Canada: Health Care System Overview and SWOT Analysis

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Abstract

This is the fourth article of the International Health Care Systems series. The first part of the article provides an overview of the Canadian health care system, including its historical evolution, health financing, service delivery, and aspects like equity, cost-control, and health technology. The second part analyses the strengths, weaknesses, opportunities, and threats for the Canadian health care system.

Keywords: **Canadian health care, Medicare, universal health coverage, single payer, SWOT analysis**

An Overview of the Canadian Health Care System

Canada is the second largest country in the world in terms of area and is a high-income, advanced economy. In 2019, 11.6% of the nation's GDP was spent on health.[1] The public share in total health spending is around 70%, financed mainly through taxes raised by federal, provincial, and territorial governments.[2]

The history of Canadian universal health coverage (UHC) is relatively recent.[3] Up to the 1950s, its health system largely resembled that of the United States (US). In 1947, following the world war 2, the rural province of Saskatchewan started the first publicly-financed hospital insurance plan in North America, which created a regional system of hospitals.[4,5] Other provinces soon followed Saskatchewan's example, and in 1957, the federal government passed the Hospital Insurance and Diagnostic Services Act, providing cost-sharing for hospital services and laying the conditions for federal transfers to provinces.[2,4,6] In 1962, Saskatchewan again lead by example by extending coverage for physician services, and in 1966, the federal Medical Care Act was passed which provided cost-sharing for physician care. By 1971, universal coverage for hospital and physician care was fully realized across all provinces and territories.[2] In 1984, the Canada Health Act was passed, which superseded the two aforementioned laws and set nationwide standards for health care.

Canada has a tax-financed, single-payer health insurance system (also called Medicare) administered by provincial/territorial governments and supported by the federal government.[6] Each province/territory has its own health plan providing universal, comprehensive coverage for hospital and physician services free at the point of care. Through national legislation, the federal government sets the criteria for federal cash transfers to provinces, including principles like comprehensive, universal, and portable coverage; non-profit mode of administration etc.[6] The federal government is also involved in certain aspects of health and pharmaceutical regulation, research , and provides services for certain special populations like Inuits and First Nations.[2] Provinces and territories have the main responsibility for financing and administering health services (including public health services), and details of health plans vary from one province/territory to another.[2,3] Provinces/territories also provide coverage to certain select groups (e.g. elderly, social assistance recipients) for services like prescription drugs, long-term care, and chiropractic care which are not covered under the universal public system.[2,6] Their provisions vary across provinces and territories and may attract user fees.[2] Most of dental care is funded privately. Federal transfers account for less than one-fourth of provincial/territorial spending, the remaining being derived from their own revenues.[2]

About 30% of health spending is private, comprised

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of out-of-pocket payments and private health insurance (PHI).[2] PHI covers services like prescription drugs, dental and ophthalmic care and is largely employment-related. In a bid to avoid preferential access to care depending on income and uphold equity, PHI has been barred from covering services that are available under provincial health plans, and physicians not under the government plan cannot charge patients directly for services.[3,4] The supreme court in the landmark 2005 *Chaoulli vs Quebec* lawsuit ruled that such prohibition of private insurance can be detrimental for those needing urgent care, following which the province of Quebec introduced private insurance and service provision for a certain set of services including cataract surgery, joint replacement, cancer surgery etc.[2,3] Other provinces have also contemplated such reforms.

Health care is delivered through both public and private providers but is largely public-funded. Most physicians are in private practice and can admit and care for their patients in hospitals.[6] Majority of acute hospital care is provided by public or non-profit private hospitals.[2] Physician services have traditionally been remunerated through the fee-for-service mode, with fees negotiated between physician associations and provincial governments.[4,5] Extra-billing and balance-billing are prohibited by law.[6] For controlling costs, several provinces have increasingly employed other modes of payment, such as capitation, and also payment caps that are sensitive to volume of services delivered.[4,5,6] While referral is not mandatory to access specialist care, specialists receive a higher fee only on referral by a family physician.[3,4] Hospitals are paid a global budget for their operating expenses which are negotiated with provincial governments.[6] Provincial approval is required for capital expansion projects in hospitals, including purchasing new technologies and constructing new facilities.[4,6]

Government control over resource allocation and payment for services, and regionalization of hi-tech interventions, are the main modalities for controlling costs.[5] Elective care under Medicare is rationed and is often subject to considerable waiting times. In the 1990s, federal deficits led to considerable spending restraints, resulting in aggravated waiting times and public dissatisfaction with services.[2,4,6] Notwithstanding improvement in fiscal health and government spending in the ensuing years, provinces have faced pressures to contain costs in the face of increasing demands.[6] Recent reforms have focused on reorganizing health services for greater efficiency and improving responsiveness, quality, timeliness, and patient satisfaction.[2,4]

Following the *10-year Plan to Strengthen Health Care in 2004*, additional federal transfers have been utilized by provinces towards shortening of waiting times, strengthening primary care, and expanding home care coverage.[2] Substituting hospital care with outpatient and home care has been emphasized, and primary care practice by inter-professional teams rather than solo physicians has been encouraged.[2,6] Regional Health Authorities (RHA) were introduced for vertical integration and better coordination of care, although the recent trend has favored centralization and reduction in the number of RHAs in view of possible economies of scale and cost control.[2] Health Technology Assessment (HTA) agencies and quality councils for quality improvement measures are also operational in many provinces to assist provincial ministries. For example, the Canadian Agency for Drugs and Technologies in Health (CADTH) conducts the Common Drug Review (CDR) to decide the drugs to be included in provincial formularies. Also, certain provinces and RHAs have applied "lean production" methodologies with a view to improving technical efficiency.[2]

SWOT Analysis

Strengths

UHC in Canada is guaranteed by law and is institutionally stable. Public spending accounts for 70% of the total health spending, almost all of which is tax-financed. Thus, health insurance for covered services is independent of employment or income and contributions are progressive, which makes coverage truly universal in nature and ensures equity in financing. Further, there are no user fees for services under universal insurance, which again upholds equity. The system provides considerable financial protection for the services that are covered. Benefits are portable across provinces within Canada and even outside the country, for e.g. those crossing the border into the US for treatment. Patients have free choice of physicians and hospitals, which is not constrained by the characteristics of their insurance plans[3] or by their ability to pay.

Differences in health care use depending on income, though present, are not very pronounced unlike in the US, its neighbour.[2,3,4] There is a prominent pro-poor skew in the utilization of primary care services.[2,3] Primary care doesn't have patient cost-sharing, and the referral system has an inbuilt incentive to seek care from generalists.[3]

Controls on high-end services reduces injudicious use of resources and helps hold down costs. Canada has a modest number of CT and MRI units per capita among advanced nations and the OECD.[7,8] When compared with the US, physician fees and cost per patient day in hospitals are low, which holds down overall costs - despite Canadians having more doctor consultations and a higher average average length of hospital stay per capita than Americans.[4] Provinces act as

monopsonistic purchasers of healthcare services which drives down overall costs. Further, administrative expenditure is relatively modest.

Health system performance in terms of life expectancy and amenable mortality is favorable,[2] through behind that of countries like Australia, Spain, and France. Public satisfaction with the health care system is high, particularly with respect to financial protection.[2,5]

Weaknesses

A good number of services including prescription drugs and dental care are not covered under universal insurance and are either largely served by PHI or remain uninsured, which risks of inequities in access and financing.[2] Tight controls over services and resources results in substantial waiting times for non-urgent care, which has been a recurrent subject of public dissatisfaction with the health care system. Resulting treatment delays are particularly problematic for vulnerable groups such as the elderly.[5] As per data from the Commonwealth Fund International Health Policy Survey, 2013 (as cited by Valle[9]), Canada had the highest waiting times for family doctor consultation among 11 developed OECD nations, and only between 31% to 46% of Canadians could secure same-day or next-day doctor consultation for non-emergency purposes.[9] This results is many people having to travel to the US for treatment.[5] Canada's number of hospital beds per capita is also a modest figure among OECD nations.[10]

There are also geographical and rural-urban disparities, particularly with respect to sections like Inuits and First Nations, which reflects in their poorer life expectancies and other health gaps.[9] Given the absence of patient cost sharing under Medicare, the system is prone to demand side moral hazard and overuse. Further, the traditional fee for service mode of reimbursing physicians can be cost-inflationary. Private insurance doesn't cover services listed under Medicare, which restricts timely access to services for those in need and having the ability to pay.

Opportunities

Recent initiatives with respect to improving the overall responsiveness of the health care system, improving care quality, reducing waiting times, and reforming primary care offer promise with respect to the future of health services. The healthcare workforce has also grown since 2000 supported by increased indigenous production of health professionals, immigration of foreign doctors, and lower out-migration.[2] Canada is also expected to have a quicker economic recovery from the impact of the Coronavirus pandemic than its neighbour the US, owing to better control of the pandemic spread.[11]

Threats

Rise in health care expenditures, particularly private expenditure, has been considerable and threatens the fiscal sustainability of Medicare.[2] Major determinants of increasing costs have been prescription drugs, hospital costs, and physician costs including higher remuneration. Further, an aging population, although not yet a major driver of costs,[2] presents a significant future challenge,[9] along with increased absorption of new and expensive technologies.

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