HiT Summary

Canada

Introduction

Government and recent political history

Canada is a constitutional monarchy based upon a Westminster-style parliamentary democracy. It has two constitutionally recognized orders of government: the central or "federal" government (consisting of the democratically elected members of the House of Parliament and appointed members of the Senate of Canada); and the provinces and territories.

Population

Canada's population is almost 32 million. The largest cities are Toronto (5.2 million) and Montreal (3.4 million). Population density averages 3.33 persons per km^2, but most of the population is concentrated in the country's more southern urban centres. The population is ageing, although the proportion aged 65 and over remains relatively low (12.8%). Aboriginal peoples constituted 4.4% of the total population in 2001. Canada has a high level of immigration; in 2003 18.4% of Canadian residents were born outside the country.

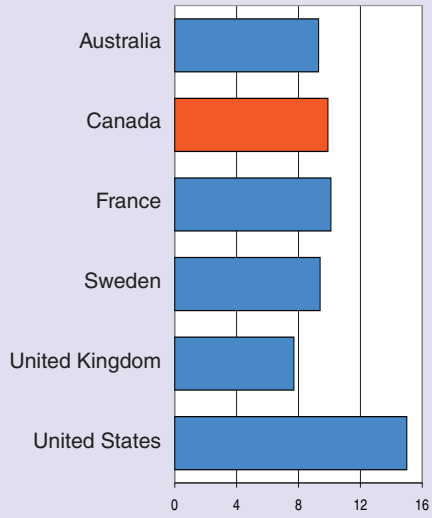
Average life expectancy

In 2001 life expectancy among women in Canada was 82.2 years, compared to 77.7 years for men. At the end of the 20th century, Canada ranked 5th among all OECD countries.

Leading causes of death

The main causes of death are circulatory disease, cancer and diseases of the respiratory system.

Fig. 1. Total health care expenditure as a percentage of GDP, comparing Canada with selected countries, 2003



Source: OECD Health Data 2005.

Although the infant mortality rate has declined steadily since 1970, Canada ranks only 17th among OECD countries with 5.2 deaths per 1000 live births.

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Recent history of the health care system

The current 13 single-payer, universal systems of hospital and physician care (termed "Medicare") evolved from a series of reforms following the Second World War. In 1947, 1949 and 1950 Saskatchewan, British Columbia and Alberta, respectively, implemented universal hospital services plans, termed "hospitalization". In 1957, the federal Hospital Insurance and Diagnostic Services Act was passed in Parliament, setting out common conditions that provinces would have to satisfy in order to receive shared-cost financing through federal transfers. By 1961 all provinces had agreed to work within the federal framework of hospitalization.

By 1972 all provinces and territories had also implemented universal public insurance for physician care. Federal cost-sharing transfers began flowing in 1968 to the provinces, conforming to the four general principles of universality, public administration, comprehensiveness and portability under the federal Medical Care Act. In 1977, the federal government and the provinces agreed to replace the cost-sharing transfer with a block transfer funding mechanism.

The Hospital Insurance and Diagnostics Act and the Medical Care Act were replaced by the Canada Health Act (1984), which outlines five conditions that provinces must continue to meet in order to receive funding from the federal government: universality, public administration, comprehensiveness, portability and accessibility.

Health expenditure and GDP

Total expenditure on health care in Canada was estimated at almost 10% of GDP in 2003. Relative to the five comparator countries, this is lower than the percentage of GDP devoted to health in the United States and France, but higher than the percentage of GDP in Sweden and the United Kingdom. Public expenditure constituted approximately 70% of total health expenditure in the same year. The remaining 30% of health expenditures are in the private sector, paid either out of pocket or through private health insurance.

Overview

Canada has a predominantly publicly financed health system with services provided through private (for-profit and not-for-profit) and public (arm's-length or state-run) bodies. There are 13 single-payer, universal systems for "medically necessary" or "medically required" services – largely hospital and physician services defined as "insured services" under the federal Canada Health Act. The 13 provinces and territories vary considerably in terms of the financing, administration, delivery modes and range of public health care services. The federal government is responsible for collecting and providing health data, research and regulatory infrastructure, in addition to directly financing and administering a number of health services for selected population groups.

While the health care system has been successful in maintaining a high level of population health and has undergone a series of reforms, many challenges are emerging. These include the ageing population, increasing health care expenditure, particularly for pharmaceuticals, lengthy waiting times, and shortages of health human resources.

Organizational structure and management

There are three main levels to the organizational structure of the health system: the federal government, the provinces and territories, and the intergovernmental level.

Federal level

The federal government is responsible for protecting the health and security of Canadians by setting the standards for the national Medicare system, as well as public health, drug and

food safety regulation, data collection and health research – as outlined in the Canadian constitution. The federal government also has responsibility for directly providing health care for selected population groups, including First Nations people living on reserves and the Inuit, members of the armed forces, veterans, the Royal Canadian Mounted Police and inmates of federal penitentiaries.

Provincial and territorial level

Each province and territory have legislation governing the administration of a single-payer system for universal hospital and medical services. They are responsible for funding hospitals, either directly or through global funding for regional health authorities, setting rates of remuneration for physicians (after negotiation with the professional associations), providing public health services and, in some cases, assessing health technologies and funding health research. Provinces also provide, directly or indirectly, a variety of home care and long-term care subsidies and services. All provinces administer their own prescription drug plans, providing varying degrees of coverage to residents. Regional health authorities within the provinces are responsible for allocating health resources and planning public health programmes.

Intergovernmental level

Intergovernmental councils, committees and organizations facilitate and coordinate numerous policy and programme areas. Included in this level are advisory committees to the Conference of Federal/Provincial/Territorial Ministers of Health in four areas: health delivery and human resources; population health and health security; information and emerging technologies; governance and accountability. Over time, federal, provincial and territorial governments established and funded a number of arm's-length intergovernmental health organizations including: Canada Health Infoway Inc.; the Canadian Coordinating Office for Health Technology Assessment; the Canadian Council for Donation and Transplantation; the Canadian Health Services Research Foundation; the Canadian Institutes for Health Information; the Canadian Patient Safety Institute; and the Health Council of Canada.

Planning, regulation and management

Health facilities and organizations, including hospitals and regional health authorities, are accredited on a voluntary basis through a nongovernmental organization (the Canadian Council on Health Services Accreditation). Health institutions and their providers, in particular physicians, are liable to patients for negligence. The provincial minister of health and cabinet are ultimately accountable to all provincial residents for administering and delivering public health care and thus for the performance of regional health authorities.

Professional standards and codes of conduct are set through the relevant profession's regulatory body and the provincial laws that give the profession the right to self-regulate, subject to certain terms and conditions. There are three different approaches to provider regulation in Canada: "exclusive scope of practice", also known as licensure; "right to title", also known as certification or registration; and "controlled acts system", which regulates specific tasks or activities. Although specific regulatory approaches for provider groups can vary considerably across provinces, the approach is remarkably consistent among certain professional groups such as physicians and dentists.

Decentralization of the health care system

The administration of public health services in Canada is highly decentralized, owing to at least three factors: provincial responsibility for the administration and delivery of most public health care services; the historic arm's-length relationship between government on the one hand and the hospital sector and physicians on the other; and recent regionalization reforms in which

subprovincial organizations are now responsible for the allocation of most publicly-funded health resources.

Health care financing and expenditure

Health care financing

The main source of health care financing in Canada is taxation by the provincial, territorial and federal governments (70% of total health expenditure), the bulk of which comes from individual income taxes, consumption taxes and corporate taxes. In addition, some provinces raise supplementary health revenues through earmarked taxes known as premiums. Private financing (27%) is split between out-of-pocket payments (15%) and private health insurance (12%). The remaining 3% of expenditure comes from social insurance funds, mainly for health benefits through workers' compensation, and charitable donations targeted to research, health facility construction and hospital equipment purchases.

Health care coverage

Under the Canada Health Act, all residents of a province or territory are eligible to receive "insured services" free at the point of delivery. This includes landed immigrants after an initial residency period (but not foreign visitors), as well as serving members of the Canadian military or the Royal Canadian Mounted Police and inmates of federal penitentiaries.

Health care benefits and rationing

The Canada Health Act stipulates that provinces must provide "medically necessary" or "medically required" services to their residents. These "insured services" under the Act include virtually all hospital, physician (including some dental surgery) and diagnostic services. Services excluded from this package include most dental care, most vision care, long-term care, home care, and pharmaceuticals prescribed outside of hospitals. Currently 33.8% of all prescription drugs, 21.7% of all vision care and 53.6% of all dental care are funded through private health insurance. Most of this insurance is employment-based and treated as part of compensation packages, rather than privately purchased by individuals. Provinces vary in the extent to which non-Canada Health Act insured services are covered or subsidized in the provincial health plans.

Out-of-pocket payments

Out-of-pocket payments make up the second most important source of funds for health care and the single most important source of financing for private health goods and services, namely vision care, over-the-counter medication, and complementary and alternative medicines and therapies. Also, about 20% of prescription drugs are financed in this way.

Voluntary health insurance

The third largest source of health care financing is complementary private health insurance. The majority of private health insurance is employment-based insurance and designed to provide coverage for health goods and services not covered by Medicare. Although largely employment-based and paid for by employees and employers (and in few cases purchased solely by individuals, e.g. the self-employed), private health insurance is supported through tax expenditure subsidies. Private health insurance that attempts to provide a private alternative, or faster access, to medically necessary hospital and physician services is prohibited or discouraged by a range of provincial regulations. Six provinces – British Columbia, Alberta, Manitoba, Ontario, Quebec and Prince Edward Island – prohibit the purchase of private health insurance for Medicare services, although the prohibition in Quebec has been called into question by the Supreme Court

of Canada's ruling in July 2005 (*Chaoulli* v. *Quebec*).

Health care expenditure

Canada spent about C$30 billion on health care in 2004: approximately 43% was directed to hospital and physician services, mostly "insured services" under the terms of the Canada Health Act; 23% was spent on provincial programmes and subsidies for long-term care, home care, community care, public health and prescription drugs; 4% on direct federal services; and 30% was spent on private health care services, largely dental and vision care services, as well as prescription and over-the-counter drugs. Over the past decade, private health care spending has risen faster than public spending; this rise has largely been driven by growth in the pharmaceutical sector.

Provision of services

Public health services

Public health services are categorized by six discrete functions: population health assessment; health promotion; disease and injury control and prevention; health protection; surveillance; and emergency preparedness and response. The federal, provincial and territorial governments, as well as regional health authorities, perform some or all of these functions, and all governments appoint a chief public/medical health officer to lead their public health efforts. In addition, the Canadian Public Health Association is a voluntary organization dedicated to improving the state of public health in Canada.

Since the outbreak of SARS in 2003, the federal government has expanded its national infectious disease control and prevention infrastructure and established the Public Health Agency of Canada with a mandate to provide or coordinate a number of public health functions. In addition, the Public Health Agency's office in Winnipeg, Manitoba, now houses the newly created International Centre for Infectious Diseases. The federal government also runs a number of specific health promotion and education programmes concerning alcohol and drug abuse, family violence, fetal alcohol syndrome, mental health, physical activity, safety and injury, AIDS prevention, and tobacco reduction.

Provincial and territorial ministries of health are responsible for a number of immunization and screening programmes. Provincial efforts at comprehensive screening vary considerably. Since the 1990s, national screening initiatives in breast and cervical cancer have been launched, coordinated by the Cervical Cancer Prevention Network and the Canada Breast Cancer Screening Initiative. However, there has been no intergovernmental screening initiative on colorectal cancer to date, with only a pilot programme in Ontario.

Primary/ambulatory care

General practitioners, or family physicians, serve as the patient's first point of contact; they are gate-keepers to higher levels of the health system. Physicians typically work independently on a fee-for-service basis. Patients have freedom of choice in selecting a family physician, although most choose to have long-standing relationships with their family physicians.

In recent years, primary care has been the focus of public health care reform efforts in Canada. A noteworthy change is that the majority of provinces are changing their laws to enable nurse practitioners to deliver a broad range of primary care services. Increasing investment in primary care has been associated with some jurisdictions replacing fee-for-service remuneration with alternative payment contracts for physicians, improving around-the-clock access to essential services, and accelerating the development of telehealth applications in rural, remote and northern areas of the country.

Secondary/inpatient and specialized ambulatory care

Virtually all secondary, tertiary and emergency care, as well as the majority of specialized ambulatory care and elective surgery, is performed within hospitals. The prevailing trend for decades has been towards the separatist model of hospital, in which the hospital specializes in acute and emergency care, while primary care is left to family physicians or community-based facilities, and long-term care to nursing homes and similar institutions.

Like most OECD countries, Canada experienced a fall in the number of hospitals in recent years; from the mid-1980s to the mid-1990s, there was a 20% drop in the total number of hospitals offering inpatient care. Hospital admissions declined by 12.8% from 1995 to 2001; however, on the whole, average length of stay actually increased by 1.4%, with considerable variation across provinces ranging, for example, from a decline of 11.8% in Saskatchewan to an increase of 19% in Alberta.

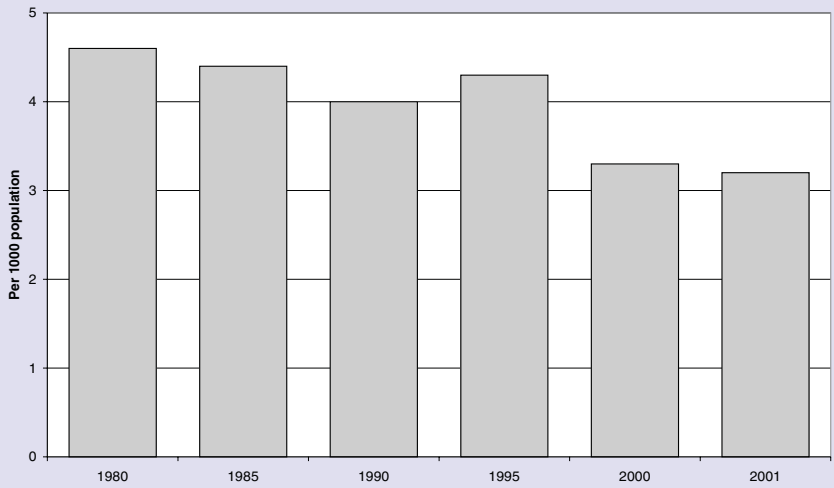
Long-term care and home care

Most long-term care for dependent, and often frail, elderly people is provided in nursing homes. These facilities are either run by the regional health authorities, or are independent private-for-profit or not-for profit organizations. For individuals requiring less intensive care or living assistance, home-based care may be an option, although its availability and quality varies considerably from province to province.

Human resources and training

The Canadian Medical Association is the umbrella national organization for physicians, including specialists and general practitioners, responsible for lobbying on behalf of its members and conducting an active policy research agenda. The Royal College of Physicians and Surgeons is responsible for overseeing the postgraduate training of physicians. The provincial and territorial medical associations are self-governing divisions within the national association, while

Fig. 2 Beds in acute care hospitals, 1980–2001



Source: OECD 2004.

the provincial colleges are responsible for regulating and disciplining physicians.

Except for the United Kingdom, Canada now has fewer physicians per 1000 population relative to the four other comparison countries of Australia, France, Sweden and the United States. By the early 1990s, specialist physicians had begun to outnumber family physicians. Canada has had a relatively high number of nurses per capita relative to the comparison countries, although the number declined significantly in the 1990s.

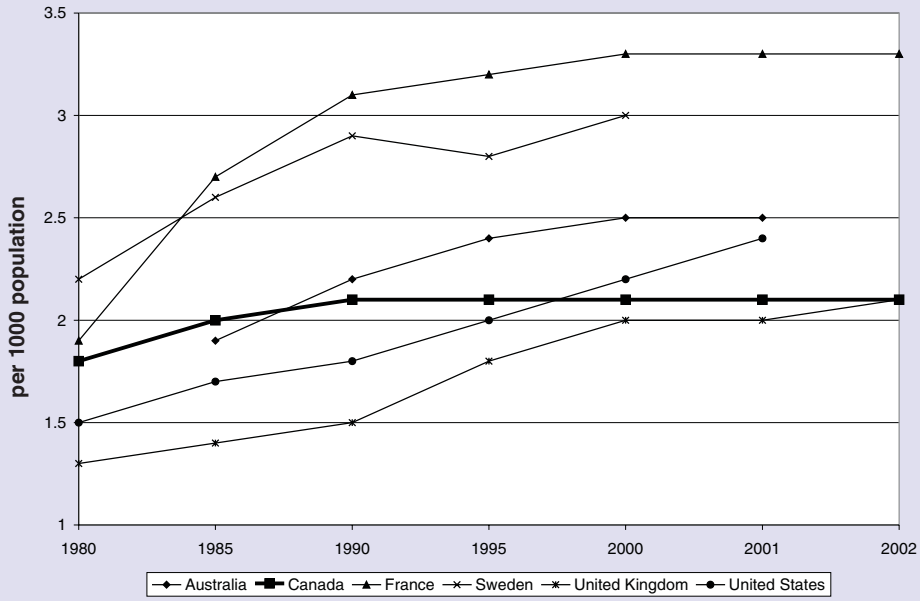
Pharmaceuticals and health care technology assessment

After hospital care, prescription drug therapy combined with over-the-counter drugs now constitutes the second largest category of health care expenditure in Canada.

Both federal and provincial governments are responsible for regulating prescription drugs. At the federal level the Therapeutic Products Directorate of Health Canada determines the initial approval and labelling of all drugs. Provinces then deploy various cost-containment strategies such as restrictive provincial formularies and reference pricing based on the lowest-cost (patented or generic) alternative. Health Canada prohibits direct-to-consumer advertising of drug products and places some limits on the marketing of prescription drugs to physicians. Also at the federal level, the Patented Medicine Prices Review Board regulates the retail prices of patented drugs; generic drug prices are not regulated.

Health technology assessment activities operate at both provincial and intergovernmental levels. Provincial activities are coordinated at the federal level, to some extent, by the Canadian Coordinating Office for Health Technology Assessment, which aims to provide evidence-based information on existing and emerging health technologies. This organization established

Fig. 3 Active physicians, 1980–latest available year, Canada and selected countries



Source: OECD 2004.

the Common Drug Review in order to provide a national assessment on the clinical effectiveness and cost efficacy of new pharmaceuticals, although the final formulary listing decisions remain in the hands of individual provincial and territorial governments.

Canada has a low number of advanced diagnostic imaging technologies relative to the OECD average: 4.8 MRI units, 10.6 CT scanners and 0.5 PET scanners per million people. In 2000 the federal government established a Medical Equipment Fund to assist provinces in purchasing diagnostic and medical equipment in short supply, and training for specialized staff.

Financial resource allocation

Most of the revenue raised by the federal government for health expenditures is transferred to the provinces, although some is spent directly by the federal government, for items such as public health, pharmaceutical regulation and drug product safety, as well as First Nations and Inuit health care services.

The federal cash transfer, renamed the Canada Health Transfer in 2004, flows to the provinces and territories on a per capita basis. The development of a needs-based funding mechanism has been opposed by wealthier provinces.

In most provinces, the responsibility for financial resource allocation has shifted from health ministries to regional health authorities. These are required to submit a budget to the appropriate provincial ministry of health. Some provinces, particularly the western provinces, use a population-based funding method that attempts to evaluate the differing population health needs of each region, while others use more historically-based global budgets. Some provincial governments explicitly forbid regional health authorities from running deficits, while others permit budget deficits under certain conditions.

Payment of hospitals

Regional health authorities have both the freedom to allocate their budget among various health organizations and to determine the method of allocation and payment. Most hospitals and clinics providing medically necessary services are allocated global budgets by regional health authorities.

Payment of physicians

Physicians are remunerated for the most part on a fee-for-service basis, constituting 83% of total physician remuneration in Canada. Some exceptions include community clinic physicians, particularly in Quebec, who are paid salary. More recently, some provinces have pursued alternative payment contracts with family/general practitioners, based on a blended system of salary, capitation and fee-for-service. For example, a remuneration model has been developed in Ontario to provide incentives to promote preventive health care and better chronic disease management.

Most other health care personnel, the majority of whom are nurses, are paid salary to perform within hierarchically-directed health organizations. The majority of pharmacists are salaried and work for commercial pharmacies.

Health care reforms

Health care reforms in Canada can be grouped into two stages: 1988–1996, and 1997 to the present. The first stage was marked by public fiscal constraint owing to high government debt, first at the provincial level and then later at the federal level; the second stage was characterized by increasing health expenditures influenced by a more buoyant economy and lower public debt.

In the first phase of reform, costs were cut by reducing hospital bed numbers and the supply of human resources. The rationalization of service delivery was accompanied by a structural reorganization through regionalization (by

devolving funding from provincial governments to regional health authorities), with the aim to improve the coordination and continuity of health services. To support health services integration, both orders of government aimed to improve their health information and data management infrastructures. Most notably, in 1994 the federal government established the Canadian Institute for Health Information, which is now one of the world's premier health information agencies with extensive databases on health spending, services and human resources.

Canadians are in the midst of the second phase of health care reform. This period is marked by an increase in public health spending, concerns about the fiscal sustainability of public health care, and increasing discussion of market-based reforms predicated on either private finance or private delivery. As a result of growing public dissatisfaction and long waiting lists, provincial governments have invested heavily in their systems, to address shortfalls in human resources and medical equipment.

A series of commissions and task forces were established to advise the governments on the direction of reform. Most importantly, the Prime Minister established the Commission on the Future of Health Care in Canada, commonly known as the Romanow Commission. This Royal Commission recommended a series of changes, some of which have been implemented. Some of the Commission's recommendations were to: increase federal transfer funding to provinces; accelerate primary care reform; expand home care to include mental health as well as postacute and palliative care; establish a National Drug Agency, national drug formulary, catastrophic drug coverage and medication management; and consolidate funding and experiment with Aboriginal Health Partnerships.

Conclusions

The provincial and territorial Medicare systems continue to uphold the fundamental objective as outlined in the Canada Health Act (1984) to deliver "medically necessary" or "medically required" services on a universal basis without financial obstacles. Although financial barriers to physician and hospital services have been removed, there are some nonfinancial barriers, including timely access to certain types of health care, namely diagnostic test and surgical procedures, specialist physicians and even family physicians in some parts of the country. In 1999, an important initiative to deal with waiting times was established, and the Western Canada Waiting List Project developed priority-setting scoring tools for waiting lists in five clinical areas: cataract surgery; general surgery procedures; hip and knee replacement; magnetic resonance imaging; and children's mental health.

In July 2005, in the case of *Chaoulli* v. *Quebec*, the Supreme Court of Canada decided that the Government of Quebec's prohibition on private health insurance was contrary to that province's Charter of Human Rights and Freedoms in a situation when an individual's lengthy wait for Medicare services might seriously compromise the health of that individual. This decision calls into question the Canadian model of single-tier Medicare that prohibits or discourages a parallel tier of private insurance for services covered under Medicare.

In terms of indicators of health status, Canada fares quite well in aggregate indicators such as life expectancy, potential years of life lost, perinatal mortality, survival rates from stroke, and take-up of measles immunizations; however, it does not fare as well in terms of survival rates of cancer, respiratory disease and heart disease. Also the number of deaths attributed to overweight and obesity soared between 1985 and 2000. Yet, to the extent to which the health system is working effectively to reduce excess deaths – or avoidable mortality – Canada ranks fourth among 19 OECD countries.

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An important health care reform has been regionalization, which has changed Medicare by more effectively integrating hospital, physician and associated services covered under the Canada Health Act with those provincially covered or subsidized health services that are not part of the Act.

Despite considerable reform efforts, some issues remain largely unaddressed, including the regulation and growing cost of prescription drugs, as well as the impact of the highly fragmented system of Aboriginal health care.

The Canadian Health System profile was written by Gregory Marchildon (University of Regina). It was edited by Sara Allin (European Observatory on Health Systems and Policies) and Elias Mossialos (European Observatory on Health Systems and Policies). The Research Director for the Canadian Health System profile was Elias Mossialos.

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The Health Systems in Transition (HiT) profiles are country-based reports that provide an analytical description of each health care system and of reform initiatives in progress or under development. The HiTs are a key element that underpins the work of the European Observatory on Health Systems and Policies.

The Observatory is a unique undertaking that brings together the WHO Regional Office for Europe, the governments of Belgium, Finland, Greece, Norway, Spain and Sweden, the Veneto Region of Italy, the European Investment Bank, the Open Society Institute, the World Bank, CRP-Santé Luxembourg, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine. This partnership supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of health care systems in Europe.