POLICY BRIEF:
COVID-19 reinforces the need for health reform

Colin Craig | June 2020

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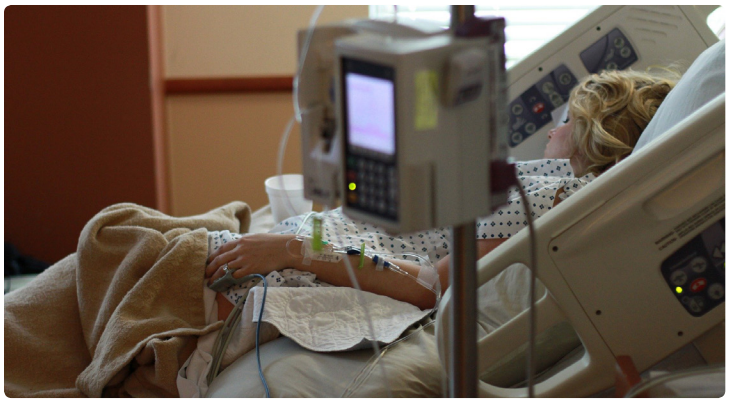
Executive summary

Prior to COVID-19, Canada's state-run health care system was struggling.

It was not uncommon to hear of patients waiting a year or two for surgery and suffering with pain, anxiety, depression or complications from taking painkillers while they waited. It was also not uncommon to hear of patients being treated in the hallways of busy hospitals and in some cases, media outlets have covered stories of patients dying while waiting for care.

Coming out of the COVID-19 period, our system will face even more stress. This is largely due to the thousands of elective (and arguably some non-elective) surgeries that governments put on hold during the pandemic. Treating the backlog will cause even longer wait times.

While many doctors, nurses and other staff rose to the occasion to help treat patients during COVID-19, the pandemic drew attention, once again, to the weaknesses in the system in which they work. This policy brief examines the lack of health care resources in Canada compared with other developed nations. Second, we take a closer look at five countries in the Commonwealth Fund's extensive 2017 report – Australia, New Zealand, the United Kingdom, Norway and the Netherlands – that were found to perform better than Canada's system, while costing about the same or less than what our nation spends.



Key findings from this report include:

- Compared with other nations in the Commonwealth Fund study, Canada came in last or second last when it comes to doctors, nurses and hospital beds per capita.
- The five countries that perform better in the Commonwealth Fund's study all have one thing in common: they offer patients a choice – use the public health care system, or purchase health care services from a private provider.
- Australia's government provides a universal public health care system for all citizens, but uses as series of rebates, taxes and regulations to encourage Australians to purchase private insurance and reduce the strain on the public system. As of 2016, 47% of Australians owned private insurance for private hospital care coverage, while nearly 56% had general treatment coverage.
- New Zealanders can choose to use only their country's publicly funded health care system or purchase private health insurance to provide additional choices – something approximately 33% of New Zealanders choose to do.
- In the Netherlands, citizens are required to purchase health insurance from private providers (non-profit and for-profit firms) that operate in a government-regulated market. Government subsidies help keep insurance costs affordable for the public, especially lower income individuals.
- In the United Kingdom, patients can use only the country's public system or choose to purchase private insurance on top for elective treatment at private hospitals. Approximately 11% of the population buys private insurance for elective treatment.
- Norway is similar to the UK and New Zealand in that all patients have access to the public system or they can purchase private insurance to increase their choices. Approximately 9% of the population has some kind of private insurance, mostly paid for by employers.

Unlike these five countries we examined, Canada offers no rebates or incentives to purchase private health care options or to pay for private medical insurance coverage. In many cases, Canadian governments ban the purchase of private health care options. In addition, the *Canada Health Act* (CHA) bans user fees (called co-payment in some countries) for some services, including for visits to physicians.

This legislation not only denies Canadians access to the sorts of private health care options available in other countries, but also prevents the Canadian health care system from being improved. Patients ultimately suffer while our nation resists meaningful reform.

Ultimately, this policy brief shows that unless Canada reforms our health care system, we could be vulnerable once again should another pandemic arise.

Figure 1

Health care system performance rankings (2017)

	Overall ranking
United Kingdom	1
Australia	2
Netherlands	3
New Zealand	4
Norway	4
Switzerland	6
Sweden	6
Germany	8
Canada	9
France	10
United States	11

Source: Commonwealth Fund, 2017a.

Canada's health care system vs. the world: The world wins

Canada is fortunate to have thousands of doctors, nurses and other health professionals who are talented individuals and care deeply about patients. The problem is the health care system they work in is not an effective model. Ultimately, Canadians are not receiving value for the money they pay for Canada's health care system. Any number of credible, empirical sources makes this clear. The most expensive system in the country is in Alberta, which spends more per person than any other province. As Alberta's auditor general wrote in 2017: "Albertans already pay for the most expensive health system of any province in Canada yet they are not receiving the level of care being provided by the best-performing health systems in other jurisdictions."[1]

Alberta is only one internal example. International studies have made the same finding of the Canadian health care system as a whole. For instance, a 2017 Commonwealth Fund study that compared 11 developed countries on health care performance rankings put Canada ninth, with only France and the United States coming in lower (Figure 1).[b]

A 2019 study from the Fraser Institute also found that Canadians were not receiving value for dollars spent. Out of 28 countries with universal health care systems, and after adjusting for age, Canada comes in as the second-highest health care spender (as a percent of GDP and tenth-highest per capita). Canada was at the middle of the pack when it comes to beds and health care professionals per capita, including doctors and nurses. In terms of resources such as MRIs and CT scanners, however, Canada was near the bottom. As the Fraser Institute concluded, "Overall, the data examined suggest that, although Canada's is among the most expensive universal-access health-care systems in the OECD, its performance is modest to poor."[3]

Fewer doctors, nurses and hospital beds for Canadians

In order to best understand these rankings in terms of actual patient care, we should consider three clear OECD measurements. These measurements involve criteria affecting services that can be delivered to sick or injured Canadians, and include: doctors, nurses, and hospital beds (all per 1,000 people).

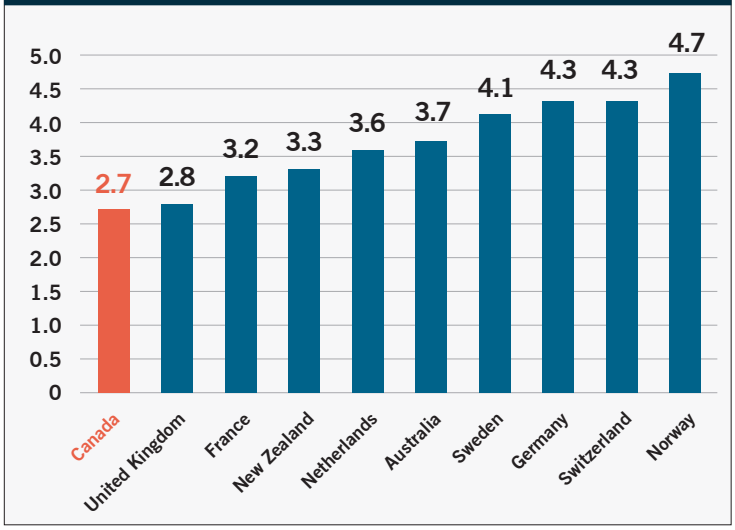
[a] As an example, see Alberta, where section 26(2) of the *Alberta Health Care Insurance Act*, RSA 2000, c A-20 ("AHCIA") provides that "an insurer shall not enter into, issue, maintain in force or renew a contract or initiate or renew a self-insurance plan under which any resident or group of residents is provided with any prepaid basic health services or extended health services or indemnification for all or part of the cost of any basic health services or extended health services."

[b] For the remainder of this study, we have mostly excluded the United States in comparisons as that country does not have universal health care coverage.

The data corroborates what the Alberta Auditor General, the Commonwealth Fund, and the Fraser Institute have all found: Whether in doctors, nurses, or hospital beds, Canadians are not receiving the quantity and thus the quality of services they might expect of their more expensive health care system. In doctors per 1,000 people, Canada is dead last out of the ten countries surveyed. In nurses per 1,000 people, Canada is second-last. For beds per 1,000 people, Canada is again second-last (OECD 2019). These statistics, as well as others on health care outcomes, demonstrate in part why the Canadian health care system was ranked poorly by the Commonwealth Fund.

Figure 2

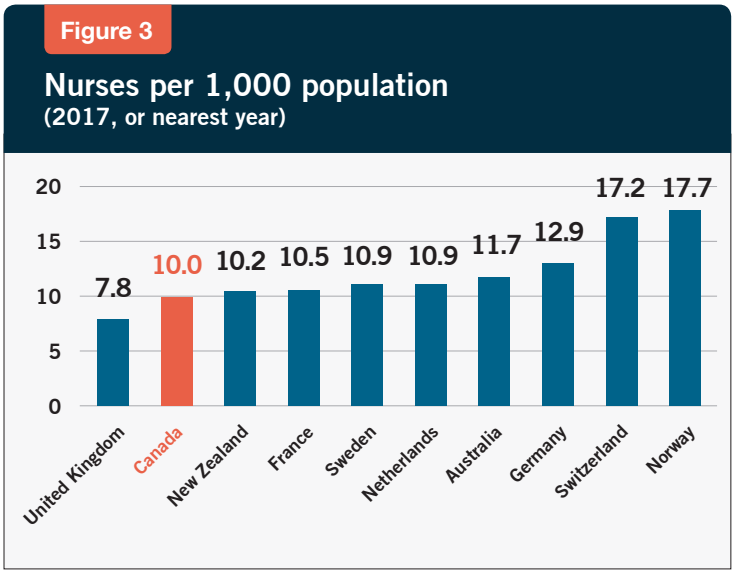
Doctors per 1,000 population
(2017, or nearest year)



Source: OECD 2019.

Figure 3

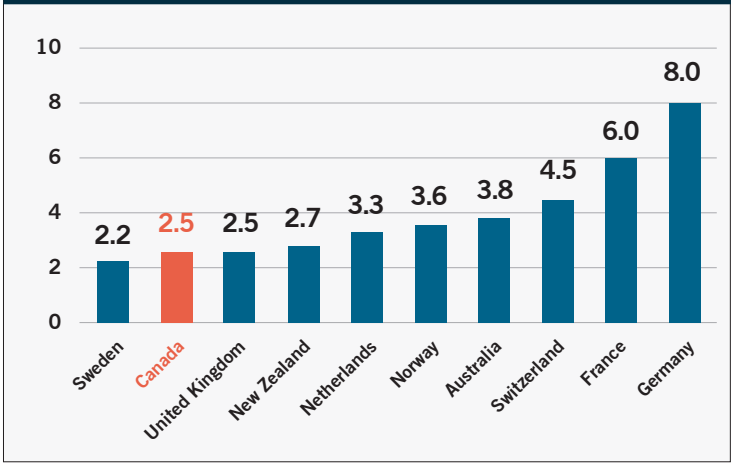
Nurses per 1,000 population
(2017, or nearest year)



Source: OECD 2019.

Figure 4

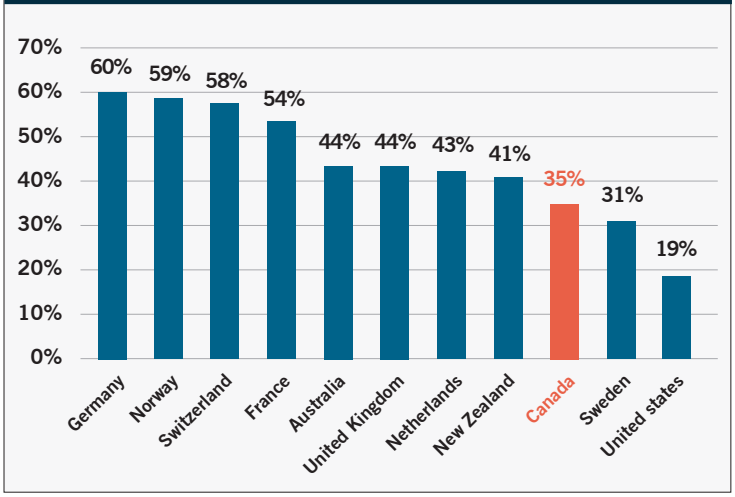
Total hospital beds, per 1,000 population
(2017, or nearest year)



Source: OECD 2019.

Figure 5

Overall view of the health care system from citizens: "Works well, minor changes needed"



Source: Commonwealth Fund, 2017b, 8.

Result: Canadians are unhappy with their health care system

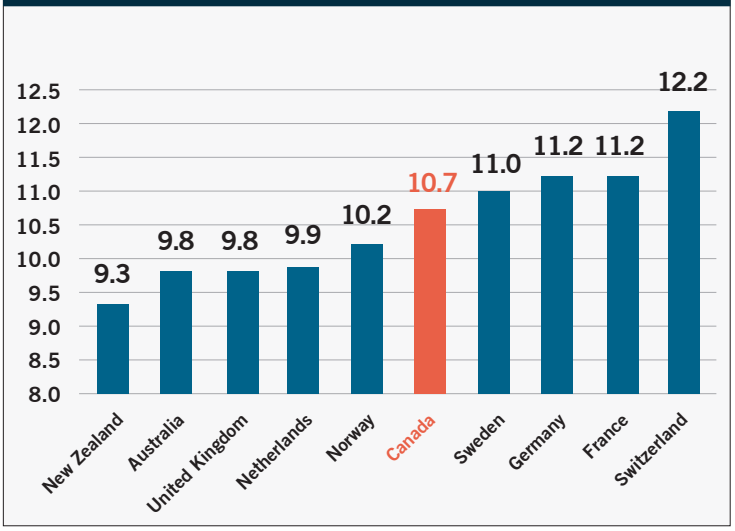
It is perhaps unsurprising that a 2017 Commonwealth Fund study found that citizens in every other country except Sweden and the United States showed more satisfaction than Canadians do with their health care system. Only 35% of Canadians thought Canada's health care system worked well and required only minor changes (Figure 5).

Better outcomes with less money

To understand how Canadians are not receiving value for money in terms of health care dollars spent, we might consider the five countries that spend less than Canada as a percentage of the economy, but ranked higher than Canada on the Commonwealth Fund's measurement of performance. These countries are New Zealand, Australia, the United Kingdom, the Netherlands, and Norway (see Figure 1).

Figure 6

Health care spending as a % of economy
(2018)



Source: OECD 2019.

Snapshots of selected countries' health care systems

Here are snapshots of each country, including how more choices in health care – especially in private and non-profit insurance – are offered or even encouraged by their governments.

Australia

When it comes to health care, Australians have a choice: use only the government-run Medicare system or purchase private health care insurance.

If a patient does not have private insurance, he or she can use the public system for everything from visiting a family doctor about a nagging sore throat to receiving a hip operation or a life-saving procedure in a hospital.

According to the Australian government's website:

> *"Medicare covers all of the cost of public hospital services. It also covers some or all of the costs of other health services. These can include services provided by GPs and medical specialists. They can also include physiotherapy, community nurses and basic dental services for children."*[5]

While hospital procedures such as hip replacements and cancer surgery are fully covered by Australia's Medicare system (or a combination of Medicare and private insurance), patients sometimes pay a user fee when visiting a family doctor. The amount patients pay depends on the doctor they choose to visit.

Currently, doctors in Australia are free to set their rates just like any other private profession. Many doctors charge the same rate the government contributes towards a patient's visit. This is known as a "Medicare rebate", and it is currently $38.20 AUS ($34.00 CDN).[6][7]

When a patient visits a doctor who charges this fee, the doctor will typically bill the government for the appointment directly. This is known as "bulk billing". According to the Australian Institute of Health and Welfare, approximately 66% of Australian patients had all of their fees for visiting with family doctors paid for by the government in 2016-17.[8]

Bulk billing covers visits to participating GPs and specialists, but does not cover expenses like vaccinations, ambulance services, dentists, cosmetic surgery or other procedures outside of Medicare practices. (Note: Some states fully cover the cost of ambulance services for patients.)

If, however, a patient visits a doctor who charges more than what the government will pay, the patient pays the difference. This is known as a "gap fee." Low-income patients can apply to the government to have some of their "gap fees" reimbursed

at a later date. All patients benefit from an annual cap on gap fees of $477.90 AUS ($416.90 CDN). Once a patient has reached this out-of-pocket spending limit, the government will cover gap fee expenses beyond this threshold.[9] [10]

A major benefit of private health insurance in Australia is that it gives Australians more choice. When it comes to surgery for example, private insurance will often allow patients to choose not only the surgeon, but also the hospital and date.[11] An added benefit is that patients who use the private system free up spots in the public health care system's queue. Depending on the plan, private insurance can cover hospital care, general treatment, and ambulance services.

The Australian government uses tax rebates and penalties to encourage citizens to purchase private health insurance. Patients receive a tax rebate when they buy private health care insurance, while patients above a certain income level receive a tax penalty if they do not buy it.

As one insurance provider notes: "The Australian Government has a number of initiatives in place to encourage us all to take out private health insurance. These initiatives include the Australian Government Private Health Insurance Rebate, the Medicare Levy Surcharge and Lifetime Health Care Cover Loading."[12]

Each of these initiatives can be outlined as follows:

- The government provides a *Private Health Insurance Rebate* that subsidizes most Australians to buy private health care insurance. Subsidies are scaled according to income. Single Australians can earn up to $140,000 and family incomes can reach $280,000 before the rebate is cut off (CA$126,800 to CA$ 253,600).[13]
- The *Medicare Levy Surcharge* is applied to the tax bills of higher-income Australians who have not purchased private health care insurance. The tax surcharge is an additional 1%, 1.25% or 1.5% of income, depending on earnings. A single Australian whose income is above $90,000 would pay the tax the same as a family with an income over $180,000 (equivalent to CA $81,522 and CA $163,044 respectively).[14]
- *Lifetime Health Cover:* The Australian government encourages young Australians to enroll in private health care by mandating increasingly higher private insurance premiums the longer Australians wait to purchase private insurance. These premiums go up by an extra 2% for every year after age 31 that they continue to go without coverage.

  For example, after ten years without buying private insurance coverage, a 41-year-old Australian would pay an extra 20% premium on top of the regular premium for private health care insurance. In other words, if the regular insurance premium for private health care coverage for a 41-year-old (with exactly similar health and lifestyle) was $300 monthly, the 41-year-old who started to buy coverage at that age would pay $360 monthly (the regular $300 premium plus $60, i.e., the 20% penalty). The maximum extra penalty is 70%.[15]

The result of the Australian government's incentives towards private health care is that in 2016, 47% of Australians owned private insurance for private hospital coverage, while nearly 56% had general treatment coverage (i.e., for faster access for nonemergency services, rebates for selected services, and others).[16]

As with European countries profiled here, Australians can choose among non-profit and for-profit health insurers.

Australia's private health insurance is dominated by two major providers; Bupa and Medibank. Each is a for-profit corporation, and holds about 27% of the market share. In third place is Hospitals Contribution Fund of Australia (HCF), which is non-profit and holds about 10.4% of the market share.[17] The remaining providers are smaller for-profit and non-profit companies. They include Union Health, a 100% member-owned non-profit health fund that sells health benefits to unionized employees. Union Health was founded in the 1970's by the Queensland Teachers Union and represents about 0.6% of the Australian private health insurance market.[18]

By using the carrot-and-stick approach – especially a tax levy on high-income earners if they do not buy private insurance – Australia's government incentivizes wealthier Australians to pay for more of their own care, given they can afford it. This is why private health insurance coverage only covers about 22% of low-income Australians (the lowest fifth), and about 57% of the top income earners (the top fifth).[19]

Spending and government/private breakdown: Health care spending in Australia is 9.8% of GDP, nearly a full percentage point of GDP less than Canada.

New Zealand

New Zealand's public health care system provides much of the same health care procedures as Canada's, but for a lower cost.

However, there are also some key differences between Canada's system and the New Zealand model.

- New Zealanders pay co-payments (user fees) for visiting their general physician, as well as for nurses' services. According to the Commonwealth Fund, the cost (co-payment) for visiting a family physician was between $15.00 and $45.00 (CA $13.00 and $39.00). For New Zealanders residing in low-income areas, patient co-payments are capped at NZD17.50 per visit (CA $15.00), though the government pays physicians more in such areas to make up for the cap.[20] It should also be noted that primary care is free for children.
- New Zealanders also have the choice to use private care if they do not want to use the public system. 33% of New Zealanders buy private health insurance to cover cost-sharing (i.e., specialist fees, and elective surgery in private hospitals), as well as for non-urgent treatment.[21]

New Zealanders can buy private insurance from a variety of organizations (nonprofits and "Friendly Societies", but also for-profit companies). This insurance helps cover some of the costs of co-payments, elective surgery in private hospitals, and private outpatient specialist consultations.[22] As with Australia, New Zealand blends public/private insurance and ultimately provides better services – including shorter wait times – at a lower cost of GDP.

Spending and government/private breakdown: Health care spending in New Zealand accounts for 9.3% of GDP, or 1.4 percentage points less than in Canada.

Netherlands

In the Netherlands, patients choose between one of four private health insurance providers, three of which are non-profit. These four insurers negotiate prices with health care providers (doctors, nurses, others, and companies or non-profits that employ them) to deliver health care efficiently and effectively. As the OECD describes health reforms passed in 2006: "the role of government changed in 2006 from direct control of volumes and prices to rule-setting and overseeing the proper functioning of markets."[23]

Writing for the Evidence Network, Dr. Lee Tunstall notes, "Managed competition is where there is a market of health care insurers that consumers can choose from, but these are regulated by government." Dr. Tunstall describes Holland's health care system as an "efficient, universally-accessible system that has successfully integrated a strong competitive market component."[24]

Although patients do choose among private providers, the Dutch government plays a role by managing competition in the nation's health care system, as well as by subsidizing citizens where necessary. About 40% of the insured population receive a taxpayer-funded subsidy to purchase insurance. The lowest incomes have 70% of their premiums, as well as the average deductible, covered by these subsidies.[25]

For Canadians, the Dutch system is akin to being able to choose between a non-profit insurer such as Blue Cross, and a for-profit insurer for health care. The Dutch can choose between four such providers for basic health insurance (OECD 2017 and Tunstall, undated), while Canadians, on the other hand, are entirely restricted to the basic health insurance provided by their provincial governments. In addition to payroll premiums, the Dutch do pay a deductible of approximately $510 annually for health care services. As Dr. Tunstall notes, this charge includes coverage for most medications and "visits to family doctors and maternity care are not subject to this deductible and all costs are therefore covered."[26]

Spending and government/private breakdown: Health care spending in the Netherlands accounts for 9.9% of GDP or 0.8% of GDP less than Canada.

Norway

In Norway as in Canada, health care coverage is universal, and much of it is financed through taxes. One difference is that the Norwegian government requires its citizens to pay what Canadians would call user fees.

For example, copayments of roughly CA $23.00 to $50.00 are charged for visits to general physicians and specialists, as well as for same-day surgery.[27] There are also two annual ceilings on what Norwegians pay out of pocket, one per visit as per above, as well as an annual payment cap of about $350.00 (CDN).[28] After that threshold, the government will pay for the rest via taxation. This approach ensures that everyone pays a little, but that lower-income citizens are not burdened with the stress of huge medical bills.

Another key difference with the Norwegian system is that patients have the option of paying for private health care if they do not want to use the public system. Private health insurance is allowed, and provided by for-profit insurers. This increases the number of choices available to patients. As the Commonwealth Fund notes, about 9% of the population has some kind of private insurance – mostly paid for by employers – which is used to move employees/patients through the system for elective surgeries more quickly. However, compared with Australia or New Zealand for example, private insurance in Norway covers less than 5% of elective services.[29]

Spending and government/private breakdown: Health care spending in Norway accounts for 10.2% of GDP, half a GDP point less than in Canada.

United Kingdom

Similar to Canada, the United Kingdom operates a publicly funded health care system – the National Health Service or 'NHS'.

Everyone from low-income patients to wealthy patients in the United Kingdom can visit a family doctor to discuss a health concern without having to pay a user fee. The visit is fully funded by the government through general taxation. The same is true if a patient visits a hospital for a more serious procedure, such as treatment for cancer, a hip operation, etc.

However, where the United Kingdom's health care system differs is in private options.

If patients in the UK do not want to wait the standard length of time for a hip operation in the public system – say, up to six months – then they can choose to pay for health care at private health care facilities.

In the U.K., 11% of the population buys private insurance for elective treatment at private hospitals. This would be equivalent to a British Columbian being allowed to buy private health insurance for quicker treatment through the privately-owned Cambie Surgical Centre.[30]

This approach helps reduce the strain on the public health care system while providing patients with more choice. Data from the Commonwealth Fund report suggests that patients in the UK face shorter wait times both for visiting a specialist as well as for receiving elective/non-emergency surgery.

The United Kingdom has an estimated 548 private hospitals, and between 500 and 600 private clinics. These facilities offer a range of services, including some treatments that are either unavailable in the National Health Service or those which typically have long waiting times. Private clinics do not usually provide emergency, trauma, or intensive-care procedures.[31]

Furthermore, the NHS *does* contract with private hospitals and clinics to provide some procedures to patients in the public system. However, the proportion of these procedures is currently low: approximately 3.6% in 2013.[32] According to the World Health Organization, "There have also been initiatives to foster privatized service delivery and internal competition (2014), allied to strengthened regulation and the use of targets to encourage better efficiency and quality."[33]

Spending and government/private breakdown: Health care spending in the United Kingdom accounts for 9.8% of GDP, almost a full percentage point less than in Canada.

Conclusion

Canada's health care system ranks ninth out of the 11 countries surveyed by the Commonwealth Fund for health care system performance. Only France and the United States came in lower. Canadians are not receiving value for their tax dollars – this is made especially clear with the measure of doctors, nurses, and beds per 1,000 members of the population. Canadians themselves are also clearly dissatisfied, with only 35% expressing confidence that the system works well and that no major changes are needed.

Fortunately, this dissatisfaction is not without remedy. As health care performance rankings have shown, better health care systems are available, and they provide models for improvement. Among the eight countries ranked by the Commonwealth Fund as having superior health care systems to Canada's, this study focused on the five that spend less as a percentage of GDP than Canada does: New Zealand, Australia, the United Kingdom, the Netherlands, and Norway. All five spend less on health care, all have universal systems, and all rank higher than Canada in health-care performance.

The key differences between these five countries and Canada include how the others all allow for competition in health care insurance coverage—including coverage for private treatment that is also available in the public systems. Some countries, including Australia, encourage the purchase of private insurance for both hospital visits and general and primary treatment. There are other models as well, with all five countries providing examples of how politicians treat citizens better by allowing for many more choices that benefit patients.

Canada could provide much better results for its own patients if its provincial governments copied the best of these alternative systems. It is important to note that each of these five countries emphasizes something currently rejected in Canada – namely, the role of competition and the private sector (insurance and delivery) in both ensuring the public health care system is more effective and simply to provide timely, quality health care outcomes.

Each of these countries provides potential models for reform of Canadian health care, having ranked higher in terms of care, but with lower costs. These models recommend:

- Private insurance including competition among multiple private providers;
- Private insurance for elective surgeries and in some countries also for acute surgeries;
- Cost-sharing in the health care system;
- Allowing private sector choice in insurance, including incentives for low-income and middle-income earners with penalties for high-income earners who do not purchase it (as in the example of Australia).

Ultimately, this policy brief shows that unless Canada reforms our health care system, we could be vulnerable once again should another pandemic arise.

About the author

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