Organization of the health care system and the recent/evolving human resource agenda in Canada

1. Organization - the structural provision of health care.

Canada has a predominantly publicly financed health care system with a national health insurance program achieved through thirteen provincial and territorial health insurance plans, linked through the national principles of the Canada Health Act (CHA), which the provinces and territories must meet in order to receive the full federal cash contribution under the Canada Health and Social Transfer (CHST). The federal government provides financial support to provincial and territorial governments, most notably through the CHST. It is estimated that in 2002-03, these transfers:

- will total almost $46 billion (about $1,465 per person);
- will account for about 24 per cent of aggregate provincial and territorial revenues.

As part of the 2003 First Ministers' Accord on Health Care Renewal, the Government of Canada will establish a new long-term Canada Health Transfer (CHT) by March 31, 2004. It will include the portion of the current CHST (both cash and tax points) corresponding to the current proportion of health expenditures in provincial social spending supported by this federal transfer. In establishing the CHT, the federal government will ensure predictable annual increases in health transfers.

The aim of the CHA is to ensure that all eligible residents of Canada have reasonable access to medically necessary insured services on a prepaid basis, without direct charges at the point of service.

Principles of the Canada Health Act include public administration, comprehensiveness, universality, portability and accessibility (i.e. access to medically necessary hospital and physician services unimpeded by financial or other barriers).

In addition to monitoring adherence to the CHA and providing funding, the federal government's role in health care includes delivering direct health services to specific groups of Canadians including veterans, First Nations peoples living on-reserve, military personnel, the RCMP and inmates of federal prisons; and fulfilling other health-related functions such as health protection, health promotion and disease prevention.

The planning, administration and delivery of health care services is the responsibility of each individual province or territory. In all, provinces except Ontario, regional health authorities are responsible for the day-to-day provision of health care.

How the System Works

Canada's health care system relies extensively on primary care physicians who account for about 51% of all practicing physicians in Canada. They are usually the initial contact with the formal health care system and arrange for access to most specialists, hospital admissions, diagnostic testing and prescription drug therapy. Family physicians currently work predominantly in private offices in informal group practices with increasing

numbers opting not to have hospital privileges; however, recommendations for reform in primary care, which are slow in being implemented, include the development of multidisciplinary, clinic-based teams. Specialists work in both private office and hospital settings in single or multi-specialty group practices. While nurses are generally employed in the hospital sector, they also provide community health care including home care and public health services.

Over 95% of Canadian hospitals are operated as private non-profit entities run by community boards of trustees, voluntary organizations or provincial regional health authorities. Hospital medical staff, family physicians and specialists, are appointed under each hospital's bylaws, and granted privileges within designated areas of clinical activity.

Relationship with social services e.g. home care

Public home care programs include both health care and support services provided to an individual at home. Services include assessment and case management, home care nursing, physiotherapy, occupational therapy, homemaker services and meal programs. However, there is great variation amongst the provinces as to the level of service provided.

Key constraints in provision

Canada is a sprawling country; therefore providing adequate health care to rural and remote Canadians is a major problem. Shortages of physicians in general, as a result of earlier cuts to medical school and residency positions and reluctance of practitioners to practice in rural and remote areas, have contributed to the distribution problem. Recent decreases in interest in pursuing family medicine as a career are a concern for equitable distribution in rural and remote areas. As well, a shortage of nurses has created problems in the provision of care in hospitals and lack of nurse practitioners has been one of the issues in the slowness of implementation of reforms in primary health care.

The creation of waiting lists for many diagnostic services has occurred as a result of a dearth of technologically advanced equipment and failure to replace old equipment, as well as shortages of specialists and technologists. This has created delays in therapeutic interventions for serious illnesses.

Training arrangements for doctors

There are 16 government funded medical schools in Canada with one planned to begin taking students in 2004; there are no privately funded schools. The majority of medical students will have completed an undergraduate degree, not necessarily in the sciences; the duration of the program at two schools is three intensive years, while the others are four year programs.

Postgraduate training in either family medicine or in one of the 59 specialties is the responsibility of the medical schools; the programs are accredited by The College of Family Physicians of Canada (CFPC) for training in family medicine and by The Royal College of Physicians and Surgeons of Canada (RCPSC). The RCPSC and the CFPC

have established Maintenance of Certification programs for the continuing professional development of their members.

The Medical Council of Canada (MCC) facilitates portability and reciprocity between the different provinces through the MCC Qualifying Examination (MCCQE) Part I and Part II examinations leading to a standard qualification in medicine, the Licentiate of the Medical Council of Canada (LMCC). For graduates of international medical schools, success in the Evaluating Examination is required for entrance to the Qualifying Examination. The LMCC is one of the requirements of the medical licensing authorities for the issuance of a license to practice medicine.

Each provincial and territorial government is responsible for licensing physicians to practice medicine within its boundaries. The provincial and territorial governments have mandated this responsibility to the medical licensing authorities.

Training arrangements for nurses

Basic nursing education is available in many communities in Canada. Universities and diploma schools of nursing offer an initial program, which prepares candidates to write the national examination and to enter the practice of nursing. Students in British Columbia, Alberta, Ontario, Quebec, and the territories can still choose either a diploma or a degree program to prepare for a career in nursing but they must be aware of the trend toward a university level of education. Ontario's College of Nurses will require a degree in nursing for entry to practice beginning in 2005. In all other provinces students must choose to obtain a baccalaureate degree in nursing to prepare for a career. Diploma graduates who are already practicing as the requirement changes will be able to continue without mandatory upgrading. Diploma graduates who wish to study for a degree can apply to university, or institute schools of nursing that offer special and shortened programs for registered nurses.

Specialty areas of nursing require experienced nurses and nurses who have gone on in their studies through specialty courses or graduate school. Canada has 21 master's programs in nine provinces. Doctoral programs in nursing are available in British Columbia, Alberta, Ontario and Quebec. Some schools are now offering graduate courses by distance.

2. Finance

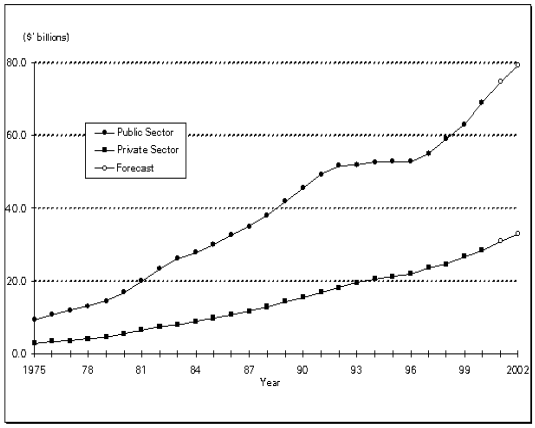
1a) Aggregate and per capita spending on health care (total public and private) and as a percentage of Gross Domestic Product

Total Health Expenditure, Canada, 1990 and 1996 to 2000 (actual) and 2001 to 2002 (estimates), Canadian Institute for Health Information

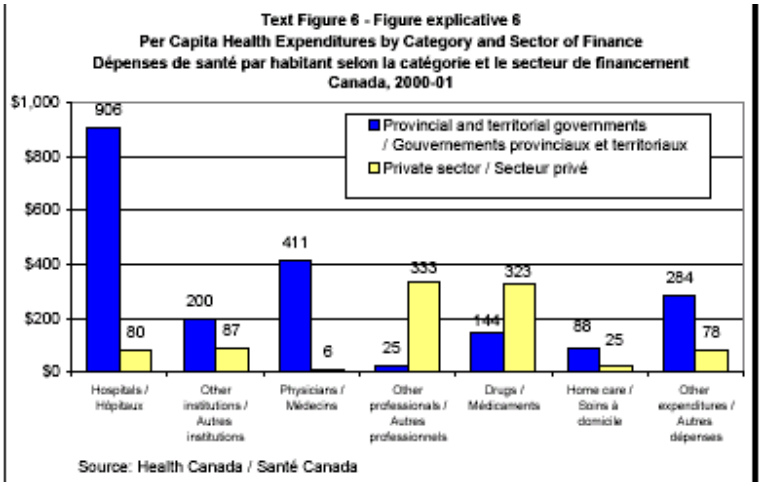
	Total Health Expenditure in current dollars		Total Health Expenditure in constant 1997 dollars	Total Health Expenditure as a % of GDP

	Total	Per Capita		Total	Per Capita			
Year	($' 000,000)	($)		($' 000,000)	($)		(%)	
1990	61,027.6	2203.10		69,842.6	2521.32		9.0	
1996	74,779.7	2520.22		75,695.0	2551.07		8.9	
1997	78,574.2	2620.26		78,574.2	2620.26		8.9	
1998	83,634.6	2764.92		82,471.3	2726.47		9.1	
1999	89,788.6	2942.99		87,467.2	2866.90		9.2	
2000	97,420.0	3163.93		92,541.8	3005.50		9.1	
2001 f	105,605.2	3394.51		98,691.7	3172.29		9.7	

1b) Health Expenditure by Source of Finance (public and private), Current Dollars, Canada, 1975 to 2002, Canadian Institute for Health Information



2) Per capita spending on health care by category and sector (public and private separately), 2000-01



The totals for per capita spending in 2000-2001 were $2028 as public and $932 as private spending for an overall total of $2960 in Canadian dollars.

Using 0.68 as the rate of exchange (at mid-year 2000), the following US$ equivalences for the per capita spending above by category and sector were:

	Public	Private	
Hospitals	596.41	52.86	
Other institutions	131.66	57.27	
Physicians	270.55	3.95	
Other professionals	16.46	219.21	
Drugs	94.79	212.63	
Home Care	57.93	16.46	
Other expenditures	167.20	51.35	
Total	1335.00	613.73	= US$1948.73

Thus, the totals for per capita spending in 2000-2001 were $1335.00 as public and $613.73 as private spending for an overall total of $1948.73 in U.S. dollars.

3) Method(s) of remuneration of physicians and other health professionals (where relevant)

In 2002, according to the Physician Resource Questionnaire of the Canadian Medical Association, most doctors (58%) were paid on a mainly fee-for-service basis; 8% are paid mainly by salary; 5% were paid on a sessional or capitation basis and 26% received a mixed method of remuneration (3% no reply). Academic specialists are increasingly being paid by alternate funding plans.

Nurses and other health professionals are mainly paid on a salaried basis through hospital budgets. Some therapists and midwives (where provincial regulations allow) practice as private practitioners.

4) Recent rate of growth of expenditure on health care and/or announced changes in future government spending.

Canada's First Ministers agreed in September 2000 on a shared action plan for renewing health care and investing in early childhood development. To support this action plan, the federal government committed to invest $21.1 billion of additional cash through the CHST over five years, including $2.2 billion for early childhood development. Legislation to implement this growing and stable funding became effective October 20, 2000. This federal funding commitment was confirmed in the 2001 federal budget.

This brings the total CHST cash transfer to the provinces and territories through the CHST to $18.3 billion in 2001-02, $19.1 billion in 2002-03, rising to $21.0 billion in 2005-06. In 2005-06, CHST cash will be 35 per cent above 2000-01 levels. Combined with the growth in the value of the CHST tax points to $19.3 billion, the federal transfer to provinces and territories will grow to $40.3 billion by 2005-06. To ensure further predictability, by the end of 2003-04, the federal government will establish the CHST cash transfers for years 2006-07 and 2007-08.

5) The current forecast for economic growth for 2003 and the next two years

After recovering vigorously from a mild downturn in 2001, economic activity in Canada has maintained its momentum. Employment growth has remained strong and is set to continue so, albeit at a slower pace. Although some signs of softening have recently appeared, partly connected to global uncertainties, the sustained expansion of consumer demand and a further pick-up of business investment should ensure that any moderation will be mild and short-lived, and growth should return to above potential rates some time next year. GDP is predicted to increase by 3.1% in 2003 and 3.5% in 2004 (OECD, 2003).

Recent outbreaks of SARS in Ontario and a single case of BSE in Alberta have created concern for the economy at large.

3. Health Human Resources

1) Total number of physicians employed by type, and number per 100,000 population, Source: CIHI

Year	Total Number (#/100,00)	Family Physicians (#/100,000)	Specialists (#/100,000)
1997	55,207 (183)	28,092 (93)	27,115 (90)
1998	56,163 (185)	28,519 (94)	27,644 (91)
1999	56,914 (186)	28,784 (94)	28,130 (92)

2000	57,803 (187)	29,113 (94)	28,690 (93)
2001	58,546 (188)	29,627 (95)	28,919 (93)

2) Total number of physicians in training, by specialty, 2002-03, Source: CAPER

Specialty	Ministry Funded positions	Re-entry	Visa
Family medicine	1465	30	12
Medical specialties	3410	109	23
Lab specialties	159	6	2
Surgical specialties	1514	29	21
Total	**6555**	**176**	**58**

3) Total number of first year medical school places in 2002/03 = 2009; Source: ACMC

Since the 1996/97 school year, the number of applications to medicine has exceeded the number of spaces available by almost 13 to one.

4) Total number of registered nurses employed, and number per 100,000 population

CIHI currently collects contains demographic, education and employment information on Registered Nurses (RNs) in Canada. New database development projects are underway to collect information on other categories of nurses e.g. licensed practical nurses (LPNs) and registered psychiatric nurses (RPNs). Information on distribution of nurses between hospital and other sites of employment are currently not readily available.

Number of RNs Employed in Nursing, Canada 1997-2001

	Number	Number per 100,000 population
1997	228,713	760
1998	227,814	751
1999	228,534	746
2000	232,566	753
2001	231,512	743

Source: Registered Nurses Database, Canadian Institute for Health Information

For the first time in 2001, CIHI's report includes data on nurse practitioners in Canada. Nurse practitioners have advanced practice training with an increased emphasis on health assessment, health promotion and illness prevention. Data available for Newfoundland and Labrador, Ontario, Alberta and the Yukon indicate that there are 620 nurse practitioners in Canada. Currently, new or amended provincial/territorial legislation allows for an expanded role for RNs as nurse practitioners in eight jurisdictions (Newfoundland and Labrador, Nova Scotia, New Brunswick, Ontario, Manitoba,

Saskatchewan, Alberta and Yukon). Other jurisdictions are working on implementing similar legislation.

Although most RNs (64% in 2000) still work in hospitals, the number employed in community health is gradually increasing. Information about LPNs and RPNs is more limited. However, we know that in 2000 there were more than 63,000 LPNs and 5,000 RPNs working in Canada. The latter are only licensed in the four western provinces.

In 1999, 5,729 students were admitted to nursing programs, whereas over12,000 applications were received.

5) Allied health professionals broken down by category

Regulatory approaches for health care providers differ across Canada. Midwives and massage therapists, for instance, are regulated in only some provinces. Others, such as licensed practical nurses, practice under a certification framework in some jurisdictions and a licensure framework in others. More than 30 health professions are now regulated under legislation in at least one province or territory.

The following table shows the variation across the provinces and territories in supply of health professionals per 100,000 population, including some of the allied health professionals:

Health Professionals per 100,000 Population.

	Physicians - 2000										
	Total Physicians	GP/FP	Specialists	Registered Nurses 2000	Chiropractors 2000	Dental Hygienists 2000	Dentists 2000	Dietitians 2000	LPNs 2000	Medical Laboratory Technologists 2000	Medical Radiation Technologists 2000
NF	172	106	66	1,002	6	13	30	23	533	59	49
PE	128	75	52	903	5	31	43	36	448	75	49
NS	201	101	100	923	7	44	48	40	329	79	53
NB	152	90	63	974	6	33	35	33	294	81	62
QC	214	106	108	796	13	49	54	26	210	37	50
ON	180	85	95	697	23	56	60	19	225	60	45
MB	181	92	89	875	18	49	49	23	202	83	52
SK	154	91	62	835	16	27	34	22	151	91	43
AB	166	86	80	736	23	43	54	20	136	61	48
BC	195	106	88	681	18	44	65	21**	108*	59	42
YT	136	116	20	779	30	50	60	-	-	53	-
NT	112	69	43	1,027	-	30	71	-	157	41	-
NU	25	21	4	333							

	Midwives 2000	Occupational Therapists 2000	Optometrists 2000	Pharmacists 2000	Physiotherapists 2000	Registered Psychiatric Nurses 2000	Respiratory Therapists 1998
NF	-	25	6	96	37	-	14
PE	-	24	8	86	34	-	12
NS	-	26	7	100	45	-	24
NB	-	27	12	75	53	-	26
QC	1	35	16	77	43	-	29
ON	2	29	10	72	43	-	15
MB	2	37	8	78	46	89	17
SK	-	22	11	109	52	103	11
AB	1	32	10	96	54	38	28
BC	1	30	8	80	57	54	13
YT	-	20	10	86	-		-
NT	-	10	-	43	-	-	6
NU							

Notes: . Data are preliminary as of November 2001 and are subject to change. Rates per 100,000 population.
With the exception of physician and registered nurse data, personnel per 100,000 ratios for the Northwest Territories include Nunavut Territory data.
* Data for 2000 British Columbia LPNs are estimates.
**B.C dietitions include dietitions and nutritionists
¨ Not Available.

Source: Southam Medical Database, CIHI.
Health Personnel Database, CIHI.
Registered Nurses Database, CIHI.

Additional information can be obtained by accessing the following websites:

http://www.cihi.ca
http://www.acmc.ca
http://www.caper.ca/Main.html
http://www.cma.ca and search on "statistical information on Canadian physicians"
http://www.hc-sc.gc.ca/english/care/index.html
http://www.physicianhr.ca/reports/literatureReviewGapAnalysis-e.pdf