that placing greater emphasis on home care, particularly to care for the frail elderly, could also relieve stress on acute care and on institutionalized long-term care. However, encouraging ‘aging at home’ strategies would represent a considerable expansion of what the public pays for, and as such movement has been slow. [45, 46] Accordingly, there has been a tendency for programs initially designed to encourage aging at home to instead modify their focus to concentrate on encouraging moving ‘alternate levels of care’ (ALC) patients from hospitals to more cost-effective alternatives, rather than concentrating on the longer-term potential for improving efficiency by providing care for vulnerable populations who have not yet been hospitalized.

A related focus has suggested changing how providers are paid. The starting point was that most physicians worked in solo or small group practices and billed their provincial/territorial public insurance plans on a fee-for-service basis, with the billing codes negotiated separately in each province/territory between the provincial medical association and the provincial ministry of health. This gave providers incentives to increase the volume of care. Blended models were available (using mixes of fee-for-service, capitation, salaries, etc.) Hospitals were paid on the basis of global budgets, and had an incentive to minimize the number of services they provided. Fewer than 10% of physicians were working as part of a





multidisciplinary team. Canadians were able to choose their physician (although referrals were generally required for specialist care). Physicians were also free to choose their patients, set their own hours and working conditions, and decide which services they wished to provide; this has been shown to affect their preferred primary care model. [47] (Individual hospitals decided whether or not to grant hospital privileges to specialists). One perception was that this reliance on fee-for-service medicine was suboptimal, and many reform models sought to shift the mix of payment models.

One problem is that all payment mechanisms have advantages and disadvantages. If the problem is under-use, then payment on the basis of services would provide an incentive to do more, and relieve access problems. If the problem is over-use, then movement to fixed payments (including capitation and global budgets) could help improve cost control. [48] If the problem is misuse, then greater attention to appropriateness, including clarification of best practices, might seem called for. [49] In the absence of clear evidence about the best approach, Canada, like many other countries, has incorporated a mix of reforms, including a shift away from fee-for-service payment for physicians, and, somewhat paradoxically, a shift towards service-based payments for hospitals.

### Health human resources

Essential to health care delivery is health human resources (HHR) including those who work in the formal sector (i.e., those who get paid) and the informal sector (i.e., volunteers, family and friends who are not paid). An ongoing dispute is what the 'right' number of providers are, particularly since many of these are paid from public sources. There have been swings in perceptions from surplus to shortage, depending on whether the agenda is focusing on costs or on access. [50-52] Balancing supply and demand is further complicated because education, registration, and licensure exist at the provincial/territorial level. A high proportion of health care is delivered by workers in regulated health professions. There are about 25 of these across Canada, although the precise details also vary across jurisdictions. To practice, regulated health professionals must belong to their provincial profession-specific regulatory college. For example, to practice as a nurse in British Columbia, she/he must be a member of the College of Registered Nurses of British Columbia. These regulatory Colleges, whose governors include both public and

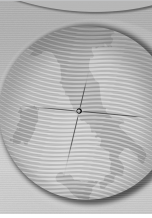
professional members, have been delegated the authority to regulate professional practice of their members in the public interest; this involves the setting and enforcing of standards and guidelines, and ensuring their members meet the designated training and educational standards. Another ongoing issue is the balance between regulated and unregulated workers, who do not have to meet such requirements. As care shifts from hospitals to community, there has been a tendency to seek cost savings by relying more heavily on these unregulated workers, particularly in the long-term care and home-care settings. There have, accordingly, been increased discussions on how best to use various categories of workers, including the extent to which it is necessary to standardize training and education. Other discussions have focused on how to integrate foreign-trained health workers, particularly when controls over entry to practice rest at the provincial/territorial level. There have been increased efforts to coordinate these requirements to simplify mobility of health professionals into and within Canada. [53]

### Greater emphasis on health promotion and the determinants of health

Another set of reforms seeks to prevent poor health. [54] It ranges from a focus on secondary prevention (including screening and chronic disease management) to a broader concentration on population health (including targeted and universal approaches) and the socio-economic and environmental determinants of health. Poverty and equity receive periodic attention, but relatively little emphasis, particularly to the extent these determinants fall outside the realm of health care. [55] Again, there is considerable inter-jurisdictional variation, and a proliferation of ill-coordinated local and community-based interventions.

### Public health: the federalism dilemma

A number of disease outbreaks made it evident that federalism weakened the ability to respond to public health emergencies. The 2003 Severe Acute Respiratory Syndrome (SARS) outbreak in Toronto, Ontario was the most obvious example, but other public health emergencies had also arisen, including threats to water safety (e.g., a major *E. coli* O157:H7 outbreak in the town of Walkerton, Ontario), food safety (e.g., Bovine Spongiform Encephalopathy), and concerns about how to manage influenza pandemics. Responsibility for public health activities also varies by jurisdiction, usually with a distinction between services to individuals, and services to



populations. Many services to individuals may be provided through primary care. For example, immunization may be provided in many settings, including in physician offices, public health units, schools, workplaces, or shopping malls, with only limited provincial immunization registry systems in place and no national tracking system available. [56] Such disconnections in the flow of public health information were highlighted during the SARS outbreak, when communication between the local health unit (which was managing the outbreak), the province (with formal responsibility for public health) and the national government (who was responsible for reporting to international bodies) proved sub-optimal, leading to imposition of a WHO travel advisory after the outbreak had been locally controlled. Leaving responsibility for health protection and emergency response at the provincial/local level clearly presented major risks, particularly if they arose in jurisdictions with fewer resources available, and seemed inherently inefficient. Accordingly, a series of reviews suggested reinforcing a national approach, fully recognizing that the approach would have to be consultative. [57]

One response was to set up the Public Health Agency of Canada (PHAC) and give it a leadership role in encouraging health promotion (including the dissemination of information on the determinants of health); the prevention and control of chronic diseases, injuries and infectious diseases; and preparedness and response to public health emergencies. However, the PHAC has limited policy levers; it depends upon formal and informal coordination with Health Canada (which retained control over federal health funds, food/product regulation, and environmental health) and with provincial/territorial governments. This

coordination may or may not occur. [58] An additional complication is that the current national government interprets federal powers narrowly and the Canadian Auditor General suggested that it had not taken on the leadership necessary to manage emergencies. [59] Recent events, including a listeriosis outbreak stemming from contaminated processed meat products in a federally regulated plant, and the management of H1N1 influenza, have demonstrated that coordination is still not optimal, and confusion about appropriate policy responses is still evident. [60, 61]

The summary appears to be that the glass is both half full and half empty. Health care and health outcomes in Canada are generally good, although there is always room for improvement. Reforms tend to take place at the local or provincial level, with considerable variation within and across jurisdictions. To a large extent, the success of this non-system depends on informal policy processes and individual provider-patient relationships. Breakdowns in care are likely to attract considerable attention, including mentions in provincial legislatures. A number of reforms are under way and while some of these reforms spread to other jurisdictions within the province/territory or country, others do not. Others focus on the accomplishments, and hope they can be sustained through the economic difficulties currently affecting so many countries.

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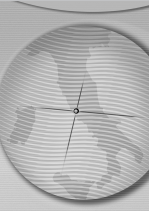
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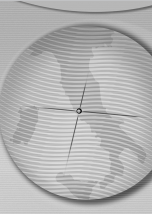
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