UNIVERSAL HEALTH COVERAGE IV – Single Payer: Canada

The third brief in this series dealt with the two-tier systems used to finance UHC by Israel and the Netherlands. This brief now turns to the single payer system used by Canada.

Single payer means one-entity funds the health system – this entity is almost always a public entity. Previously, I have written on the single payer system in place in the United Kingdom and the many challenges it currently faces. [1]

In 1961, the recently elected provincial government in Saskatchewan (a southern-central prairie province that sits above the Dakotas) passed into legislation a comprehensive UHC system with affordable premiums subsidized by public funds. At the time, the provincial government was accused of "communism". [2] By 1971, each of Canada's 10 provinces had followed suit and established single payer health care.

Who's covered and how?

All Canadian citizens and permanent residents are covered under the provisions of the Health Act. Non-residents are provided with free emergency services, but are charged a fee for walk-in services. Canadians apply for a health insurance card from their local authority, and simply show this to receive insured services free at the point of service.

Unofficially, the system is known as 'medicare'. The formal terminology is provided by the Canada Health Act of 1984. The system can be thought of as a publicly funded, privately provided, single-payer, national, provincially administered health care system. [3]

In other words, it is publically funded through tax. Almost all doctors are in private practice, and charge the public authorities administering the insurance funds on a fee-for-service basis. The majority of hospitals are private and receive operating budgets from the provincial/territorial government. [4] Each province or territory has a single public authority – the single payer – that funds (and operates and administers) the health care system. It is national as all systems operate under the federal health act, but it is provincially administrated as health care is a provincial responsibility.

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What's covered?

Canada is relatively unique in that neither the federal Canada Health Act nor provincial legislation stipulates that any specific services must be provided. Rather, the Act stipulates five principles that the federal government expects the heath care insurance plan of each province or territory to meet the following criteria:[5]

1. **Public Administration**

a. must be operated on a non-profit basis by a public authority appointed by the provincial government;

b. the public authority must be responsible to the provincial government; and

c. the public authority must be subject to regular audits of its accounts.

2. **Comprehensiveness**

a. must insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners.

3. **Universality**

a. must entitle 100% of the insured persons of the province to the insured health service provided for by the plan, on uniform terms and conditions.

4. **Portability**

a. must not impose any minimum period of residence in province greater than three months before eligibility for access to insured health services;

b. must provide for the cost of any previous resident whilst they are in a minimum waiting period in another province.

5. **Accessibility**

a. must provide insured health services on uniform terms and conditions for all;

b. must provide for payment in accordance with a tariff or system of payment authorized by the law of the provice;

c. must provide for reasonable compensation for all insured health services rendered by medical practitioners or dentists; and

d. must provide for the payment of amounts to hospitals in respect of the cost of insured health services.

The insured services provided for vary little between provinces. The principle of comprehensiveness assumes that provincial and territorial governments will err on the side of inclusiveness when determining what services to insure.

All medically necessary services are covered, from primary to specialist level. There has been very little significant change to what services are insured in recent years. The only major exception to this is abortion, which all provinces and territories except Prince Edward Isle now provide. This gives some idea of the extent to what services are generally insured.

Private insurance is actively discouraged by provincial/territorial legislatures who have the capacity to do so due to their role in regulating the licensing of new facilities and their relationships with existing medical associations. PHI is only permitted for the comparatively small number of services not covered by provincial/territorial medicare.

The majority of private health expenditure comes in the form of out of pocket payments for prescription pharmaceuticals, which obviously account for the large percentage of non-medicare health provision. However, complementary PHI for services such as non-medically necessary dental care and prescription glasses, as well as supplementary PHI for certain benefits such as private hospital rooms and upgraded ambulance services also contribute to overall private expenditure.

Financing

In 2012, total health expenditure amounted to just under $200 billion, or 10.9% of GDP. This placed Canada above the 9.3% average of OECD countries. As with all OECD countries (save the United States), the public sector is the predominant source of financing. At 70% publically funded, Canada is slightly under the OECD average 72%. [6]

All services covered by medicare are free at point of service, and entirely financed by tax-derived government revenues. These predominantly come from the provincial and territorial governments, as well as the federal. The transfers from the government are conditional on the provinces/territories meeting the terms of the Health Act.

However, the provinces and territories of Canada are extremely disparate in terms of geography, wealth distribution and population density. The average cost of health care in the remote northwest territory of Yukon is far higher than the southern provinces. Because of this, the provinces/territories also receive unconditional transfers for purposes of equalization. This is aimed at

ensuring that all Canadians have "access to reasonably comparable services at reasonably comparable levels of taxation". [7]

The remaining 30% of health expenditure is covered by PHI and OPP payments. PHI comes mainly in the form of employment-based insurance, and is on the rise to due to the "continuing centrality of PHI as part of employment-based benefit packages in unionized and professional workplaces". [8]

In the past, all provinces utilized flat-rate monthly health service premiums to contribute toward financing rising costs. However, the provinces have increasingly tended to introduce progressive structures or eliminate premiums altogether – largely due to federal contributions.

British Colombia, the only province still to include flat-rate monthly premiums as a source of revenue for health financing, actually increased rates by four per cent this year. [9] Any individuals earning over $30 000 must now pay $75 a month, or $136 a couple, or $150 for families of three or more. [10] The move has become increasingly unpopular. But this clearly demonstrates the extent of each province's discretion in how it administers its health care system.

Conclusion

The Canadian model is both valuable and relevant for South African policy makers to consider as a working example of single payer UHC. Canada like South Africa is incredibly heterogeneous – both in terms of the distribution of wealth and population. The challenges impeding equitable UHC implementation in the Northern Cape are significantly disparate from those in Gauteng or the Western Cape. Some form of equalization scheme similar to that employed by Canada should be considered in order to achieve equity benchmarks across the provinces.

In the fifth and final brief, Charles Simkins evaluates the different types of UHC considered in this series. He dispels the commonly held myth that health care is a public good; demonstrating that health care cannot be normatively specified. He argues that the government's priority should be increasing the number of services included in the minimum platform of health care available to its citizens, and doing the best it can with the funds it has available.

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Bibliography

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