FUNDING AND DELIVERY OF HEALTH CARE IN CANADA: A TALE OF 10 SYSTEMS

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Historical Context

1867 British North America Act (Confederation of provinces)

Feds – large tax base

Matters of national concern and costly activities

Quarantine, marine hospitals, natives, armed forces

Provinces - modest tax bases

Roads, education, "the establishment, maintenance and management of hospitals, and asylums"

Health care a natural extension of hospitals

Post war policy development: Cost-sharing

1945 Federal-Provincial conference on a NHS

Problem:

- Multiple pre payment schemes from pre war period
- Escalating role and costs of personal health care
- Inequalities in funding capacity of provinces

Solution:

- Widespread public and professional support
  Rejected as interfering in provincial jurisdiction

- Limited to Federal grants for hospital construction

Cost sharing as a policy lever

New hospitals meant new revenue requirements

Provinces introduced universal hospital insurance

Provinces lobbied to extend cost sharing

1961 Hospital and Diagnostic Services Act
1968 Medical Care Act (Physician services)

Federal cost sharing of hospital and physician services but no influence on provincial health care policy

Canada Health Act 1984 (Medicare)

Consolidation of previous legislation

Federal cost-sharing conditional on five principles

Public Administration of each provinces plan

Portability of coverage between provinces

Universal coverage for all residents

Comprehensive coverage of medically necessary care

Reasonable access to services

Fiscal influence on provinces: Physician extra-billing

Dollar for dollar reduction in federal cost share

All provinces legislated to stop extra-billing

Overview of current system

'Insured services' (hospital and physician services)

- 'first dollar' coverage (no user charges)
- No private insurance: payment not permissible

Other services

- Left to discretion of each province
- Non-physician ambulatory services, dental and optical care, prescription drugs, home care, long term care, etc
- Private insurance (largely through employment schemes) flourishes (thanks to tax treatment)

Simply the best ?

Everyone has equal access to quality health care

Federal Minister for Health 1988

Very successful in equalizing access to health care

Bob Evans, UBC 1992

Provides access to the best health care system in the world

Premier of Ontario 1993

Relative risk of health care use and need by household income quintile. Canada 1991

In last 12 months	1 (poorest)	2	3	4	5(richest)
Visited FP	1.05	1.04	0.98	1.01	1.00
Visited dentist	0.47	0.64	0.74	0.85	1.00
Activity-limiting health problem	3.50	2.33	1.67	1.50	1.00

Medicare in the 1980s

Removed price at point of delivery to allocation resources

>Did not replace it with anything else – simply 'nationalised' payments to physicians and hospitals

>World capital of piece work medicine (FFS) – docs paid for what they do, not what they achieve or for whom

>Hospitals funded on basis of population-based volumes

Provinces became monopsony buyers of doctors' and hospitals 'services

Incentives for efficiency weak under 50% cost sharing

Real increase (%) in public spending on health care 85-90

Total	19.8
Per Capita	11.8
% GDP	8.4

Medicare in the 1990s

The declining role of federal government

Federal funding shifted from cost sharing to grants

Federal contribution to 'insured services' fell from 25% to 17.5 % over the decade

Balance of care shifted from hospitals/physicians

Share (%) of public expenditure on health care 1990s

Hospitals	-20
Physicians	-12
Other professionals	12
Prescribed drugs	44

Triple Jeopardy for the Provinces

Increasing share of cost of 'insured services' shifted on to provinces

Leaves less of provincial health care funding for non-insured services just as need for these services increases rapidly

Reducing provincial tax revenues - need to find cuts in spending

Medicare in the new millenium in Ontario

Delisting services

- Reducing the number of items physicians could bill for failed – they just billed for other items instead

Delist professions

- Remove public funding for eye tests, physio etc
- Increasing use of hospital based providers for ambulatory care - increased wait times for secondary care
- Public funding partial for many treatment episodes (eg physio for orthapedics, stroke etc)

Medicare in the new millenium in Ontario

Primary care reform:

Shift providers away from FFS towards alternate payments in ways that protect or increase income

This supported physicians 'lifestyle choices' and led to reduction in time for service delivery

Increasing proportion of population have no FP

Increasing pressure on A&E departments

Medicare in the new millenium in Ontario

Ontario drugs benefit plan (ODBP)

Provincial plan to cover cost of prescribed drugs for seniors and those on welfare

Cost-effectiveness analysis used to determine what enters the formulary

As NICE has found - far from containing costs this fuels the fire of cost escalation

Minister and premier questioned sustainability of programme

Medicare in the new millenium in Ontario

Federal government seek to reduce wait times

Agreement with provinces for Federal funding earmarked for procedures that are politically sensitive (hips and knees, MRI, cataract etc)

Funding conditional on reduced wait times

Provinces divert resources from other procedures to achieve targets/funding

“Shifting the deck chairs on the Titanic”

The relentless pursuit of the private sector

Support for the public system

But reducing role of public funded services in the way care is delivered

Prohibition on private insurance for 'insured services' Struck down by Quebec court. Wait times deemed failure by MoH to provide reasonable access to care. Private insurance a reasonable alternative

Subsidies for private insurance of 'non insured' care

Offset against income tax - regressive

Middle classes gain nothing from expanding cover (the 'Obama' problem)

Whither or wither Medicare?

System designed around 1970s model for heath care (physicians and hospitals)

Broadening the Canada Health Act to bring in other services unlikely to happen

Provinces eager to escape the restrictions of the CHA and embrace two tier health care

International trade agreements (GATT, NAFTA) restrict expanding coverage

Incremental expansion of private sector