The Canadian Health Care System, 2012

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What is the role of government?

Canada's provinces and territories have primary responsibility for organizing and delivering health services, including the education, accreditation, and licensure of health care providers. Many provinces and territories have established regional health authorities that plan and deliver publicly funded health services on a local basis. Some jurisdictions have consolidated a number of these authorities in recent years. Unlike the financing of the universal health insurance program, which is largely the responsibility of the public sector, health care delivery is almost entirely the domain of private actors. The federal government cofinances provincial/territorial health insurance programs through the Canada Health Transfer (described below), with funding conditional on the provinces'/territories' adhering to the five criteria of the Canada Health Act. The Canada Health Act sets pan-Canadian standards for hospital, diagnostic, and physician services. The federal government regulates the safety and efficacy of medical devices, pharmaceuticals, and natural health products; funds health research; and administers several public health functions.

Who is covered?

The Canadian provinces and territories administer their own universal health insurance programs covering all provincial and territorial residents. The federal government supports the public programs through fiscal transfers conditional on their meeting the five criteria of the Canada Health Act, including universal coverage for medically necessary hospital, diagnostic, and physician services (Medicare). Each province and territory is responsible for establishing its own specific residency requirements; undocumented immigrants, including denied refugee claimants, those who stay in Canada beyond the duration of a legal permit, and those who enter the country "illegally," are not covered in any federal or provincial program, although the provinces/territories do provide some limited services. Coverage of other health services is generally provided through a mix of public programs and private health insurance, or financed by out-of-pocket payments. The federal government provides additional health care benefits (and compensates provincial/territorial governments) for physician and hospital services provided to First Nations and Inuit, members of the Royal Canadian Mounted Police and the Canadian Forces, veterans, refugee claimants, and inmates in federal penitentiaries. Around two-thirds of Canadians also have private health insurance, which covers services that are not covered under the public programs (see below).

What is covered?

Services: To qualify for federal financial contributions under the Canada Health Transfer, provincial and territorial health insurance plans must provide first-dollar coverage of medically necessary physician, diagnostic, and hospital services, including inpatient prescription drugs, for all eligible residents. Provincial and territorial governments also provide varying levels of additional benefits, such as outpatient prescription drug coverage, vision care, dental care, home care, aids to independent living, and ambulance services. The federal government directly provides and funds a wide range of preventive services through the Public Health Agency; provinces/territories also provide public health promotion and prevention services (including immunizations) as part of their public programs. There is no nationally defined statutory benefits package; most public coverage decisions are made by provincial/territorial governments in conjunction with the medical profession. The federal government licenses medical devices and equipment, but purchasing decisions are made at the provincial or territorial level.

Cost-sharing: There is no cost-sharing for publicly insured physician, diagnostic, and hospital services. All prescription drugs provided in hospital settings are covered through the public program, with variable additional outpatient coverage offered by provinces/territories. Physicians are not allowed to charge patients prices above the negotiated fee schedule.

Safety net: Cost-sharing exemptions vary among the provinces/territories. There are no caps on out-of-pocket spending. However, the federal government supports tax credits for medical expenses through the Medical Expense Tax Credit, which applies to individuals who have significant medical expenses (above 3% of income) for themselves or their dependents. A disability tax credit and an attendant care expense deduction also provide relief to individuals (or their dependents) who have prolonged mental or physical impairments, and to those who incur expenses for care that is needed to allow them to work.

How is the health system financed?

Publicly funded health care: Public programs are funded by general taxation. The federal government contributes cash funding to the provinces and territories on a per capita basis through the Canada Health Transfer—block grants that accounted for about 20 percent of total provincial and territorial health expenditures in 2011. The current provisions to compensate for smaller tax bases in some less wealthy provinces/territories will be abolished after 2014 (see below). Public funding accounted for an estimated 71 percent of total health expenditures in 2011 (OECD 2012).

Privately funded health care: In 2010, out-of-pocket payments by private households represented about 14.3 percent of total health spending (OECD 2012). The main components of out-of-pocket spending in 2010 were dental care (20%), nonhospital institutions (mainly long-term care homes) (20%), prescription drugs (17%), vision care (12%), and over-the-counter medications (10%) (CIHI 2012). Private health insurance covers about two-thirds of the population (23 million people). In 2010 it accounted for approximately 12 percent of total health spending (CIHI 2012). Private insurance is obtained mainly through employment-based group plans, which cover services such as vision and dental care, prescription drugs, rehabilitation services, home care, and private rooms in hospital. Supplementary private insurance to provide faster access to publicly funded physician and hospital services is not available. Providers set their own fees for services covered by private insurance, and each insurer sets its own reimbursement level (e.g., based on the lowest fee among representative providers in a geographical area). Contributions to employer-sponsored private insurance are deductible from income for federal tax purposes, and are also deductible from income for provincial tax purposes in all provinces but Quebec. Premiums paid to any private insurance plan qualify as expenses eligible for the federal Medical Expense Tax Credit.

How are health services organized and financed?

Primary care: In 2010, of the total number of doctors (69,699), about half were family doctors and half were specialists (CIHI 2011a). Primary care physicians largely act as gatekeepers for further care. Most physicians are in private practices and are remunerated on a fee-for-service (FFS) basis, although an increasing number of family doctors receive alternative forms of public payment such as capitation, salary, and blended funding. Payment is sometimes linked to performance. In 2010, FFS payments made up just over 50 percent of payments to family physicians in Ontario, compared with 70 percent in Quebec and 85 percent in British Columbia (CIHI 2011b). Physicians in community clinics are salaried. Some of the new primary care teams paid partly by capitation require patients to register in order to receive capitation payments; otherwise registration is not required. Patients have free choice of primary care doctor, although in some areas choices are restricted owing to limited supply. Provincial and territorial ministries of health negotiate physician fee schedules with provincial and territorial medical associations.

Outpatient specialist care: The majority of specialist care is provided in hospitals, although there is a trend toward providing specialist services in private nonhospital facilities. Specialists are paid mostly on an FFS basis. Patients can choose

a specialist and access the specialist directly, but it is common for family physicians to refer patients to specialty care because many provinces pay lower fees for non-referred consultations.

After-hours care: After-hours care is generally provided by physician-led (and mainly privately owned) walk-in clinics and hospital emergency rooms. In most provinces and regions a free telephone service ("telehealth") is available 24 hours per day for health advice from a registered nurse. Traditionally, primary care physicians were not required to provide after-hours care, although many of the government-enabled group practice arrangements have requirements or financial incentives for providing after-hours care to patients registered with the practice. The Commonwealth Fund International Health Policy Survey (2009) of physicians found that only 43 percent of physician practices in Canada had arrangements for patients to see a doctor or nurse after hours. The Commonwealth Fund's 2010 survey of the population found that 65 percent of Canadians reported difficulty in accessing after-hours care.

Hospitals: Hospitals are a mix of public and private, predominantly not-for-profit, organizations, often managed locally by regional health authorities or hospital boards representing the community. They generally operate under annual, global budgets, negotiated with the provincial/territorial ministry of health or regional health authority. However, several provinces are beginning to introduce activity-based funding for hospitals. Activity-based funding has also been used to pay for additional services targeted, in national efforts, at addressing waiting times for services such as cancer treatment and cataract surgery. Hospital-based physicians generally are not hospital employees and are paid FFS.

Mental health care: The Canadian system includes universal health care coverage for physician-provided mental health care, alongside a fragmented system of allied mental health services. Hospital mental health care is provided in specialty psychiatric hospitals and in general hospitals with adult mental health beds. The Canada Health Act does not mandate public coverage of nonphysician mental health services (such as services of psychologists or social workers) outside of hospitals, but the provinces/territories all provide a range of community mental health and addiction services. Psychologists may work privately, and are paid through private insurance or out-of-pocket payments, or in publicly funded organizations under salary.

Long-term care: Long-term care (LTC) services and end-of-life care provided in nonhospital facilities and in the community are not considered insured services under the Canada Health Act. Provinces and territories may choose to fund services, and all do, but coverage varies among and within provinces/territories. Financing for LTC institutions is mostly public (72%); spending on nonhospital institutions accounted for about 10 percent of total health expenditure in 2010 (CIHI 2012). Some provinces have established minimum periods of residency as a condition for being eligible for admission to a facility. A mix of private for-profit, private not-for-profit, and public facilities provides LTC with variation in ownership across the country. About half of the provinces and territories provide some home care services without means testing, but access may depend both on assessed priority and on availability within capped home care budgets. Supply shortages limit the availability of publicly funded services, increasing the demand for private home care services. Most provinces charge user fees for nonprofessional home care services (e.g., homemaking, transportation, meal delivery, respite care). The provinces and territories are responsible for delivering palliative and end-of-life care in hospitals, and many provide some coverage for professional services outside these settings (e.g., doctors, nurses, and drug coverage). A significant number of deaths still occur in hospitals and in institutional long-term care (approximately 60%, compared with about 30% in the home).

What are the key entities for health system governance?

Because of the highly decentralized nature of health care in Canada, the provinces have primary jurisdiction over administration and governance of their health systems. Most provinces have established statutory relationships with devolved purchasing organizations; some of these arrangements include performance management within the broader

context of accountability agreements. At the national level, several intergovernmental, nonprofit organizations have been established in the past decade to improve overall system governance by monitoring and reporting on health system performance (the Health Council of Canada); disseminating best practice in patient safety initiatives (the Canadian Patient Safety Institute); and providing information on health and health care and standardizing health data collection (the Canadian Institute for Health Information). Nongovernmental organizations that play important roles in system governance include the professional organizations (e.g., the Canadian Medical Association), the provincial regulatory colleges responsible for governing the professions through their licensing role and by developing and enforcing standards of practice, and Accreditation Canada, which manages the voluntary accreditation of health care organizations including regional health authorities, hospitals, long-term care facilities, and community organizations. Most health care providers are self-governing under provincial/territorial law.

What is being done to ensure quality of care?

Over the past decade, as part of the 10-Year Plan to Strengthen Health Care (2004–2014), the federal government has increasingly earmarked funds it provides to the provinces/territories to support innovation and stimulate systemwide improvements in quality. For example, the federal Wait Time Reduction Fund (CAD$5.50 billion [US$5.5 billion] over 10 years) led to significant reductions in surgical and diagnostic wait times in its priority areas (cancer care, cardiac care, sight restoration, joint replacement, and imaging). All provinces publicly report waiting-time data and provide the Canadian Institute for Health Information with comparable data.

There is increasing use of health technology assessment in Canada to support and inform purchasing decisions, service management, and clinical practice. Health technology assessment organizations include the Canadian Agency for Drugs and Technologies in Health (CADTH), a national body, and specialized provincial agencies in Alberta, Ontario, and Quebec. CADTH's health technology assessment program produces information about the clinical effectiveness, cost-effectiveness, and broader impact of drugs, medical technologies, and health systems. The Common Drug Review at CADTH reviews the clinical and cost-effectiveness of drugs and provides common formulary recommendations to the publicly funded drug plans in Canada (except Quebec). These nonbinding recommendations support greater consistency of public drug plan access and evidence-based resource allocation.

The federally funded Canadian Patient Safety Institute promotes best practices and develops strategies, standards, and tools. Another program, the Optimal Use Projects program operated by CADTH, provides recommendations (though not formal clinical guidelines) to health care providers and consumers in order to encourage the appropriate prescribing, purchasing, and use of medications.

From 2000 to 2006, the Primary Care Transition Fund invested CAD$800 million (US$804 million) to support provinces and territories with the transitional costs of implementing large-scale primary care reform initiatives. Most of the funding was allocated for improvements in access, health promotion, disease prevention, and care integration and coordination, and to encourage the use of multidisciplinary teams. Major achievements in reforming primary care include widespread introduction of multidisciplinary teams in Ontario, Quebec, and Alberta; patient enrollment in Ontario and Quebec; the advancement of alternative payment methods to fee-for-service; and expanded primary care education for physicians and nurses.

There is no system of professional revalidation for physicians in Canada, but each province has its own process of ensuring that physicians engage in lifelong learning. For example, three provinces require physicians to participate in an education program in order to keep their professional license; others rely on peer review and self-assessment.
There is no information available on doctors' performance, but the Canadian Institute for Health Information produces regular reports on health system performance, including hospital standardized mortality rates and waiting times.

The Health Council of Canada assesses progress in improving the quality, effectiveness, and sustainability of the health system, but many quality improvement initiatives take place directly at the provincial and territorial level, with many jurisdictions having established quality councils to monitor and publicly report on health system performance.

Few formal disease registries exist, although many provincial cancer care systems maintain some type of patient registry. Provincial cancer registries feed data to the Canadian Cancer Registry, an administrative survey that collects information on cancer incidence in Canada.

What is being done to improve care coordination?

The number of doctors practicing in multidisciplinary teams is growing. In 2004, as part of an intergovernmental plan for health care (the 10-Year Plan to Strengthen Health Care), all governments agreed to provide at least half of their respective populations with access to multidisciplinary primary care teams by 2011. By 2007 about three-quarters of family physicians were working in physician-led multiprofessional practices (Marchildon 2012); most progress has been seen in Ontario (with 200 Family Health Teams serving about one-quarter of the population), Alberta (where about three-quarters of the province's family physicians work in 39 Primary Health Networks), and Quebec (with plans for 300 Family Medicine Groups to serve three-quarters of the population) (Hutchison et al., 2011). There were significant financial incentives to participate in these multiprofessional practices. In Ontario, for example, with the shift from FFS to blended capitation funding models, there was a 58 percent increase (inflation-adjusted) in payments to physicians between 2003–2004 and 2008–2009 (Henry et al., 2012). During that time family physicians in Ontario also received financial incentives for preventive services such as immunizations and cancer screening, and priority services such as attending births, home visits, palliative care, and prenatal care.

Some reforms have aimed at improving the systematic management of disease. Organized at the provincial level, many include incentive payments for physicians. British Columbia recently introduced its Full Service Family Incentive Program to support the management of congestive heart failure, diabetes, and hypertension; physicians receive annual payments for each patient with one of these conditions whose clinical management is consistent with recommendations in provincial clinical practice guidelines.

What is being done to address health disparities?

Health disparities are a significant issue in health policy in Canada, where specific groups suffer from a higher burden of illness than other residents. Poor people, homeless people, and the approximately 1 million Canadian aboriginals face, on average, poorer housing conditions, fewer educational and employment opportunities, and a significantly higher burden of illness than the general population.

There is no single or central body responsible for addressing health disparities, but several provincial or territorial governments have recently established departments and agencies devoted to addressing population health issues and health inequities. In 2004, the federal government established the Public Health Agency of Canada, which has a mandate to address population health issues, including "reducing health disparities between the most advantaged and disadvantaged Canadians." In 2005, the federal government launched the Aboriginal Health Transition Fund, a CAD$200 million (US$201 million) initiative to address gaps in health status between aboriginal and nonaboriginal Canadians by improving access to health services. In 2004, federal, provincial, and territorial governments agreed to implement a CAD$100 million (US$101 million), five-year initiative to increase the number of aboriginal people working in health care, adapt health care education to support culturally appropriate health care, and improve the retention of health care workers in aboriginal communities.

Research and data collection are other areas where efforts have been made to better understand Canadian health disparities. The Canadian Institute for Health Information hosts the Canadian Population Health Initiative, which was established to examine population health patterns and help inform policies to reduce inequities and improve health.

What is the status of electronic health records?

Canada Health Infoway, a federally funded independent not-for-profit organization, works with governments and health organizations to accelerate the adoption of electronic health records and other electronic health information systems (e.g., telehealth, public health surveillance). Uptake of health information technologies has been limited and varies widely across Canada: according to the 2010 National Physician Survey, about one-third of Canadian physicians were using a combination of paper and electronic records, and 16 percent were using only electronic records.

How are costs contained?

Cost control is principally attained through single-payer purchasing power, and increases in real spending principally reflect government investment decisions and/or budgetary overruns. Cost control measures include mandatory annual global budgets for hospitals/health regions, negotiated fee schedules for health care providers, drug formularies, and reviews of the diffusion of technology. They also include human resource restrictions vis-à-vis physicians and nurses.

The federal Patented Medicine Prices Review Board (PMPRB), an independent, quasijudicial body, regulates the introductory prices of new patented medications in Canada. The PMPRB's mandate is to ensure that patented drug prices are not "excessive," on the basis of their "degree of innovation" and through a comparison with the prices of existing medicines in Canada and in seven other countries including the United States and the United Kingdom. The PMPRB regulates the "factory gate" prices and does not have jurisdiction over prices charged by wholesalers or pharmacies, or over pharmacists' professional fees. Jurisdiction over prices of generic drugs and control over pricing and purchasing for public drug plans (and, in some cases, pricing under private plans) is held by the provinces, leading to some interprovincial variation in drug prices.

What major innovations and reforms have been introduced?

Financing reforms: In December 2011 the federal government made a unilateral decision to reform the Canada Health Transfer in fiscal year 2013–2014 (the end date of the 10-Year Plan to Strengthen Health Care). After 2014, federal funding will be distributed to provinces on a purely per capita basis, ending the current provisions to compensate for variations in tax bases across provinces that benefited the less-wealthy provinces.

Mental health: In May 2012, the federally funded Mental Health Commissions of Canada (set up in 2007) published the first national mental health strategy: *Changing Directions, Changing Lives: The Mental Health Strategy for Canada.* The strategy calls for, among other things, an increase in federal and provincial funding for mental health.

Cost containment: Following the recent economic recession, federal and provincial/territorial governments face harder budget constraints. Recent reforms aim to contain costs and to achieve better value for money. Some provinces have enacted generic drug pricing reforms: in Ontario, public plan prices of generics were reduced from 50 percent of the brand-name drug price to 25 percent in 2010 (with the same reduction applying to private plans as of 2012). Also in 2010, British Columbia commenced a three-year phased-in reduction of generic prices from 65 percent of brand-name price to 35 percent. Other areas, such as Saskatchewan and Manitoba, have applied "lean" production methodologies to health care delivery, following the lead of the Institute for Healthcare Improvement in Cambridge, Massachusetts (Marchildon, 2012). In 2012, the Ontario government cut fees for hundreds of physician services, with the expectation that it would save over CAD$3 million (US$3 million) that year.

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