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Canada’s Health Care System: Lessons for the United States?

Concern about the 35 million to 37 million persons who lack health insurance and the relentless rise in medical costs has prompted public policymakers and Congress to reexamine the financing and delivery of medical services in this country.

Canada's experience in providing universal access to basic health care services while restraining health care spending to less than 9 percent of Gross National Product (as compared with 11 percent in the United States) may offer a valuable frame of reference for any restructuring of the U.S. health care system.

A review of the Canadian health care system indicates, on the minus side, administrative inefficiencies, conflicts with providers, and relatively slow adoption of new technology. Canada has, however, eliminated some of the major challenges facing the United States: uneven access to care, high levels of uncompensated care, and cost shifting. Moreover, Canada’s infant mortality rates, which are much lower than U.S. rates, attest to the nation’s relative success in providing basic health care services to its population.

As a model for the United States, the Canadian health care system will ultimately be judged not only on its strengths and weaknesses but also on how well it responds to such changes as the aging of Canada’s population, the apparently growing demand for health care in relation to other goods and services, and continuing innovations in technology.
Introduction

Concern about inadequate health care for some Americans and about the high and growing cost of health care in the United States has stimulated widespread interest in reexamining the fundamentals of our health care system—how it is financed and how services are produced and delivered. Many reform advocates are looking to Canada’s health care system as one that they believe is particularly instructive. Economic, demographic, and cultural similarities between Canada and the United States, they argue, suggest that Canada’s health care system might provide a model for “reform.”

Canada’s national health insurance system appears notably successful in many ways. Health care consumes less than 9 percent of Canada’s Gross National Product (GNP), compared with 10.7 percent of U.S. GNP in 1986 and 11.1 percent in 1987. All Canadians receive complete health insurance coverage for basic hospital and physician services without deductibles or copayments. Furthermore, Canadians retain the right to choose their physician and hospital, and physicians retain the right to locate where they wish and to charge on a fee-for-service basis.

Gross measures of population health are also cited as attesting to the success of the Canadian health care system. In 1985, the average life expectancy at birth in Canada was 72.9 years for men and 79.8 years for women, compared with 71.0 and 78.3 years, respectively, for men and women in the United States. In the same year, Canada’s infant mortality rate was 25 percent lower than the U.S. rate: 7.9 deaths occurred per 1,000 live births in Canada, compared with 10.6 deaths per 1,000 live births in the United States.

However, Canada’s health care system fosters some problems that are not as apparent in market systems of health service delivery, where total spending for health services is unregulated. Whereas Canadian hospitals are much more likely than those in the United States to be full (a feature that generally compares favorably with the costly excess capacity of many U.S. hospitals), waiting times to see physicians and/or nurses can be lengthy, and required facilities may be unavailable.

Because spending for health care in Canada is decided by a political process, rather than a market process, the allocation of resources to health care may not reflect the value Canadians would place on receiving more health care services, and more highly technical services, than they do now.

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1 The merits and problems of a national health insurance system have been debated in the United States for more than four decades. The U.S. Congress considered various proposals to implement national health insurance as recently as the late 1970s, during the Carter administration. These measures were rejected in favor of retaining primarily private, voluntary health care financing and a decentralized market system of health services delivery.

However, the difficulties of many Americans—the 35 million to 37 million who lack health insurance—in obtaining needed health care have captured the attention of the U.S. Congress and the president. Recognizing that employer plans now insure more than two-thirds of all nonelderly people in the United States, one legislative proposal in the 101st Congress, the Basic Health Benefits for All Americans Act (S. 768), seeks to expand coverage by replacing voluntary employer-sponsored insurance with a system of mandatory employer-paid health insurance and would establish a government program to cover those who are not receiving health insurance under the employer-based system and are ineligible for Medicare or Medicaid. Furthermore, concern about the inadequacy of the health insurance provided by some employer plans has inspired other legislative proposals that would have required employer plans to provide certain minimum benefits for tax qualification. Seeking election in 1988, President Bush proposed that Medicaid, the nation’s public health insurance program for the poor, be greatly expanded to include the nearly 60 percent of poor Americans (about one-third of the uninsured) who do not now qualify for Medicaid coverage.

2 Canada’s recent estimated health expenditures as a percentage of GNP are: 1985, 8.62 percent; 1986, 8.96 percent; 1987, 8.78 percent; and 1988, 8.68 percent.

3 In February 1989, MacLean’s Magazine reported that 1,000 people were on waiting lists for heart surgery in Toronto hospitals, with waits of as long as one year. In 1984, a Quebec hospital reported a list of 2,000 patients awaiting elective surgery for up to one year (Regush, 1987).
This Issue Brief describes the Canadian health care system and evaluates it from four perspectives: access and coverage, cost control, flexibility and individual choice, and financing for long-term care services.

◆ The Canadian Health Care System

Canada’s health care system consists of two complementary plans: public hospital insurance and public physician insurance. These plans, which were introduced, respectively, in 1957 and 1966, replaced existing private plans and, in each case, extended coverage to include sizable populations that had been uninsured.4

Canada’s hospital and physician insurance is provided through separate plans in each province. The federal Hospital Insurance and Diagnostic Services Act of 1957, which authorized Canada’s public system of hospital insurance, offered each province a federal grant of approximately 50 percent of the cost of a public hospital insurance program. At the time, only Saskatchewan had a public insurance plan. Responding to this federal incentive, all provinces soon adopted a public insurance plan for hospital services. In 1966, the Canadian government legislated similar financial incentives for the provinces to establish public insurance plans for physician services.

By 1971, every province had established its own public insurance programs for both hospital and physician services.

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In all provinces, general tax revenues support most or all of the costs of hospital and physician care.

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In 1977, Canada replaced its system of federal matching funds with block grants to each province. This change capped federal support to encourage the provinces to contain health care costs. Federal block grants, however, have not been raised to keep pace with the provinces’ cost increases. As a result, federal support for the provincial plans has fallen from 50 percent of program costs (per the original authorizing legislation) to only 38 percent of program costs in 1988.

4No data indicating the number of people without health insurance coverage were collected in the 1950s. However, an estimated 85 percent of hospital expenses were paid by third parties in 1957, when Canada introduced public hospital insurance. Immediately prior to 1966, when public physician insurance was introduced, about 60 percent of the population had some form of medical insurance (Evans, 1984).
Canada’s fee-for-service system has encouraged providers to increase the number of their patients.

Recently, seeking to manage the cost of Canada’s health care, the provincial governments have imposed tighter controls on the number of doctors and on physician fees, hospital budgets, and home care budgets. These controls have directly resulted in supply shortages and queues for some types of health care services, restricting access to some types of care. In particular, because of budget constraints that limit hospitals’ ability to expand services, some patients now experience long delays for the services of physicians in surgical specialties that require hospitalization.

However, for other types of services (for example, those of family doctors or general psychiatrists), Canada’s fee-for-service system has encouraged providers to increase the number of their patients. As a result, Canada’s health care supply shortages have been uneven.
Government controls on provider fee increases have occasionally disrupted service supply and have created some shortages. Minimal increases in physician fees have created antagonism between physicians and the provincial governments, sparking a strike by Ontario physicians in 1986. Constraints on nurses’ salaries have created acute shortages of nurses, particularly those specializing in intensive care.\(^7\)

\(^7\)Under the current contract with the Ontario Nurses Association, the starting salary for a registered nurse is $23,183, while the maximum salary is $27,132 (in U.S. dollars). These salaries are generally comparable to those in the United States, where the estimated mean salary among nurses was $24,000 in 1986 (U.S. Department of Labor, 1987).

**Cost Control**

Coincident with the stringency of regulation (not with the introduction of national health insurance), Canada’s history of health care costs is divisible into two distinct periods: an initial phase marked by rapid expansion of facilities and services, followed by a phase of much more constrained expansion. In 1951, Canada spent 1.5 percent of its GNP on hospital services and 0.7 percent on physician services (Evans, 1984). By 1985, expenditures on hospital and physician services as a percentage of GNP had doubled, reaching 3.5 percent and 1.4 percent of GNP, respectively (Evans et al., 1989) (chart 1; also see chart 2). The number of hospital inpatient days per 1,000 population increased.
from 1,419 in 1951 to 1,724 in 1982. On average, physicians nearly doubled their provision of services over this period, raising per capita physician income more than 300 percent between 1951 and 1976 and another 70 percent by 1982.

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Canada’s experience indicates that, with universal insurance, governments can impose effective ceilings on cost escalation.

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Nevertheless, Canada’s experience indicates that, with universal public insurance, governments can impose effective ceilings on cost escalation. In the early 1980s, each province imposed limits on hospital budgets, physician fee schedules, and the number of new medical students and interns. Since 1982, spending for hospital and physician services has remained between 8.5 percent and 9 percent of GNP. Because the government is the sole payer for hospital and physician services, it can impose cost ceilings, eliminating the cost escalation that occurs when these services are financed by private payers.

**Hospital Budgets**

While hospitals have considerable freedom in resource allocation within their budgets (encouraging cost minimization), province-imposed annual budgets for each hospital constrain the number of inpatient days and the extent of services hospitals can afford to provide, as well as the provision of physician services that require hospital facilities.

As a result, annual hospital budgets have strongly influenced the way health care is provided in Canada, discouraging surgery and the use of costly new technologies in favor of less technical, nonsurgical alternatives. To adopt a new technology, each hospital must petition the provincial government, a process similar to state certificate-of-need regulation in the United States. Hospitals compete for the right to acquire new equipment and must present convincing arguments to the provincial department of health. Although particular decisions have been contested, there has been little evidence that providers or the general population are concerned about this particular process of adopting new technology.

However, there has been widespread concern about budget restrictions that have threatened the finances of some Canadian hospitals. (Similarly, in the United States some hospitals have disputed the adequacy of Medicare payments.) The annual budgetary process and the question of supplementary financing for hospital deficits have become political issues, and (like public health care financing programs in the United States) require considerable attention from the administration, the legislature, and oversight government agencies.

Despite controversy over hospital budgeting and a consequent shortage of available hospital beds, the use of hospital care is markedly greater in Canada than in the United States. While Canadians used 1,724 hospital inpatient days per 1,000 population in 1982, the U.S. population used only 1,102 per 1,000 population. In 1986, hospital use in the United States fell to 833 inpatient days per 1,000 population, less than one-half the rate of inpatient hospital use in Canada.

Nevertheless, Canada’s spending for both hospital and physician services as a percentage of GNP is less than U.S. spending for these services. In 1985, Canada spent 3.5 percent of GNP for hospital care (compared with 4.2 percent in the United States) and 1.4 percent of GNP for physician services (compared with 2.1 percent in the United States) (Evans et al., 1989).

**Physician Services**

As the sole payer for physicians’ services, the provincial
governments are able to negotiate fee schedules from a position of strength. Ontario's 1989 physician fee increases, which averaged 1.75 percent, were imposed essentially by fiat, after negotiation with the Ontario Medical Association failed.

Since fee-for-service payment accommodates the tendency of providers to increase service delivery to maintain or raise their incomes, the provinces have also sought to control spending for physician services by regulating physician supply. The number of physicians who practice in Canada is affected by the policies and activities of hospital medical advisory committees, medical schools, and provincial colleges of physicians and surgeons as well as by provincial governments and the Canadian federal government. By controlling funding for medical education, the provincial governments strongly influence the supply of physicians. The federal government, according to a 1975 agreement with the provincial ministers of health, curtails immigration of foreign physicians to Canada.

Available evidence indicates that much of Canada's success in constraining the cost of physician services is due to reductions in real physician fees below the levels they would otherwise have been, not to a reduction in service delivery. Canadian physicians' fees (that is, physician service prices), in real dollars, increased much more rapidly under private insurance prior to 1966 than they have under public insurance since then. Real annual increases averaged 1.02 percent between 1946 and 1956, and 1.18 percent between 1956 and 1966. However, between 1966 and 1976, real annual increases averaged only 0.15 percent. Between 1979 and 1981 (a period of rapid inflation in Canada as well as in the United States), physician fees actually declined in real terms by an average of 0.5 percent per year (Evans, 1987).

Comparison of U.S. and Canadian data on physician fee growth is difficult because of differences in the amount of technological change that has occurred in the two health care systems. Recent increases in U.S. expenditures for physician care appear to be related more to physician fee increases (reflecting both price inflation and qualitative changes in physician services) than to increases in the total number of physician visits. Since 1981, U.S. physician fees have increased at an average annual rate of 7.9 percent per year, or 4.0 percent per year in real terms (Feldstein, 1988).

**Administrative Costs**

Administrative costs for insurance are markedly lower in Canada than in the United States (Evans et al., 1989). In Canada, record keeping and provider reimbursement are the responsibility of the provincial governments. In the United States, private insurers incur these costs as well as the advertising and marketing costs of a competitive financing system. The administrative costs of the Canadian health care system were an estimated 0.11 percent of GNP in 1985, or about $15 per person (in U.S. dollars). This contrasts sharply with estimated U.S. administrative costs which amount to 0.66 percent of GNP, or about $106 per person (Evans, 1987). Roughly one-quarter of the difference between the cost of the Canadian and the U.S. health care systems is the much higher overhead cost of financing health services delivery that has developed during the last 25 years in the United States (Evans et al., 1989).

Per capita health care expenditures vary significantly among the provinces. Differences in spending for health care services as a percentage of total provincial expenditures (table 1) may reflect differences in negotiated provider fees, different ways of providing health care services, and differences in per capita Gross Provincial Product.

**Flexibility and Individual Choice**

The appropriate federal/provincial division of administrative authority and financial obligation is a continuing issue for the Canadian health care system. (It is analogous to the division in the U.S. Medicaid program, which is jointly funded by federal and state governments and administered by the states.) While
the provinces have constitutional authority over health care delivery. The federal government has sought to offset inequalities in average income and fiscal capacity among the provinces by providing federal funding for health care. As a result, the federal government exercises substantial regulatory authority over the provincial programs and has been able to impose national standards. Yet the provincial governments retain

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8The British North America Act of 1867 established the division of jurisdiction between the Canadian federal and provincial governments, and clearly defined matters relating to health as subject to provincial authority. The Canadian Constitution Act of 1983 preserved and reaffirmed this allocation of authority (Barer et al., 1985).
not respond adequately to basic changes in health care technology or to the population’s increased demand for health care. In adopting new technologies, Canadians have looked to health services production in the United States as a guide.

Although Canada’s health care system is generally subject to far more government direction than U.S. health care, Canadians have retained unrestricted freedom to choose among physicians and hospitals. This contrasts sharply with the growth of U.S. health services delivery systems (health maintenance organizations and preferred or exclusive provider organizations) that attempt to control cost by restricting provider choice. While Canada’s federal and provincial governments are implicit parties to many health care decisions, freedom to choose among providers is a feature of the Canadian system that the general public values highly.

◆ Long-Term Care

In contrast to Canada’s well-established acute health care system, which is based on universal public health insurance, the financing and delivery of long-term care are in a state of change, with significant variation among the provinces.

responding to an Aging Population

Confronting the growing health services requirements of an aging population, Canada—like the United States—is concerned about the potential cost of providing long-term care. Canada’s elderly, numbering 2.4 million today, represent 9 percent of the population and account for 40 percent of hospital patient-days. The number of elderly is projected to nearly triple during the next four decades, rising to 6.4 million by the year 2031 (Jerome-Forget, 1987).9

Notwithstanding this rapid projected growth, Canada expects the aging of its population to have a relatively gradual impact on health care expenditures. By one estimate, expenditures for hospital care and for long-term care will increase 1.5 percent to 2 percent per year as a result of the changing age distribution, while physician services per capita will rise only 0.3 percent per year (Stoddart, 1987). Considering these magnitudes, increases in Canada’s health care costs related to

its aging population could be supported by annual growth in national productivity, if real productivity (that is, per capita GNP) rises 1 percent or 2 percent per year. Despite these estimates, many Canadians are concerned about the cost of providing long-term care for a growing elderly population, and seek public policies that might minimize the inevitable growth of long-term care spending.

Nursing Home Use

It is estimated that substantial cost could be saved over the next half-century by expanding nursing home capacity rather than acute-care hospital capacity.\(^{10}\) Nevertheless, Canada’s federal government has not particularly encouraged the construction of nursing homes and their use by patients with chronic care needs. Rather, each province has been free to finance and provide its own long-term care services as it wishes, which has resulted in diverse program designs and costs.

At the extreme, Manitoba has a universal public insurance program for personal care homes. About 15 percent of elderly residents in Manitoba’s personal care homes receive nonmedical “hostel” care only, and about 35 percent receive relatively light nursing and other services. Not surprisingly, “homes for special care” absorb a larger percentage of Manitoba’s health care expenditures (18 percent) than the Canadian average (14 percent) (Auer, 1987).

Other provinces provide grants to private not-for-profit long-term care institutions based on the number of patient-days they provide. The institutions commonly supplement these grants by charging patients for care.

Some features of Canada’s growing experience with financing long-term care services for the general population are directly relevant to issues that are being debated in the United States. A study of long-term care delivery in Ontario, Manitoba, and British Columbia found that the implementation of public financing for long-term care actually reduced public spending for health care as a percentage of GNP by facilitating the transfer of long-term care patients from more costly acute-care hospitals (Kane and Kane, 1985, as described in Friedland, forthcoming). Although the growth of community-based care in these provinces has also enabled communities to control the growth of nursing home bed supply, this study found a stronger economic case for expanding nursing home beds (to reduce use of acute-care facilities) than for expanding community-based services (to reduce use of institutional long-term care).

Canada’s growing experience with public financing of long-term care indicates that increased financing does not necessarily encourage runaway utilization.

Moreover, Canada’s growing experience with public financing of long-term care indicates that increased financing does not necessarily encourage runaway utilization, at least when moderate controls—case management, in particular—are in place.

Nursing home use among Canada’s elderly is comparable to that among the elderly in the United States. In 1985, 5.5 percent of elderly Canadians were in nursing homes, compared with 5.6 percent of the elderly in the United States (International Social Security Association, 1986). Nevertheless, Canada’s long waiting lists for nursing home beds have received considerable negative publicity. Widespread attention to nursing

\(^{10}\)Statistics Canada (1988) estimates that about 30 percent of projected patient-days could be spent in nursing homes rather than in acute-care hospitals. Cost savings would result from the lower operating costs associated with a nursing home patient day (20 percent of the operating cost of a hospital patient day) and lower construction costs for nursing home beds (40 percent less than a hospital bed).
home queues may reflect Canada’s high hospital occupancy rates; queues for hospital admission may foster greater interest among the general population in having hospitals discharge patients to nursing home care. The unmet and growing demand for long-term care services poses a critical challenge for Canada’s health care system, similar to that confronting the U.S. health care system.

◆ Conclusion

Deciding on systems of health care financing and delivery requires choices among alternative and often conflicting objectives. Critics of the Canadian system point to administrative inefficiencies, supply shortages, conflicts with providers, systemwide inflexibility and, potentially, some sacrifice of quality associated with the relatively slow adoption of new technology.

Nevertheless, health care costs per capita are lower in Canada than they are in the United States, and growth in health care costs has been constrained to the rate of growth in GNP. Furthermore, the entire population has comprehensive, first-dollar insurance for basic hospital and physician services. Consequently, access to care, uncompensated care, and cost-shifting—major issues for the U.S. health care system—are not issues in Canada. Canada’s infant mortality rates, which are much lower than U.S. rates, attest to its relative success in providing basic health care services to the population.

The aging of Canada’s population, the apparently growing demand for health care in relation to other goods and services, and continuing changes in technology will require ongoing adjustments in the way health care is provided and financed. Historically, the absence of market signals and the need to convince a bureaucracy of the necessity for each change have impaired the responsiveness of Canada’s health care system to changing technology and demand. As a model for the United States, the Canadian health care system will ultimately be judged not only on its shortcomings and achievements but also on whether and how it responds to change.

◆ References

“Sick to Death.” MacLean’s Magazine. 13 February 1989, p. 32.

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