Publicly Funded, Decentralized and Universal Health Systems: Canada’s Medicare Experience

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Challenges to Move Towards Universal, Comprehensive, and Sustainable Health Systems: Lessons from an International Perspective
OVERVIEW

• Evolution of universal health coverage (UHC) in Canada
• Political and fiscal decentralization
• UHC in context of the Canadian health system’s three layers
• Health system performance
• Final observations
Historical Milestones

- **1947**: Saskatchewan implements full public hospital coverage
- **1957-61**: Universal hospital coverage implemented in Canada
- **1962**: Saskatchewan introduces medical care insurance
- **1968-72**: National medical care coverage in Canada
- **1970s**: Provincial coverage and subsidies - pharma and LTC
- **1984**: Canada Health Act and discouragement of user fees
- **1990s**: Regional health authorities (decentralization)
- **2000s - present**: Administrative recentralization
Origins of Medicare

**Economic: 1930s**
- Precipitous decline in employment and incomes
- Lack of access to health services

**Political: rise of alternatives**
- New political parties emerge – new ideas
- Health insurance: public subsidization vs. single-payer public administration
- Socialized medicine – whole system approach

**Institutional: decentralized polity**
- Beveridge report and constitutional division of powers
- Reforming government elected in Saskatchewan with health at top of agenda
1946: Saskatchewan - universal hospital coverage

Principles (Design)
- Compulsory registration
- Single-payer: taxation + annual premiums
- Single—tier: all hospitals part of plan (and all independent of government)

Promise
- Adequate remuneration to hospitals
- First step only: hospital, diagnostic and inpatient drugs
- Promise to expand coverage and change organization of system as soon as fiscal resources permit
### Competing Designs: Saskatchewan and Alberta hospital plans

<table>
<thead>
<tr>
<th>Competing design features (competing principles)</th>
<th>Saskatchewan plan, 1947-8</th>
<th>Alberta plan, 1950-8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal vs. partial coverage (uniform coverage and standards vs. voluntary association)</td>
<td>Compulsory enrolment based on status as provincial resident</td>
<td>Voluntary enrolment with public subsidies to low-income individuals to purchase private health insurance</td>
</tr>
<tr>
<td>Public vs. private governance (single-payer with democratic accountability vs. multi-payer and consumer choice)</td>
<td>Government responsible for payment of all services included in public coverage</td>
<td>Private insurance carriers responsible for payment of covered services</td>
</tr>
<tr>
<td>Breadth of coverage (single-tier vs. two-tier or multiple-tier)</td>
<td>Access to single coverage package based on uniform terms and conditions</td>
<td>Access to multiple coverage packages (choice)</td>
</tr>
<tr>
<td>Free coverage at point of access to services (collective vs. individual responsibility)</td>
<td>No user charges for any covered service</td>
<td>User fees for hospital stays based on number of days (with maximum)</td>
</tr>
</tbody>
</table>
Moving to a National System

- 1957 – Federal government passes law: national standards in exchange for 50% financing
  - Coverage on “uniform terms and conditions” - universality
  - Portability and public administration
- UHC extended to medical care by some provinces in early 1960s
- Dispute over design again settled by Government of Canada by 1966
  - Federal law with same conditions
  - Implementation complete by 1972
Canada Health Act of 1984
Geographical Distance as Factor: Nunavut

Medical Air Links

Estimated Flight Distances:
- Iqaluit to Ottawa: 2,060 km
- Rankin Inlet to Winnipeg: 1,430 km
- Cambridge Bay to Edmonton, via Yellowknife: 1,800 km

Administrative Regions:
- Qikiqtaaluk
- Kivalliq
- Kitikmeot

Data Source: Statistics Canada
Regional Diversity = Decentralization
ORGANIZATION OF THE HEALTH SYSTEM IN CANADA

- Canadian Constitution
  - Federal Government
    - Minister of Health
      - Transfer payments
      - Canada Health Act
      - Federal-Provincial-Territorial Conferences and Committees
    - Collaborative contributors to multiple pan-Canadian organizations
  - Provincial/Territorial Governments
    - Ministers of Health and Respective Departments/Ministries of Health
    - Negotiations
  - Provincial/Territorial Medical Associations
  - Health Professional Unions

- Universal health coverage and extended health benefits for Canadian residents

Additional organizations:
- Health Canada
- Public Health Agency of Canada
- Canadian Institutes of Health Research
- Patented Medicine Prices Review Board
- Canadian Food Inspection Agency
## COVID: Stress Testing a Decentralized Federation

### Strengths / Advantages

- Provincially-administered UHC has proven itself
- Testing, treatment and vaccination covered under 13 PT UHC plans
- Portability condition under Canada Health Act ensures testing treatment at cost of home province wherever they are
- Provincial health systems have not been overwhelmed due to careful planning so far
- Allows for more targeted responses depending on regional and local conditions
- Provincial governments knew they were in charge from the beginning and took the leadership role in responding to pandemic

### Weaknesses / Disadvantages

- Central authority in crisis has limits
- Conflicts and contradictions in subnational government responses
- Role of Public Health Agency of Canada was quite limited
- Little excess hospital capacity posed danger in hardest hit areas
- Major problem with containment in long-term care facilities – not part of UHC systems in provinces (or federal standards)
- Major issues in data collation and sharing so it has been difficult to assess and compare
<table>
<thead>
<tr>
<th>Layer 1: Medicare (UHC) – 100% public funding</th>
<th>Services</th>
<th>Funding</th>
<th>Administration</th>
<th>Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>Universal single-payer systems; Private self-regulating professions</td>
<td>General taxation</td>
<td>Private professional, for-profit, not-for-profit; and public arms length facilities</td>
<td></td>
</tr>
<tr>
<td>Physicians</td>
<td>Core providers</td>
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<tr>
<td>Diagnostics</td>
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</table>

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<thead>
<tr>
<th>Layer 2: “Mixed” services – combined public and private funding</th>
<th>Services</th>
<th>Funding</th>
<th>Administration</th>
<th>Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription drugs</td>
<td>General taxation, private insurance, out-of-pocket payments</td>
<td>Public services generally targeted (welfare-based); public regulation of private services</td>
<td>Private professional, for-profit, not-for-profit; and public arms length facilities</td>
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</tr>
<tr>
<td>Home care</td>
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<tr>
<td>Long term care</td>
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<tr>
<td>Mental health care</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Layer 3: “Private” services – almost all private funding</th>
<th>Services</th>
<th>Funding</th>
<th>Administration</th>
<th>Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental care</td>
<td>Private insurance, out-of-pocket payments</td>
<td>Private ownership; private professions; limited public regulation</td>
<td>Private professional, for-profit facilities</td>
<td></td>
</tr>
<tr>
<td>Vision care</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Complementary medicine</td>
<td></td>
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<tr>
<td>Outpatient physiotherapy</td>
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</tbody>
</table>

THREE LAYERS: CANADIAN HEALTH “SYSTEM”
1. UHC Layer - Features

- Medicare: deep but narrow coverage
- Funded by both orders of government through general taxation (income, consumption and other taxes)
- Provincial single-payer administrations
- Single-tier of facilities and providers
- Physicians – private contractors
- Hospitals and other facilities: ownership varies in country
- National framework: *Canada Health Act*
- Major contrast with US system
# Government of Canada (Canada Health Act) Requirements for Provincial Government UHC Programs

<table>
<thead>
<tr>
<th>National standards and requirements</th>
<th>Section in Canada Health Act</th>
<th>Each provincial UHC plan must: (or be subject to discretionary transfer withdrawal from federal government):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public administration</td>
<td>8</td>
<td>Be operated on a non-profit-making basis by public authority</td>
</tr>
<tr>
<td>Comprehensiveness</td>
<td>9</td>
<td>Cover all UHC health services without major exclusions</td>
</tr>
<tr>
<td>Universality</td>
<td>10</td>
<td>Ensure entitlement to UHC on uniform terms and conditions</td>
</tr>
<tr>
<td>Portability</td>
<td>11</td>
<td>Home province to pay for its own residents when elsewhere etc.</td>
</tr>
<tr>
<td>Accessibility</td>
<td>12</td>
<td>Not impede or preclude access based on financial barriers</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Provincial governments that allow user fees are subject to:</strong></td>
</tr>
<tr>
<td>Extra-billing</td>
<td>18</td>
<td>Mandatory (dollar for dollar) federal transfer withdrawal</td>
</tr>
<tr>
<td>User charges</td>
<td>19</td>
<td>Mandatory (dollar for dollar) federal transfer withdrawal</td>
</tr>
</tbody>
</table>
## Decision Space Approach to Measuring Decentralization

<table>
<thead>
<tr>
<th>Area</th>
<th>Range of Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functions</td>
<td>Narrow</td>
</tr>
<tr>
<td>Financing (public revenues and spending)</td>
<td></td>
</tr>
<tr>
<td>Service organization and delivery (required programs, payment)</td>
<td></td>
</tr>
<tr>
<td>Human resources (salaries, contracting, public services rules)</td>
<td></td>
</tr>
<tr>
<td>Access rules (targeting, benefits)</td>
<td></td>
</tr>
<tr>
<td>Governance rules (accountability and governance structures)</td>
<td></td>
</tr>
</tbody>
</table>
Comparing Health System Decentralization

8 Federations

- Switzerland
- Canada
- Germany
- Brazil
- Mexico
- South Africa
- Nigeria
- Pakistan
## Subnational Government Decision Space for UHC services I: Financing (F) & Service Organization and Delivery (OD)

<table>
<thead>
<tr>
<th>Function</th>
<th>Indicator (e.g. Canada)</th>
<th>Range of Choice for Canadian Provinces (stronger evidence for subnational units in other countries)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F Sources of Revenue</td>
<td>Federal transfers as % of total hospital and physician spending</td>
<td>Mexico, Pakistan, Germany, Brazil, <strong>Canada</strong>, Nigeria, South Africa, Switzerland</td>
</tr>
<tr>
<td>F Expenditure Allocation</td>
<td>% of provincial spending explicitly earmarked for set purposes by federal government</td>
<td>Mexico, Germany, Brazil, South Africa, <strong>Canada</strong>, Switzerland, Nigeria, Pakistan</td>
</tr>
<tr>
<td>F User fees</td>
<td>Extent to which provincial government can raise funds through user fees for UHC services</td>
<td>Brazil, <strong>Canada</strong>, Germany</td>
</tr>
<tr>
<td>OD Required programs</td>
<td>Rules on what services must be delivered</td>
<td>Brazil, Pakistan, Germany, Switzerland, <strong>Canada</strong>, Pakistan</td>
</tr>
<tr>
<td>OD Payment mechanisms</td>
<td>Rules on payments to hospitals, diagnostic clinics and physicians</td>
<td>Brazil, South Africa, Pakistan, Germany, <strong>Canada</strong></td>
</tr>
<tr>
<td>OD Hospital autonomy</td>
<td>Choice on how hospitals are governed, organized and paid</td>
<td>South Africa, Brazil, Nigeria, <strong>Canada</strong>, Germany, Switzerland, Pakistan</td>
</tr>
<tr>
<td>OD Physician Autonomy</td>
<td>Choice of how physicians are governed, organized and paid</td>
<td>Brazil, Mexico, South Africa, <strong>Canada</strong>, Germany</td>
</tr>
</tbody>
</table>

## Subnational Government Decision Space for UHC Services II: Human Resources (HR), Access Rules (A), and Governance Rules (G)

<table>
<thead>
<tr>
<th>Function</th>
<th>Indicator (e.g. Canada)</th>
<th>Range of Choice for Provincial Governments (stronger evidence for subnational units in other countries)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HR Salaries</td>
<td>Choice of salary range</td>
<td>Narrow, Moderate, High</td>
</tr>
<tr>
<td>HR Contracting</td>
<td>Contracting non-permanent staff</td>
<td>Brazil, Mexico, South Africa, Pakistan, Nigeria</td>
</tr>
<tr>
<td>HR Public Service</td>
<td>Provincial rules on hiring and firing</td>
<td>Mexico, South Africa, Nigeria, Pakistan, Brazil</td>
</tr>
<tr>
<td>A Targeting</td>
<td>Extent to which subpopulations or services can be targeted</td>
<td>Canada, Germany, Mexico</td>
</tr>
<tr>
<td>A Portability</td>
<td>Extent to which federal government enforces reciprocal billing among provinces</td>
<td>Germany, Mexico, South Africa</td>
</tr>
<tr>
<td>G Insurance structure</td>
<td>Degree of direction on insurance arrangements for UHC</td>
<td>Switzerland, Canada</td>
</tr>
<tr>
<td>G Other organizational structures</td>
<td>Federal rules limiting size, number of, and composition of, provincial health organizations</td>
<td>Germany, Mexico, Brazil, Nigeria</td>
</tr>
</tbody>
</table>

2. Mixed Public and Private Layer (provincial level of government)

- Prescription drug plans
  - Private health insurance (group employment plans)
  - Provincial government plans

- Social care (nursing homes + home care + supportive community care)
  - Public subsidies and services (75%?)
  - Private purchase mainly out-of-pocket
3. Private Layer (regulated by provincial government)

- Most dental care
- Most vision care
- Almost all complementary and alternative (CAM) services and medicines
- More than 50% of prescription drugs
- Significant role for private health insurance
HEALTH SYSTEM PERFORMANCE
Canada’s health spending as share of GDP and life expectancy are higher than the OECD average

**Notes**
- Life expectancy at birth: Data is for 2016 (Chile).
- Life expectancy at birth: Latest available data is for 2017.
- Total health spending as a percentage of gross domestic product (GDP): 2018 provisional or estimated value.
- Total current expenditure (capital excluded except for Israel and Mexico).

**Source**
Per Capita Spending and Life Expectancy

Notes
* Life expectancy at birth: Data is for 2016 (Chile).
Life expectancy at birth: Latest available data is for 2017.
$CA PPP: Purchasing power parity in Canadian currency.
Total health spending per person: 2018 provisional or estimated value.
8 countries spent less but had higher life expectancy at birth than Canada: France, Ireland, Japan, Iceland, Italy, Spain, Korea and Israel.
Total current expenditure (capital excluded except for Israel and Mexico).
Source

© Canadian Institute for Health Information, 2019
Healthcare Quality and Access Index, 2016
(The Lancet, Vol. 391, 2-8 June 2018, 2236-71)

- The higher on the scale, the better the performance
- Mapped causes amenable to personal health to 32 Global Burden of Disease causes (e.g., diphtheria, colon cancer...)
- HAQ related to quality of, and access to, healthcare services
- High-level measure of health system performance with a focus on health interventions
- Index scale of 0 to 100
  - The closer you are to 100 on the HAQ, the better your health system performance

<table>
<thead>
<tr>
<th>Country [international ranking]</th>
<th>HAQ Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia [5]</td>
<td>96</td>
</tr>
<tr>
<td>Sweden [8]</td>
<td>95</td>
</tr>
<tr>
<td>Japan [12]</td>
<td>94</td>
</tr>
<tr>
<td>Canada [14]</td>
<td>94</td>
</tr>
<tr>
<td>Germany [18]</td>
<td>92</td>
</tr>
<tr>
<td>France [20]</td>
<td>92</td>
</tr>
<tr>
<td>United Kingdom [23]</td>
<td>90</td>
</tr>
<tr>
<td>United States [29]</td>
<td>89</td>
</tr>
<tr>
<td>Chile [49]</td>
<td>78</td>
</tr>
<tr>
<td>Costa Rica [62]</td>
<td>74</td>
</tr>
<tr>
<td>Argentina [83]</td>
<td>68</td>
</tr>
<tr>
<td>Mexico [91]</td>
<td>66</td>
</tr>
<tr>
<td>Peru [94]</td>
<td>64</td>
</tr>
</tbody>
</table>
FINAL OBSERVATIONS

• History reflects decentralization
  • Advantages (opportunity for experiment and comparison) and disadvantages (challenges in establishing national system)
  • Still struggling to find appropriate balance between centralization and decentralization

• Deep but narrow nature of UHC in Canada
  • Has been difficult to expand coverage
  • Current debate over Rx and LTC

• Question of performance