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

Dalla Lana School of Public Health

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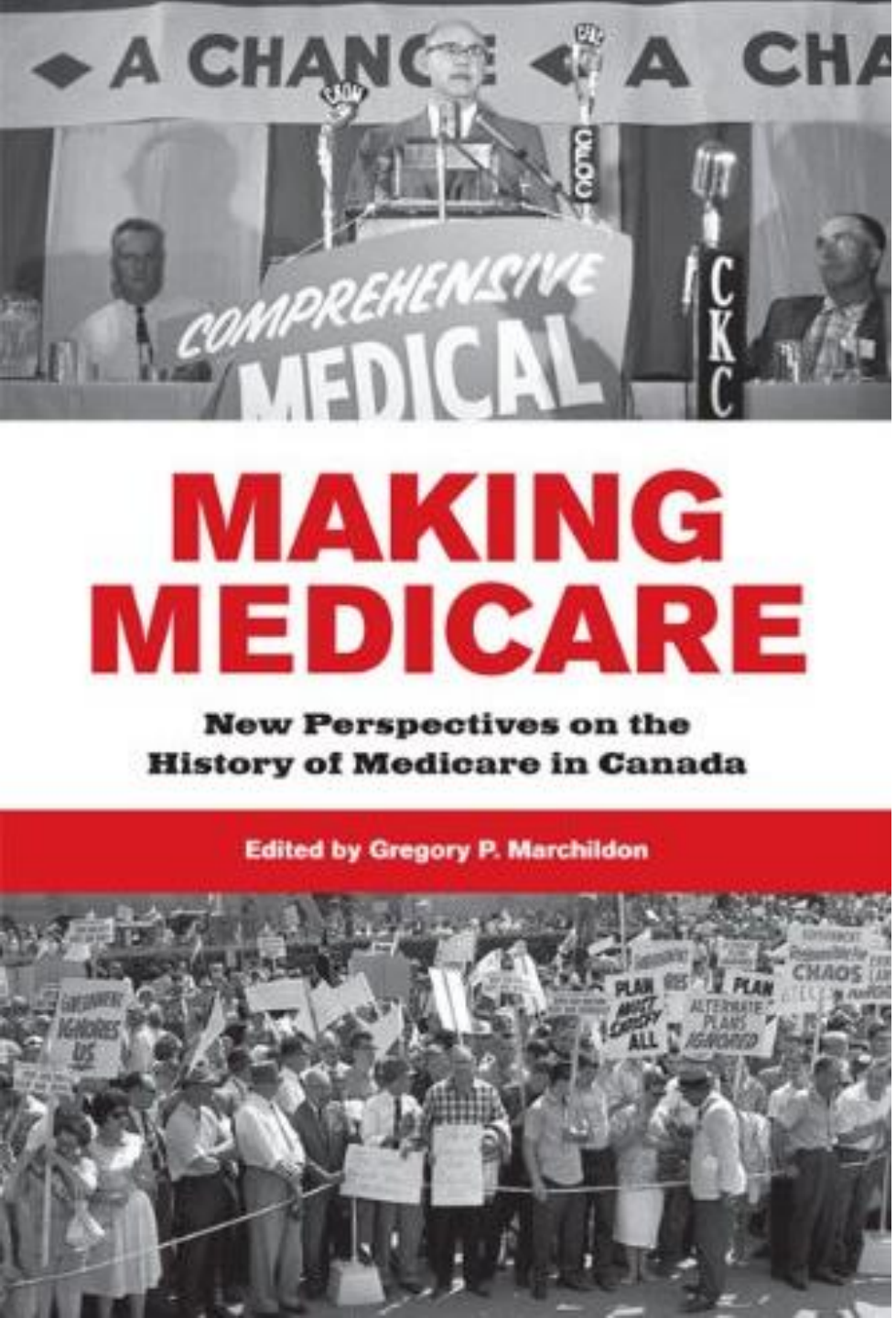
UNIVERSITY OF TORONTO

NAO North American Observatory on Health Systems and Policies

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** – administrative recentralization

Origins of Medicare

Economic: 1930s

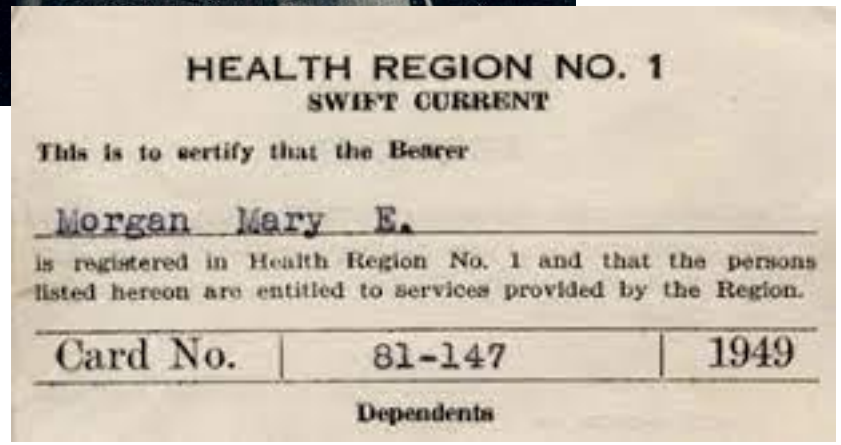
- Precipitous decline in employment and incomes
- Lack of access to health services

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


HEALTH REGION NO. 1
SWIFT CURRENT

This is to certify that the Bearer

Morgan Mary E.

is registered in Health Region No. 1 and that the persons listed hereon are entitled to services provided by the Region.

Card No.	81-147	1949

Dependents

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

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

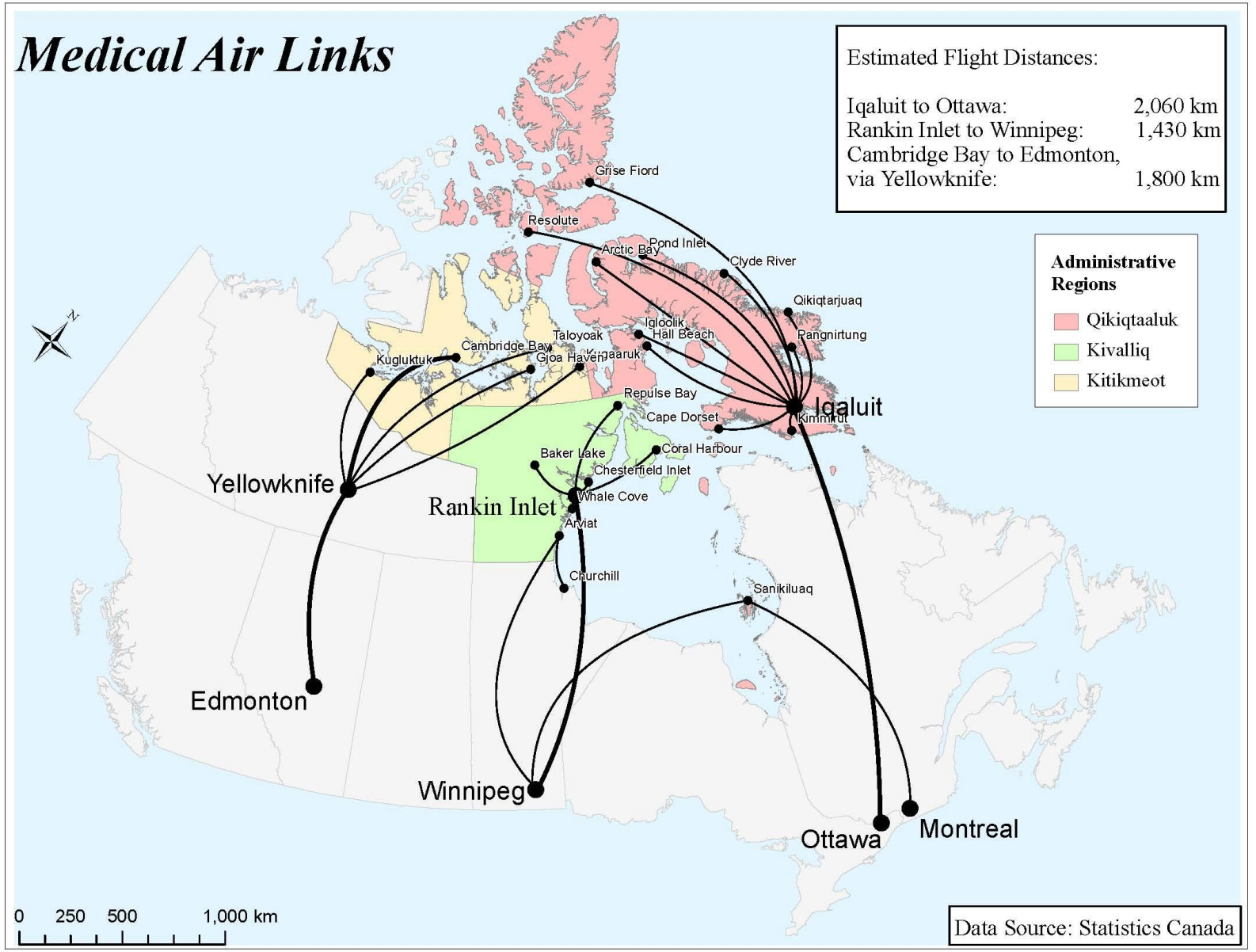
Moving to a National System

- 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

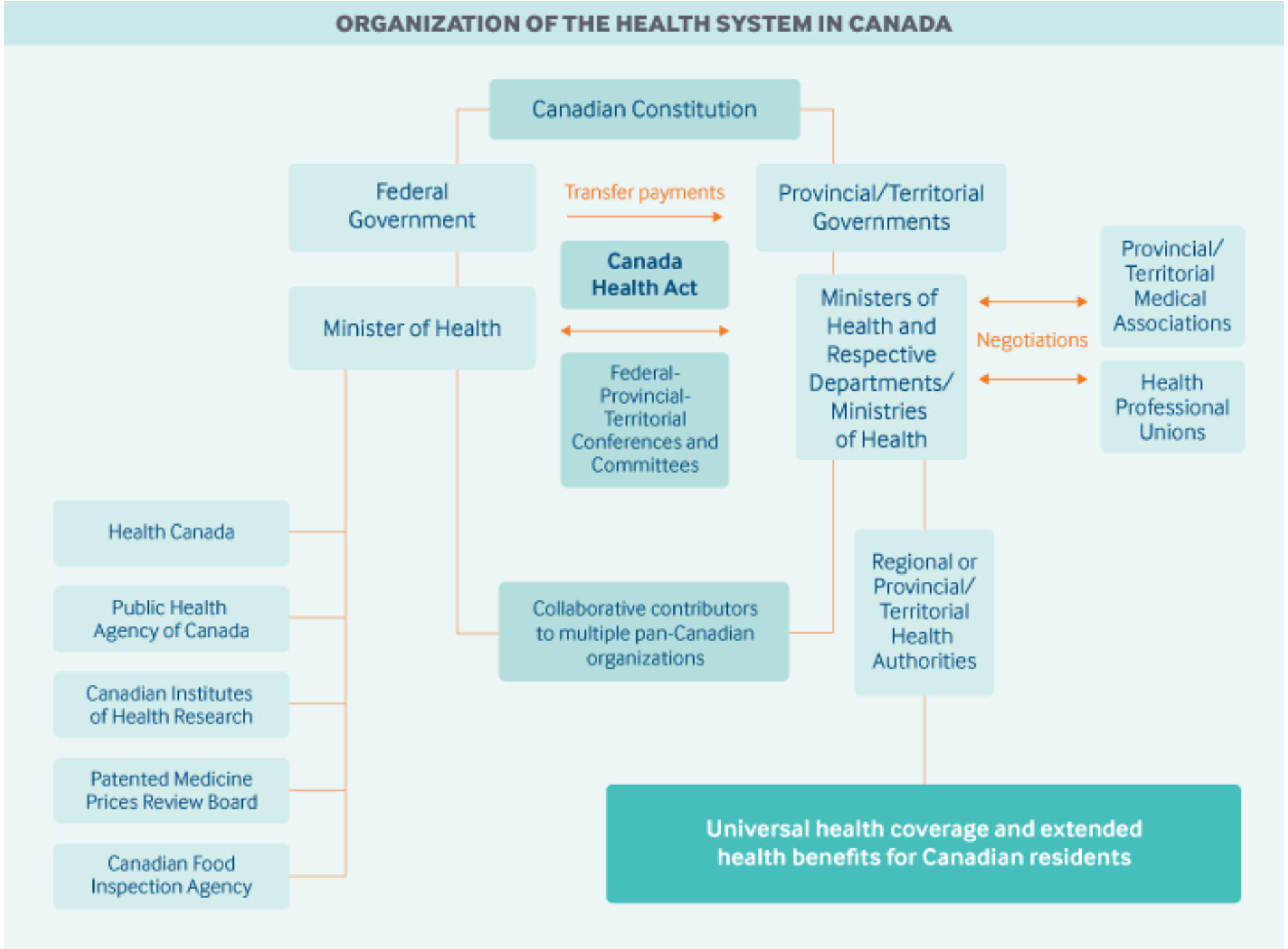
- Public Administration
- Accessibility
- Universality
- Comprehensiveness
- Portability

Canada Health Act of 1984

Geographical Distance as Factor: Nunavut



Regional Diversity = Decentralization


ORGANIZATION OF THE HEALTH SYSTEM IN CANADA
Canadian Constitution
Federal Government
Transfer payments
Provincial/Territorial Governments
Canada Health Act
Minister of Health
Federal-Provincial-Territorial Conferences and Committees
Ministers of Health and Respective Departments/ Ministries of Health
Negotiations
Provincial/ Territorial Medical Associations
Health Professional Unions
Health Canada
Public Health Agency of Canada
Canadian Institutes of Health Research
Patented Medicine Prices Review Board
Canadian Food Inspection Agency
Collaborative contributors to multiple pan-Canadian organizations
Regional or Provincial/ Territorial Health Authorities
Universal health coverage and extended health benefits for Canadian residents

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

THREE LAYERS: CANADIAN HEALTH "SYSTEM"

	Services	Funding	Administration	Delivery
Layer 1: Medicare (UHC)– 100% public funding	Hospital Physicians Core providers Diagnostics	General taxation	Universal single-payer systems; Private self-regulating professions	Private professional, for-profit, not-for-profit; and public arms length facilities
Layer 2: "Mixed" services – combined public and private funding	Prescription drugs Home care Long term care Mental health care	General taxation, private insurance, out-of-pocket payments	Public services generally targeted (welfare-based); public regulation of private services	Private professional, for-profit, not-for-profit; and public arms length facilities
Layer 3: "Private" services – almost all private funding	Dental care Vision care Complementary medicine Outpatient physiotherapy	Private insurance, out-of-pocket payments	Private ownership; private professions; limited public regulation	Private professional, for-profit facilities

1. UHC Layer - Features

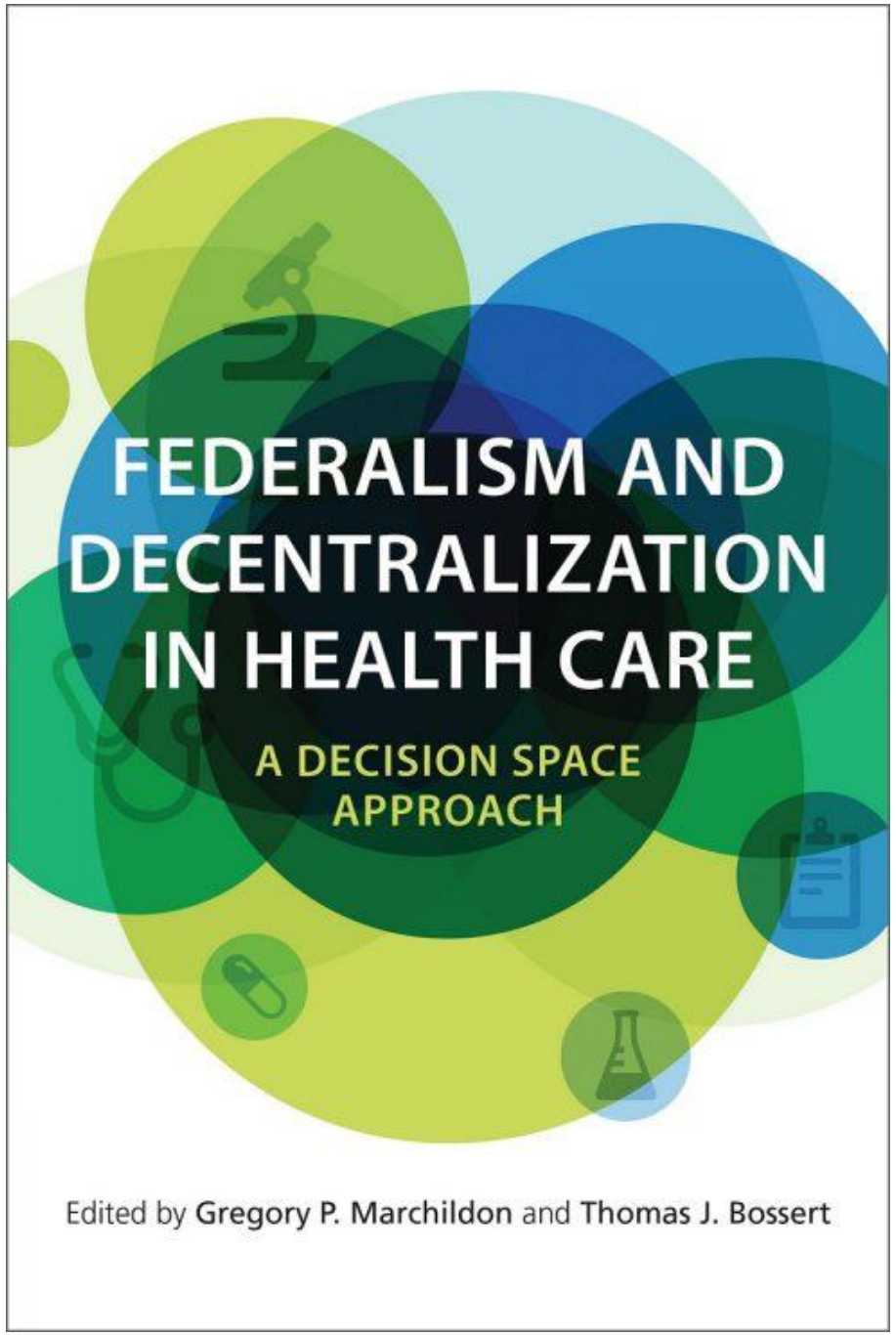
- Medicare: deep but narrow coverage
- Funded by both orders of government through general taxation (income, consumption and other taxes)
- Provincial single-payer administrations
- Single-tier of facilities and providers
- Physicians – private contractors
- Hospitals and other facilities: ownership 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

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

Decision Space Approach to Measuring Decentralization

	Range of Choice		
Functions	Narrow	Moderate	Wide
Financing (public revenues and spending)			
Service organization and delivery (required programs, payment)			
Human resources (salaries, contracting, public services rules)			
Access rules (targeting, benefits)			
Governance rules (accountability and governance structures)			



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)

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

Source: *Federalism and Decentralization in Health Care: A Decision Space Approach*, ed. G.P. Marchildon and T.J. Bossert. Toronto: University of Toronto Press, 2018

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

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

Source: *Federalism and Decentralization in Health Care: A Decision Space Approach*, ed. G.P. Marchildon and T.J. Bossert. Toronto: University of Toronto Press,, 2018

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

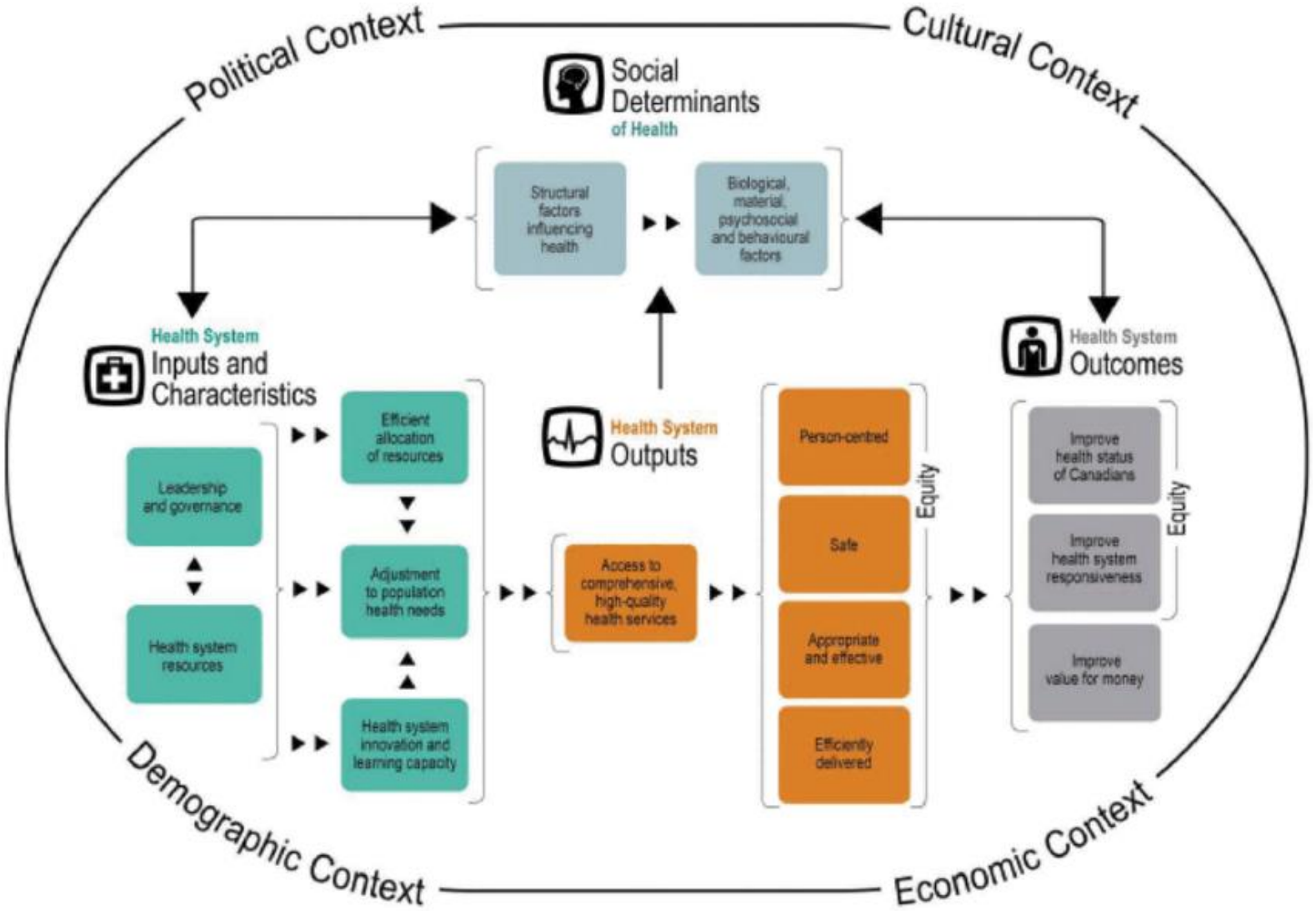
- Prescription drug plans
  - Private health insurance (group employment plans)
  - Provincial government plans

- Social care (nursing homes + home care + supportive community care)
  - Public subsidies and services (75%?)
  - Private purchase mainly out-of-pocket

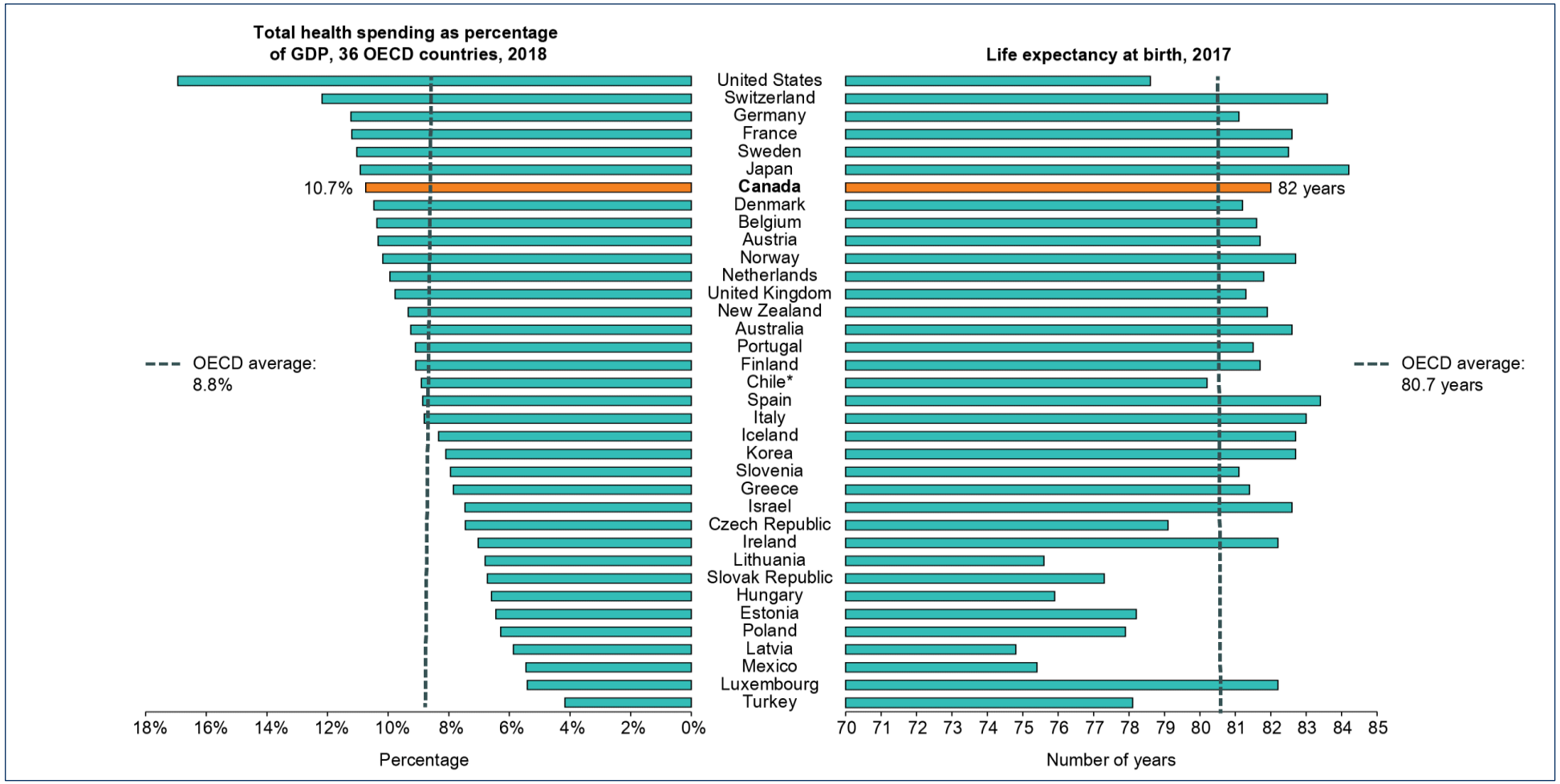
3. Private Layer (regulated by provincial government))

- 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



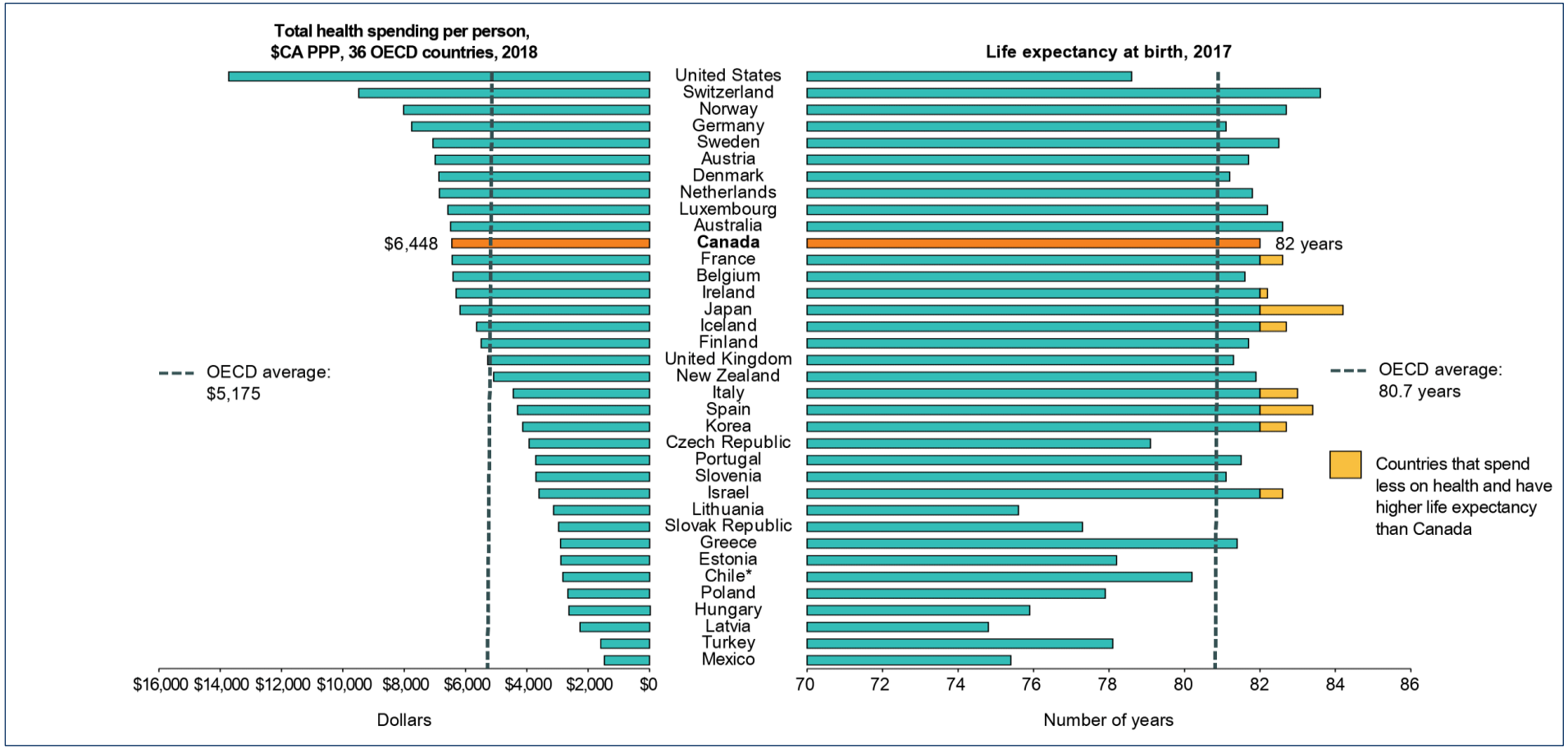
Notes

* 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 srael and Mexico).

Source

Organisation for Economic Co-operation and Development. OECD Health Statistics 2019. 2019.

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

Organisation for Economic Co-operation and Development. OECD Health Statistics 2019. 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

Country [international ranking]	HAQ Index
Australia [5]	96
Sweden [8]	95
Japan [12]	94
Canada [14}	94
Germany [18]	92
France [20]	92
United Kingdom [23]	90
United States [29]	89
Chile [49]	78
Costa Rica [62]	74
Argentina [83]	68
Mexico [91]	66
Peru [94]	64

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 R_x and LTC
- Question of performance

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