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Canada, Health System of

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Introduction

Canada is a high-income country that enjoys one of the world's highest Human Development Index rankings. The burden of disease is among the lowest in the world even though Canada's ranking, based on health-adjusted life expectancy (HALE), slipped from second place in 1990 to fifth position by 2010 (Murray et al., 2013). The Canadian health system reflects the inherent complexity and diversity of a country covering the second largest landmass in the world (Figure 1). In addition to its original Aboriginal inhabitants and official language communities of French and English, the population is made up of immigrants, many recent, from virtually every part of the globe. Most live in large urban centers that hug the southern border with the United States but vibrant communities, some predating European colonization, are sprinkled throughout the 10 provinces in the south and three territories in the far north.

Canada is a constitutional monarchy based on a parliamentary system in the British tradition and, similar to Australia, it is a federation with two constitutionally recognized orders of government. The federal government is responsible for certain aspects of health and pharmaceutical regulation and safety, data collection, biomedical, clinical and other research funding, and some health services and coverage for designated First Nation and Inuit populations. The second order of government consists of 10 provincial governments mainly responsible for a broad range of health programs and services including

Figure 1 Atlas of Canada. Source: Atlas of Canada, Natural Resources Canada.

the provision of universal coverage for medically necessary hospital and physician services known as Medicare in Canada. In most provinces, health services are organized and delivered by public bodies known as regional health authorities that have been legislatively delegated to provide hospital, long-term and community care as well as improve population health within defined geographical areas.

Political and Administrative Organization

The provinces and northern territories of Canada cover a land area of about 10 million km^2. Under the constitution of Canada, the provinces have the primary jurisdiction over health care. As a consequence, provincial governments are mainly responsible for the financing and administering of public health care in Canada. To enforce and uphold the Canada Health Act, the federal government makes cash transfers to the provinces, portions of which it can deduct from the transfers to provinces if they permit or encourage facilities or physicians to charge user fees for medically necessary and/or required services or breach the five broad principles of public administration, comprehensiveness, universality, portability, and accessibility as defined in the Canada Health Act (Figure 2).

While provincial governments play a dominant and direct role in the financing and administering of health care, they have a more arm's-length role in the delivery of many public health-care services. Most physicians, for example, are responsible for their own private practices and clinics, and receive their remuneration through a fee schedule negotiated between these governments and the provincial medical associations. Most of the health professions are self-regulated under provincial government laws that set out a general framework under which the professions operate. Many health facilities, including nursing homes and other long-term care institutions, home care and community care organizations, medical laboratories, and diagnostic clinics are privately owned and administered. The majority are community-based not-for-profit organizations but some are private for-profit enterprises conducted on a commercial basis. Figure 3 illustrates the extent to which services are delivered privately in the Canadian system even when such services are publicly funded and administered (Figure 4).

Until recently, almost all hospitals in Canada were owned and administered at the local level by municipalities or private not-for-profit corporations, including religious-based organizations. However, some (but not all) of these hospitals have recently been subsumed by new public arm's-length organizations known as regional health authorities (RHAs), which were established by the provinces beginning in the late 1980s.

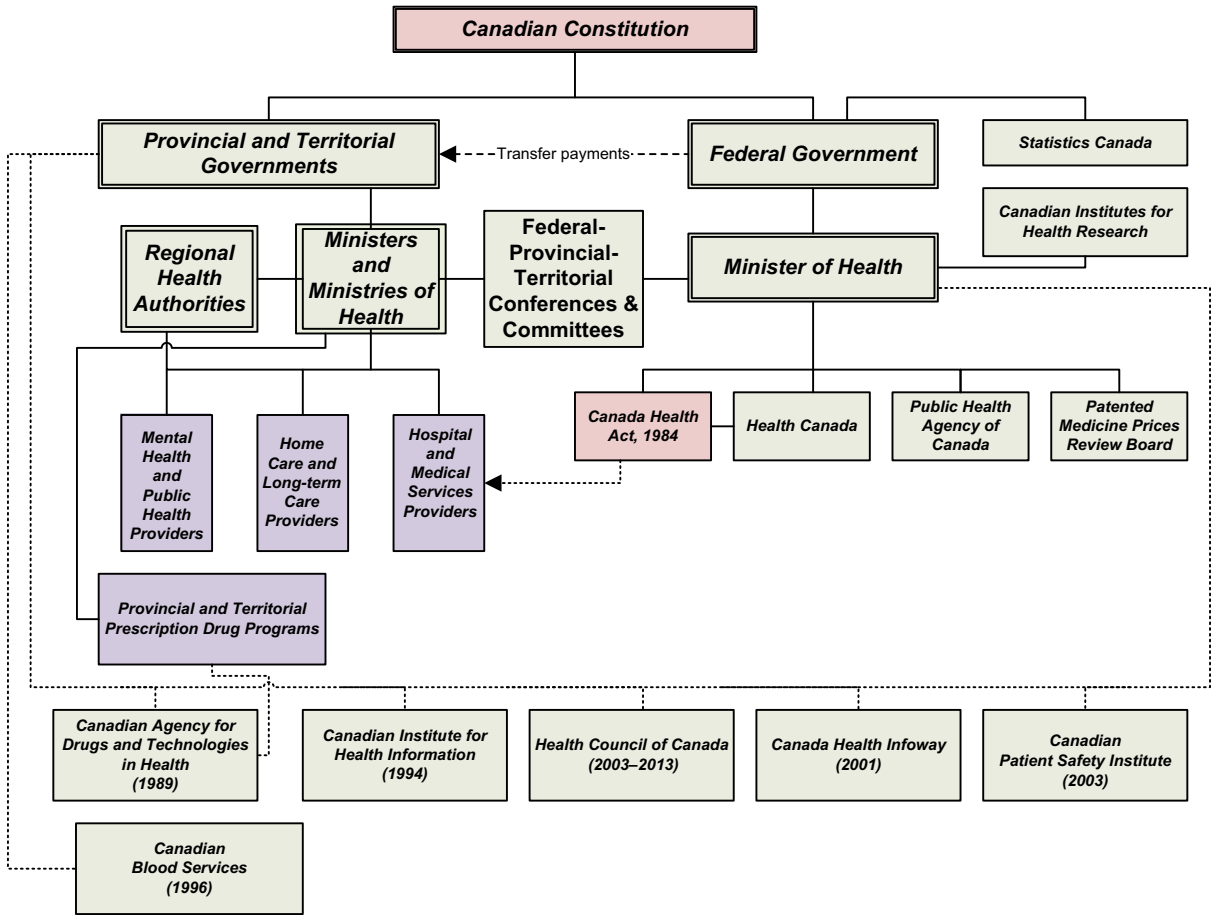

Figure 2 Political organization of the Canadian health-care system.

	Funding	Administration	Delivery
Public Canada Health Act services (hospital and physician services plus) and public health services	Public taxation	Universal, single-payer provincial systems. Private self-regulating professions subject to provincial legislative framework	Private professional, private not-for-profit, private-for-profit, and public arm's-length facilities and organizations
Mixed goods and service, including most prescription drugs, home care, and institutional care services	Public taxation, private insurance, and out-of-pocket payments	Public services that are generally welfare-based and targeted, private services regulated in the public interest by governments	Private professional, private not-for-profit and for-profit, and public arm's-length facilities and organizations
Private goods and services including most dental and vision care as well as over-the-counter drugs and alternative medicines	Private insurance and out-of-pocket payments including full payments, co-payments, and deductibles	Private ownership and control; private professions, some self-regulating with public regulation of food, drugs, and natural health products	Private providers and private for-profit facilities and organizations

Figure 3 Matrix of funding, administration, and delivery. Reproduced from Marchildon, G.P., 2005. Health systems in transition: Canada. World Health Organization on behalf of the European Observatory on Health Systems and Policies, Brussels, p. 120.

This change, commonly referred to as regionalization in Canada (see Table 1), involved the provincial governments carving up their respective territories into geographic regions and then creating RHAs to administer the delivery of a continuum of health services, from hospitals and nursing homes to home care and public health to the population resident in these regions. As arm's-length public organizations established under provincial law, RHAs have a mandate to meet the health needs of the populations within their boundaries as both purchasers and providers of services. The type and extent of services purchased from independent facilities or professionals vary considerably among RHAs and among provinces. As can be seen in Table 1, the number of RHAs varies considerably with two provinces having RHAs that cover the entire provincial population and two territories in which regionalization was never established.

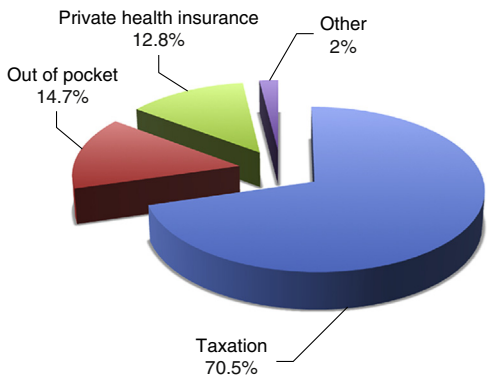

Figure 4 Revenue sources for total health expenditures in Health Canada (2003). Reproduced from Canadian Institute for Health Information (CIHI), 2005 National Health Expenditure Trends, 1975–2005. Canadian Institute for Health Information, Ottawa.

Since RHAs are delegated authorities with a law-making or regulatory capacity, provincial governments regulate health facilities and organizations. However, health-care organizations, including independent hospitals and long-term care facilities as well as RHAs are accredited on a voluntary basis through Accreditation Canada, a membership-based non-governmental body. Most health professions, including physicians and nurses, are self-regulating based on provincial and territorial framework laws. Six provincial governments have established health quality councils to work with health providers and health organizations (including RHAs) to improve quality and safety. However, no provincial quality council has been given the mandate to regulate quality or set enforceable standards.

Table 1 Population (in thousands) and regionalization in Canadian provinces and territories, 2013

Province or Territory	*Total population*	*% of total population in Canada*	*Year regionalization first established*	*Number of RHAs*
British Columbia	4582.0	13.0	1997	5
Alberta	4025.1	11.4	1994	1
Saskatchewan	1108.3	3.2	1992	13
Manitoba	1265.0	3.6	1997	5
Ontario	13 538.0	38.5	2005	14
Québec	8153.3	23.2	1989	18
New Brunswick	756.1	2.2	1996	2
Nova Scotia	940.8	2.7	1992	8
Prince Edward Island	145.2	0.4	1993	1
Newfoundland and Labrador	526.7	1.5	1994	4
Yukon	36.7	0.1		0
Northwest Territories	43.5	0.1	1997	8
Nunavut	35.6	0.1		0

Although the provincial governments are responsible for administering most publicly funded health care in Canada, the federal government nonetheless plays a critical role in health care beyond upholding the broad principles and conditions under the Canada Health Act. These other activities include: funding health research; collecting health data through Statistics Canada; financing and administering health services for First Nations people and Inuit, inmates of federal penitentiaries, war veterans, and active members of the Canadian armed forces; as well as regulating the pharmaceutical and natural health products industries.

In 2000, the federal government replaced the Medical Research Council with the Canadian Institutes of Health Research (CIHR), which in turn, is made up of 13 funding bodies supporting research on Aboriginal peoples' health, aging, cancer, circulatory and respiratory disease, gender, genetics, health services and policy, human development, children and youth, infection and immunity, metabolism and diabetes, neurosciences including mental health and addiction, and population and public health. Through CIHR funding of both investigator-driven as well as more government-driven strategic research, the federal government's original objective was to make Canada one of the top five health research nations in the world.

Intergovernmental Collaboration in Health Regulation, Planning, and Policy

Due to the decentralized nature of the Canadian federation, federal, provincial and territorial governments rely on intergovernmental collaboration to administer, deliver, and reconfigure public health care. At the apex of this collaboration is the Conference of Federal-Provincial-Territorial Ministers of Health as well as a mirror committee of deputy ministers of health (O'Reilly, 2001). In addition to this committee structure, intergovernmental organizations with specific health-care mandates and varying degrees of independence from their sponsoring governments have been established in recent years. These organizations are shown at the base of Figure 2.

The federal government regulates the safety of food and pharmaceutical products through Health Canada and the Food and Drugs Act, and the prices of patented pharmaceutical products through the Patented Medicine Prices Review Board. In 2004, the federal government, through the Natural Health Products Directorate in Health Canada, began regulating and approving traditional herb products, vitamins and mineral supplements, and homeopathic preparations.

Since the provincial governments operate their own prescription drug programs, most of which are categorical programs targeting seniors and the poor, they in turn attempt to control cost by limiting the number and type of pharmaceuticals placed on provincial formularies. Some provinces have instituted reference-based pricing policies, in which only the lower-cost therapeutic alternative is subsidized in full by the provincial drug plan.

To manage the jurisdictional and policy overlaps in pharmaceutical regulation, the federal and provincial governments work through an intergovernmental body known as the Canadian Agency for Drugs and Technologies in Health (CADTH). Conducting clinical- and cost-effectiveness studies under a Common Drug Review, CADTH makes formulary listing recommendations to all provincial governments with the exception of Quebec. Through the Canadian Optimal Medication Prescribing and Utilization Service, CADTH promotes evidence-based best practices in pharmaceutical prescribing and use. Finally, CADTH conducts a major health technology assessment program for a broad range of prescription drugs, medical devices, and other similar health technologies to assist all jurisdictions in decisions concerning the purchase of new health technologies on the basis of both clinical and cost-effectiveness.

The Canadian Institute for Health Information (CIHI) was established in 1994 to coordinate the gathering and dissemination of health data previously done by jurisdictions in isolation of each other. CIHI's core functions include identifying national health indicators, coordinating the development and maintenance of national information standards, developing and managing health databases and registries, as well as conducting and disseminating basic research and analysis. In its work, CIHI cooperates closely with Statistics Canada, a federal

government agency which enjoys an international reputation for the gathering and dissemination of population health data.

Since the late 1990s, Canadian governments have collaborated in the establishment of a number of new intergovernmental health organizations. These include Canadian Blood Services, which was set up by the provinces and territories in response to a major 'tainted blood' controversy surrounding the safety of the country's blood supply as then managed by the Canadian Red Cross. Established in 2001, Canada Health Infoway emerged out of the desire of federal, provincial, and territorial ministers of health to accelerate the development of electronic health records in all jurisdictions. In 2003, the Health Council of Canada was created to provide both an assessment of progress in priority areas of health reform, as identified by the prime minister and the premiers of the provinces and territories, as well as make recommendations for future health reform on a national basis. Beginning its work in 2005, the Canadian Patient Safety Institute was established to provide systematic evidence on medical errors and initiate change to improve patient safety throughout Canada.

Health-Care Expenditures and Financing

Approximately 70% of health expenditures are financed through public taxation while a further 30% are financed out of pocket or through private health insurance mainly in the form of employment benefit packages. Every provincial and territorial government provides universal coverage for medically necessary hospital and physician services. These 13 governments act as single payers in ensuring that their respective residents receive such services free at the point of service. This universal coverage is portable for all Canadians. Provincial governments are responsible for raising roughly 80% of the revenues for their own health expenditures. The remaining 20% comes from the federal government through the Canada Health Transfer which is used to encourage compliance with the five principles of the Canada Health Act and discourage provincial governments from allowing user fees for medically necessary hospital and physician services. Provincial tax revenues come from a number of sources including individual income taxes, consumptions taxes and corporation taxes. In those provinces such as Alberta that have abundant natural resources, resource royalties (taxes) and fees form a significant source of revenue.

Consistent with being a tax-based Beveridge-style national health system (and unlike social health insurance systems), the Canadian health system, there is limited pooling of funds in the Canadian system. However, there is a type of pooling through cash transfers from the federal government which collects taxes at the national level, to the provincial governments, and from the provincial governments (which pool federal cash transfers with own-source revenues) to regional health authorities or other health-care organizations which have no autonomous powers of taxation.

Health Human Resources

Government spending on the health workforce has climbed steadily since the turn of the century causing higher than average inflation (CIHI 2011). Medical, nursing and other health profession faculties have expanded their university seats to produce more graduates, even while an increasing number of foreign-education doctors and nurses have moved to Canada. What has generally been perceived as a health human resource shortage since the mid-1990s may yet become a surplus over the next few years.

With the exception of physicians, most health professionals and workers are employees of health-care organizations and are remunerated through salary and wage income. The majority of health workers, including nurses, are members of public sector unions with remuneration and working conditions negotiated through collective bargaining. Almost all physician remuneration is paid through fee-for-service or alternative payment agreements negotiated with provincial governments.

Delivery and Reform of Health Services

All provincial and territorial governments have public health programs. They also conduct health surveillance and manage epidemic response. While the Public Health Agency of Canada develops and manages programs supporting public health programs at the provincial, regional and local community levels, the stewardship for most day-to-day public health activities and supporting infrastructure remains with the provincial and territorial governments.

Most primary care is provided by GPs and family physicians, with family medicine recently recognized as a specialization by the Royal College of Physicians and Surgeons of Canada. Although mandated through policy and practice rather than law, GPs/family physicians act as gatekeepers, deciding whether patients should obtain diagnostic tests, prescription drugs or be referred to medical specialists. Provincial ministries have renewed efforts to reform primary care in the last decade. Many of these reforms focus on moving from the traditional physician-only practice to interprofessional primary teams capable of providing a broader range of primary health care.

Almost all acute care is provided in public or private non-profit hospitals although specialized ambulatory and advanced diagnostic services are sometimes provided in private-for-profit clinics, particularly in larger urban centers. Most hospitals have an emergency department that is fed by independent emergency medical service units providing first response care to patients while being transported to the hospital. Due to the scattered nature of remote communities without secondary and tertiary care, provincial and territorial governments provide air-based medical evacuation, a major expenditure item for the most northern jurisdictions (Marchildon and Torgerson, 2013).

Long-term care services, including supportive home and community care, are not classified as insured services requiring universal access under the five national criteria set out in the Canada Health Act. As a consequence, public policies, subsidies, programs and regulatory regimes for long-term care vary considerably among the provinces and territories. Facility-based long-term care (LTC) ranges from residential care with some assisted living services to chronic care facilities (originally known as nursing homes) with 24-h a day nursing supervision. Most residential care is privately funded whereas

high-acuity LTC is heavily supported by provincial and territorial governments (Canadian Healthcare Association, 2009).

Until the 1960s, the locus of most mental health care was in large, provincially run psychiatric hospitals which in turn had evolved out of the nineteenth-century asylum and the twentieth-century mental hospital. With the introduction of pharmaceutical therapies and a greater focus on reintegration into the community, mental health conditions have since been mainly treated on an outpatient basis or, in the case of severe episodes, in the psychiatric wards of hospitals. GPs provide the majority of primary mental health care in part because medical care is an insured service with first dollar coverage whereas psychological services are provided largely on a private basis.

Almost all dental care is delivered by independent practitioners and 95% of these services are paid privately. Dental services are paid for through private health insurance – provided mainly through employment-based benefit plans – or out-of-pocket. As a consequence of access being largely based on income, outcomes are highly inequitable.

For historical reasons, the federal government finances a host of health service programs targeting Aboriginal Canadians, in particular eligible First Nation and Inuit citizens. These services include health promotion, disease prevention and public health programs as well as coverage for medical transportation, dental services and prescription drug therapies. Despite these targeted efforts, the gap in health disparity between these Aboriginal citizens and the majority society remains large. Since the 1990s, there have been a series of health funding transfer agreements between the federal government and First Nation governments – largely based on reserves in rural and remote regions of Canada. At the same time, there has been an Aboriginal health movement advocating for a more uniquely Aboriginal approach to health and health care (Marchildon, 2013).

Public Health

Public health can be defined as the science and art of promoting health, preventing disease, and prolonging life through policies and programs that focus on the population as a whole. The implicit contrast is with health-care policies, the main focus of which is on treating already ill or injured individuals. Today, public health in Canada is generally identified with six discrete functions: (1) disease and injury control at the population level, (2) health protection at the population level, (3) emergency preparedness and response, (4) surveillance, (5) population health assessment, and (6) health promotion.

Before the introduction of universal hospital insurance in the 1950s, and universal physician care insurance in the 1960s – together referred to as Medicare – public health programs and services, at least those concerned with infectious disease control and public health and safety, constituted the main health-care responsibilities of all governments in Canada. This was reflected in the names of the departments that emerged in the early twentieth century – almost all were officially designated as departments of public health. At the same time, however, the work of such departments was largely limited to treating and preventing infectious diseases on a population basis as well as recording vital statistics such as births and deaths.

With the introduction of Medicare, the responsibilities of departments and ministers of public health were greatly expanded. At the same time, the provincial departments of health, as they were renamed, increasingly assumed the public health responsibilities of cash-strapped and tax-poor municipalities. Only larger urban centers in Canada were able to provide their inhabitants with public health services including infectious disease control and the administration and enforcement of health and safety standards.

The definition of public health, and along with it the role of government, did not change or expand fundamentally until the emergence of the determinants of health approach in the 1970s and 1980s, and the introduction of regionalization in most provinces in the 1990s. Although health scholars and program decision makers were aware of the impact of living standards, education, employment, and healthy lifestyles on health outcomes, as well as the elimination of financial barriers to Medicare for all necessary treatment and the marginal influence of illness care on the ultimate health of a population, it took considerable time for the full policy implications of this basic insight to be systematically examined.

In 1974, Marc Lalonde, the federal minister of the Department of National Health and Welfare, released a working report entitled *A New Perspective on the Health of Canadians* (Lalonde, 1974). Although it attracted little media attention at the time, the four-quadrant health field concept at the center of the Lalonde report would prove to be exceptionally influential not only in Canada but throughout the world, in large part because of its emphasis on the impact of lifestyle and environmental factors as major determinants of health alongside the long-emphasized factors of human biology and health care. The Lalonde report was the product of a group of policy thinkers in the Long Range Health Planning Branch of the federal department of health. For its 8-year existence, the branch operated more like a think tank than a bureaucratic unit within government (McKay, 2000).

The reasoning behind the Lalonde Report was subsequently used to support the federal government's decision to loosen the conditions on transfer funding in 1977 and to reduce the rate of growth of such transfers by the early 1980s. At the same time, a new Health Promotion Directorate within the federal Department funded and supervised cost-shared projects with citizen groups to pilot the new approach to health determinants. Although the projects at the local, regional, and national level initially focused on encouraging lifestyle changes, they eventually targeted larger societal and structural changes. This work had a profound impact on Health and Welfare Canada's Framework for Health Promotion as well as the major contributions of Canada to the World Health Organization's first international conference on health promotion and the release of the Ottawa Charter for Health Promotion, both of which appeared in 1986 (Epp, 1986; Boyce, 2002). Despite these advances, Canada's more traditional system of public health remained highly fragmented, poorly coordinated, and poorly funded by federal, provincial, and local governments. As a consequence, it did not fare well when faced with its first major crisis of the twenty-first century.

In 2003, Canadians were caught by surprise with a major outbreak of severe acute respiratory syndrome, or SARS. By August of that year, there were 400 probable and suspect SARS cases in Canada, as well as 44 deaths in the greater Toronto area. Health-care workers were among the most vulnerable and 3 of the 100 SARS-infected health-care workers ultimately died. As the hardest-hit country outside of the Asian continent, Canada became the focus of international attention, with the World Health Organization recommending against nonessential travel to Toronto for almost a month during the worst part of the crisis.

As a consequence of the problems of coordination and communication associated with the public health response by the city of Toronto and the governments of Ontario and Canada, Health Canada established a National Advisory Committee on SARS and Public Health chaired by Dr David Naylor of the University of Toronto. The mandate of the Naylor Committee went beyond recommendations on how to organize responses to infectious diseases crises in the future to providing directional recommendations on the future of public health in Canada. Influenced by the coordinating function of the Centers for Disease Control and Prevention (CDC) in the United States, the Naylor Committee recommended the establishment of a national public health agency in Canada (Health Canada, 2003). The federal government established the Public Health Agency of Canada (PHAC) in 2004. Although created as a government department separate from Health Canada, PHAC reports directly to the federal Minister of Health and is headed up by a Chief Public Health Officer. Although cities, provincial governments, and RHAs have long had chief public health officers, this was the first national officer for the country as a whole.

Health Status and Health System Outcomes

Similar to many other high-income countries, Canada has experienced major increases in life expectancy. While both men and women have enjoyed a decline in the mortality rate, the adult male rate declined by almost 43% between 1980 and 2005. Heart disease and cancer (malignant neoplasms) have alternated as the main cause of death. Among the cancers, lung cancer is the most prevalent killer. Ischaemic heart disease remains the most important cardiovascular contributor to death (Marchildon, 2013).

As the Lalonde Report points out, many if not most of the factors influencing health are outside the health-care system. Lifestyle and environmental factors both play a significant role in shaping an individual's diet as well as risky behaviors in terms of alcohol, tobacco, and other drug consumption. Tobacco consumption has fallen by almost 50% since the early 1980s, a result in part of aggressive anti-tobacco initiatives by the federal and provincial governments and fundamental changes in attitudes and lifestyle behaviors by Canadians. Though not as dramatic, alcohol consumption has also fallen over the same period, again in part the result of attitudinal and behavioral changes. However, Canadians have been increasing their intake of calories, apparently the result of greater reliance on prepared foods from both supermarkets and restaurants, which tend to have higher fat content. As a consequence, the rate of obesity has also gradually climbed, particularly among children and teenagers (CIHI, 2004).

Conclusion and Assessment

Canada's relatively high ranking in terms of health status is due to a number of factors including relatively low disparities in socioeconomic status and access to health care. When compared to the United States, in particular, both factors – socioeconomic status as measured by income, education, and occupation, and access based on medical rather than income – combine to produce better health outcomes (Lasser et al., 2006). However, the poor health status associated with the majority of Canada's Aboriginal peoples, many of whom are economically, geographically, and socially marginalized, has nonetheless resulted in an enormous health disparity within the Canadian population (Adelson, 2005).

In terms of health-care organization, Canada is in the mid-range of OECD countries in terms of the extent to which its system is publicly financed and administered. During the early to mid-1990s, access to, and the quality of, some health services were impaired as a result of government budget cutbacks. As a consequence, public confidence in the system was eroded although most Canadians remained committed to the solidarity principles underlying Medicare (Romanow, 2002). Since the late 1990s, both federal and provincial governments have been reinvesting in public health care in an effort to improve quality and reduce waiting time. This public reinvestment in health care has triggered concerns about the fiscal sustainability of Medicare. In reality, most of the cost drivers appear to be in the mixed and private categories of health services rather than Medicare services. In particular, the growth of private and public prescription drug plans has been in excess of double the rate in growth of hospital and physician expenditures. Despite this, most media and think tank commentators continue to focus on Medicare, occasionally suggesting alternatives to the current single-payer model of administration. These arguments were given considerable political support in a recent Supreme Court of Canada judgment. In the now famous Chaoulli case, the court concluded that the Quebec government's prohibition on private insurance for Medicare services violated the province's Charter of Rights in a situation in which a patient waits an unreasonable amount of time for elective surgery. While the decision is not likely to lead to private, multipayer insurance for Medicare services, it has fueled the ongoing debate concerning the appropriate divide between the public and the private sector in financing, administration, and delivery of health care in Canada.

See also: Health Systems of Mexico, Central America and the Caribbean; Health Systems: United States, Health System of the; United Kingdom, Health System of.

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