

# Canadian Healthcare: Need and Utilization in an Almost-Universal System

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All healthcare systems have strengths and weaknesses. They seek multiple goals – ensuring that everyone has access to high quality healthcare whenever they need (or want?) it, in a timely manner, at the lowest possible cost, regardless of where they live or how much money they make. To the extent that these goals are not fully compatible, trade-offs are inevitable. Health policy in most countries is accordingly reactive, as policy makers respond to one set of perceived problems, and in so doing create new ones. As the late political scientist, Aaron Wildavsky, noted, many policy arenas – including healthcare – exemplify problems that cannot be solved. He suggested that the mark of success for such arenas is “to contrast the problems we have now with those we had before”

and see which we prefer.<sup>1</sup>

In that connection, Canada’s “healthcare system” can be judged a success, albeit one under constant pressure. International comparisons suggest that – in stark contrast to the US – Canada is not an outlier. Costs are roughly what would be predicted for a country of its GDP, and despite considerable anguishing, are relatively well controlled. Canadian health outcomes exceed OECD averages.<sup>2-9</sup> Having succeeded, perhaps too well, at controlling costs in the 1990s, current Canadian health policy is focused on an access agenda, with much attention being given to the taming of wait lists, largely for elective procedures, and increasing the supply of health human resources. It is safe to predict that the pendulum will continue to swing, as future reforms attempt to deal

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with the problems created by the current innovations.

### Healthcare Systems

Healthcare is an unusual good. In a market economy, supply and demand are balanced using price signals, and those who cannot (or will not) pay the requested price will be priced out of the market. Some argue that similar factors apply to healthcare, and that shielding people from price signals (e.g., through insurance) creates an incentive to over-use care. This phenomenon is termed “moral hazard,” and refers to the resulting undesirable changes in behavior; for example, people with flood insurance may be more willing to build on flood plains. Indeed, a strong strain in US health reform attempts to address this purported cause for market failure by encouraging “consumer-directed” care, through which individuals must pay for a greater share of the care they receive.<sup>10</sup>

Most analysts outside the US (and many within it), however, reject that argument, on multiple grounds.<sup>11–13</sup> In addition to arguments about the importance of helping others, they point out that much of healthcare violates the fundamental assumptions underlying markets. These violations are based, in large part, on the difference between allocating resources on the basis of demand, and the pervasive belief that at least some healthcare services should be allocated on the basis of need. Most would argue that someone with a ruptured appendix should be treated, even if they do not have enough money. Accepting this view, however, means that that person cannot be priced out of the market. When this is true, efforts to use

market forces just mean that there is a floor price (whatever charity or government will pay) but no ceiling price; those who cannot afford care will drop down to the charity tier. Price signals cannot control prices under these circumstances, and alternative approaches to cost control will be needed.

Conversely, when price is lowered, market theory predicts that more will be demanded; free care will, by definition, be abused. Again, this does not appear to apply to many healthcare services, where few would want to receive services they do not need. One would expect a shoe store to advertise and market their products, and would not expect them to refuse to sell a potential customer a pair that they did not need. However, one would not expect a hospital to market half-price open heart surgery to anyone willing to pay for it, and few would argue that potential customers should be able to purchase open-heart surgery even if they were perfectly healthy.<sup>14–16</sup> In an ideal system, receipt of care would be based on appropriateness (e.g., an expectation of benefit) rather than on consumer demand.

An ongoing debate, then, is about where to draw the line. On the one hand, a fair system should ensure that financial factors do not deter utilization of necessary care. On the other, there is the question of who should pay for what.<sup>17, 18</sup> “Solidarity” is the European term for the principle that costs should be pooled, and that everyone in a particular society should be entitled to certain basic benefits. “Liberty,” in contrast, implies that people should be responsible for their own expenses, and not expect others to pay for them. Different definitions can be assigned to fairness. If costs are being pooled, what is a fair contri-

bution? The same for everyone? Contributions based on what can be afforded (e.g., base contributions on income)? Contributions based on expected costs (what Stone termed “actuarial fairness”)?<sup>19</sup> Adding an additional complication, different approaches can be used for different circumstances. Plans might cover people in certain age groups (e.g., children, the elderly), or those working for particular employers, or those with certain health conditions (e.g., cancer, HIV/AIDS), or certain categories of costs (e.g., hospitalization). No system covers everything, and policy questions clearly arise in defining what should be seen as “necessary.” In every system, there is constant tension at the boundaries, particularly for people or services that are not incorporated into the safety net. By definition, deciding that someone (or something) can be left to market forces means that those who cannot afford it will not receive it. This may, or may not, be problematic, depending upon the consequences of not receiving those services.

Many would argue that one indicator of the success of a healthcare system is the extent to which variation in access is not a function of such non-clinical factors as where people happen to live, and how much income they happen to have. As will be noted below, by those standards, Canada has been relatively successful, although there is always room for improvement.<sup>20</sup> However, success can breed invisibility. Internationally, there is currently a considerable focus on equity, with the World Health Organization stressing the importance of ensuring that everyone has access to basic healthcare.<sup>21</sup> In contrast, it is striking the extent to which equity is not a major feature of the current healthcare

reform agenda in Canada.

### **Characterizing Healthcare Systems**

Healthcare systems can be characterized on many dimensions, including how care is paid for (financing) and how it is provided (delivery). As in most industrialized countries, a sizeable proportion of the costs of care for Canadians are pooled across the population. However, Canada does not and cannot have a national healthcare system. Responsibility for healthcare rests at the sub-national level (provinces/territories), and the organization and delivery of care varies substantially from jurisdiction to jurisdiction. An additional policy dilemma faced in jurisdictions where responsibilities for financing services are decentralized to sub-national levels was how to deal with the imbalance in fiscal capacity associated with the substantial variations in wealth across the country. In Canada, there has long been consensus that fairness required ensuring that Canadians should be able to receive roughly equal levels of healthcare, whether they lived in rich or poor provinces. To alleviate differences in fiscal capacity, Canada chose to use “fiscal federalism,” whereby the national government attempted to equalize the ability of each province/territory to provide a basic level of services. As one component, it provides funds to provinces/territories for post-secondary education, health, and social services. This use of fiscal levers meant that, although it did not have jurisdiction over healthcare, the national government was able to transfer resources from richer to poorer jurisdictions. Since 1977, these have not been tied to specific program

spending, but go into provincial general revenues, although with a requirement that the health insurance plans meet specified national conditions—that the insurance plans be universal and provide “reasonable access” to insured services for all insured persons. The insurance plans (although not service delivery) were required to be publicly administered, and provisions had to be in place to deal with “portability” of coverage from one province to another.

The definition of insured services has proven somewhat problematic. In Canada, publicly-funded coverage came about gradually. It began with the most expensive parts of the system. When the system was set up, sick people would be cared for in hospitals. Accordingly, the federal government first agreed to share the costs for provincial plans insuring care in hospitals (through the 1957 Hospital Insurance and Diagnostic Services Act). In 1966, it added cost-sharing for insurance of physician services (through the Medical Care Act). These plans took some time to implement, but all provinces had complying insurance programs covering hospital and physician care by 1971, and that date is conventionally considered to be the start of “Medicare” (the term usually attached to Canada’s publicly-funded insurance program). Subsequent changes in the legislative basis, including the change in financing from shared costs to block funding in 1977, and the change in terms and conditions with repeal of the earlier acts and passage of the 1984 Canada Health Act, did not change these fundamental requirements.

Thus, although all provinces/ territories have insurance plans that provide universal coverage (all residents must be “insured persons”) without co-pay-

ments/deductibles for a “comprehensive” array of “insured services,” these insured services are defined in terms of where the care is given, and by whom. Provinces must insure medically necessary hospital and physician services; they can extend coverage beyond these limits, but do not have to. Thus, although 70% of health expenditures are publicly financed, as noted below, the historical evolution of the system has meant that the public-private shares vary considerably across sub-sectors.<sup>4</sup>

### **Distribution of Health Expenditures in Canada**

Despite considerable differences in wealth across Canada, the financing system has succeeded in largely equalizing spending. The Canadian Institute for Health Information (CIHI) notes that expenditure per capita was quite evenly distributed across the provinces. Because wealth varied, this similar spending meant that there was greater variation in this expenditure as a percent of GDP.<sup>2</sup>

The following table gives CIHI data on Canadian expenditures by “use of funds” for 2005, the last year for which data has been validated.<sup>2</sup> (The most recent figures for 2006 and 2007 are estimates.) The second column shows the distribution of total expenditures. For example, hospital spending has dropped considerably over time, and now accounts for just over ¼ of total health spending. Drug costs have surpassed physician costs. The third column gives the percent of expenditures for each sub-sector coming from publicly-funded sources. It clarifies that almost all physician costs, and the vast majority of hospital spending, come from public

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sector sources. In contrast, the costs of non-physician health professionals paid through fee-for-service (e.g., dentists, chiropractors) come almost entirely from private sector sources. (Note that professionals paid by organizations are included in those sub-sectors; hospital-based nurses, for example, would be included in the hospital sub-sector.) The final column indicates the share of public health expenditures going to each sub-sector.

Another distinction is that, despite some claims to the contrary, Canada does not have “socialized medicine” – most of this care is delivered by private providers. Hospitals are largely not-for-profit organizations (although in many provinces they are now regionalized into quasi-public regional health authorities); physicians are independent for-profit providers; etc. This contracting model contrasts with other countries, such as the UK, in which delivery was public and hospitals are part of government. In contrast to the US, however, corporate for-profit private delivery plays a relatively minor role.<sup>22</sup>

Given this pattern of expenditures, those needing hospital or physician care should be able to receive it, regardless of ability to pay. Those needing outpatient pharmaceuticals or home-based nursing, on the other hand, may or may not be entitled to public payment. What are the implications for equity? Do Canadians receive healthcare based on need? Are the moral hazard theorists correct that this leads to widespread abuse of the system?

### **Impact on Equity?**

Poverty is bad for health. Measured in terms of self-reported health status, Canada resembles the UK and US, showing a relatively high level of income-related health inequality, as compared to the other seven European countries in the study.<sup>23</sup> This would imply that need for care would be higher among those groups with the least ability to pay for it out of their own pockets.

A number of studies have shown, consistently, that Canada’s financing

**Table 1: Health spending, Canada 2005**

Sub-sector	% of total health expenditures	% public	% of public health expenditures
Hospitals	28.6	90.3	36.8
Other institutions	10.4	75.1	11.2
Physicians	13.1	98.6	18.5
Other professionals	10.8	7.4	1.1
Drugs	16.5	39.0	9.2
Capital	4.7	77.6	5.2
Public health	6.0	100.0	8.5
Administration	3.8	46.5	2.5
Other health spending	6.1	80.8	7.0
Total	100.0	70.1	100.0

arrangements tend to enhance equity. Because of data limitations, many of these studies use neighborhood income as a proxy for individual socioeconomic status (SES). This approach risks committing the ecological fallacy,<sup>24</sup> but provides some insight, particularly to the extent that neighborhoods are relatively homogeneous in terms of income.<sup>25, 26</sup>

A systematic review of the extent to which use of health services varies across different socioeconomic groups has found that, in fact, groups with lower socioeconomic status do use more services, presumably reflecting their greater need for care. This gradient is highest for primary and secondary care. However, there is still some difference in access to specialist services, implying that there may be some non-financial barriers for some populations in navigating a complex system.<sup>27, 28</sup> The patterns are complex, depending upon whether one is looking at the decision to seek care at all, or the intensity of use once care is accessed. However, need appears to drive utilization, as would be expected if financial barriers had indeed been eliminated through universal coverage;<sup>29</sup> indeed, one reason there is some variability across studies is that authors vary in how "need" is controlled for.<sup>30</sup> <sup>31</sup> Another study found that (imputed) socioeconomic status did not significantly affect waiting times for elective surgery.<sup>32</sup>

For example, in Ontario, James et al. categorized deaths into amenable to medical care, amenable to public health, ischemic heart disease, and other causes. Using census data, they then grouped census metropolitan areas into quintiles, and examined differences over time in age-standardized expected years of life lost. From 1971 (when universal

coverage began) to 1996, they found a large reduction in socioeconomic mortality gradients. Most of this reduction was attributed to physician and hospital care; the differences between the richest and poorest quintiles decreased by 60% for those causes deemed amenable to medical care, and the remaining differences were relatively small. Similar decreases were found for deaths from ischaemic heart disease, and for other causes. In contrast, no such declines occurred for the causes deemed amenable to public health, implying that greater attention should probably be paid to public health interventions (e.g., tobacco control). The authors concluded that, "because poorer quintiles had a higher baseline risk of death than richer quintiles early in the study, they had a greater opportunity to benefit (in absolute terms) from health interventions."<sup>33</sup>

Another study, using individual data, found that residents of higher income households incurred lower per capita expenditures for physicians' services than did those in lower income households. As would be predicted if use were based on need, the expenditures were indeed significantly related to self-reported health status. After controlling for health status, the authors found that there was no association between income and expenditure on physician services; this also held when they considered out-of-hospital services, and specialist care. The authors concluded that utilization of physicians' services in Ontario was indeed based on need, rather than on income.<sup>34</sup>

Some of the best analyses have used the longitudinal databases available at the Manitoba Centre for Health Policy in the Canadian province of Manito-

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ba.<sup>35, 36</sup> A number of their studies give a consistent picture.

First, the “moral hazard” argument can be conclusively refuted. They found that providing “free” care did not lead to unnecessary use. Health spending is highly skewed in all age-sex categories. Most people use very little care, i.e., the lowest spending 50% of the population accounted for about 4% of health expenditures, the lowest spending 70% for 10%, and the highest spending 1% for 25%.<sup>37–39</sup> These high cost users are a small group of very sick people, who come from all income groups.

The second conclusion is that universal coverage has indeed minimized the socioeconomic gradient in use of services. Use of healthcare services was related to need. Those with lower SES had poorer health, and used more services.<sup>37</sup> For example, one study of ambulatory care sensitive conditions found that residents of the lowest income neighborhoods had more physician visits than residents of higher income areas. However, medical care alone was not sufficient to equalize health needs; the poor also showed a higher rate of hospitalizations.<sup>35</sup> These differences could be overcome through explicit government action. For example, there was no gradient for childhood immunization; the ongoing system of using physicians and public health nurses ensured a high level of coverage for all groups. In contrast, there was a strong socioeconomic gradient for cervical cancer screening (which depended upon individual patients and providers choosing to seek this care). Screening mammography was the intermediate case – after the provincial government introduced an explicit program in 1995, the rate of screening rose, and the socioeconomic gradient

vanished.<sup>40</sup> These findings suggest that equity in access reflects a number of factors, and that reducing financial barriers is only the first step.

### **Reform Directions**

Health policy seeks to achieve many goals. Are the problems access? Equity? Costs? Quality? The health reform agenda focuses on all of these. However, there is currently remarkably little attention to filling the remaining holes in coverage, including home and community based services and prescription drugs. As noted above, once care moves from hospitals, it moves outside of the national terms and conditions. Movement of care to the community can also mean de-insuring it.<sup>41</sup> Although two major national reports<sup>42, 43</sup> noted the need to address home care and pharmaceutical coverage, there has been little action on these fronts. Instead, focus has been on reducing wait times, largely for elective procedures. Five targets were identified: cancer care, cardiac care, hip/knee replacements, cataract surgery, and diagnostic imaging (CT/MRI). In the first two cases, it has been relatively easy for professionals to define appropriateness criteria, and considerable progress has been made. The other categories are a different story – providing more capacity has led to higher demand, and little measurable impact on waiting lists. At the same time, it is difficult to argue that these are the highest system priorities, or the best way of improving the health of Canadians.

### **Can We Get There from Here?**

As noted above, Canada does not

have a “national” healthcare system. One implication is that it will be remarkably difficult to obtain national solutions. Health policy in Canada is tied up with the often-contentious relationships among levels of government. The Canadian provinces jealously guard their prerogatives, and the current Canadian national government is on record as wanting to ensure that the federal government cannot interfere in areas under provincial jurisdiction. Should they succeed in their stated policy goal, even the current federal strings on provincial programs will vanish, and even more variation will occur. To the extent that provincial governments may wish to offload their costs onto private payment – even if the total costs would be higher – there is an ongoing risk that the current system may be dismantled, quickly or slowly.

Another dilemma is living next to the United States, the only industrialized country without universal coverage. Canadian Medicare passed with all-party approval, but over time the issue has become more and more ideological. American ideas flow north of the border, and those ideologically unhappy with a strong role for government have sparked a steady drumbeat of opposition to the current system, with “access and wait times” being a major point of contention. As noted above, there is considerable variation across the country, and by most indications improvements in wait times are evident, particularly for those conditions where providers have been able to agree on criteria for when care is needed.<sup>5, 44-47</sup> Access has been the major reform thrust in recent years, but when the inevitable trade-offs are confronted, it is unclear what will result.

The conclusion is thus mixed. Can-

ada has a good system, albeit not perfect. Reforms to strengthen one aspect are likely to weaken others. Is the glass half full, or half empty? And who will get to drink?

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