

A Reflection of the Canadian Healthcare System

Navigating Strengths and Shortcomings

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Section 1. Introduction

1.1 Background on Canada's Healthcare System

Canada's healthcare system stands as a beacon of national pride, rooted in providing services based on need rather than the ability to pay, making healthcare services free of cost to eligible Canadians¹. The Canada Health Act (1984) enforces this commitment to universal access through Medicare - a publicly funded decentralized model, a collection of 13 provincial and territorial tax-funded public insurance plans. The federal government provides fiscal support based on a per capita model.

Central to the Canadian healthcare ethos are five key principles outlined in the Canada Health Act: portability, universality, accessibility, comprehensiveness and public administration². Portability guarantees that insured Canadians can maintain coverage while travelling or relocating within the country. Accessibility mandates that publicly insured services are free of charge. Universality provides access to care irrespective of individual differences. Comprehensiveness dictates that plans cover insured services provided by hospitals, physicians or dentists. Public administration requires healthcare plans to be implemented on a non-profit basis by public authority.

Three major governmental bodies oversee healthcare: Health Canada, The Public Agency of Canada and Indigenous Services Canada. Health Canada regulates food and drug safety, technological innovations and national standards for universal coverage³. The Public Health Agency of Canada manages emergency preparedness and response, chronic disease control and prevention. Indigenous Services Canada is important for providing healthcare services to Indigenous, Metis and Inuit communities emphasizing historical contexts. These governing organizations uphold the values of public health services.

¹ Martin, D., Miller, A. P., Quesnel-Vallée, A., Caron, N. R., Vissandjée, B., & Marchildon, G. P. (2018). Canada's universal health-care system: achieving its potential. *The Lancet*, *391*(10131), 1718-1735.

² Martin, D., Miller, A. P., Quesnel-Vallée, A., Caron, N. R., Vissandjée, B., & Marchildon, G. P. (2018). Canada's universal health-care system: achieving its potential. *The Lancet*, *391*(10131), 1718-1735.

³ *Canada*. (n.d.).

<https://www.commonwealthfund.org/international-health-policy-center/countries/canada>

1.2 Importance of Comparing Healthcare Performance

Although the Canadian healthcare model is based on the guiding principle of universal access, there are several shortcomings - lengthy wait times for elective care, disparities in access to services among marginalized populations and limitations on services not covered by Medicare. Overall, there is debate surrounding the efficacy of the current healthcare system including the digital infrastructure and bureaucratic processes. The 2017 Commonwealth Fund Report listed Canada as 9 of 11 high-income countries, highlighting challenges in providing quality and equitable care. Research suggests that Canada's healthcare system is lagging behind other European Union countries⁴.

The 2021 report listed Canada in the 10th position particularly emphasizing its ability to address challenges in the post-pandemic setting⁵. The recent pandemic exacerbated and highlighted pre-existing issues with the Canadian healthcare model. The pandemic strained physicians prompting one-third of physicians to switch careers. It also caused backlogs in non-COVID-19 related care, compromising the health of many patients with reductions in cancer screening, diagnosis and treatment^{6, 7}. The pandemic also led to a backlog of elective surgeries with 28 million surgeries delayed or postponed in the first 12 weeks⁸.

Comparing healthcare performance internationally is crucial for identifying areas for improvement and inspiring innovative solutions to longstanding issues, ultimately aiming for enhanced quality and reduced strain on the system. However, differing standards and measures between nations make it difficult to directly compare healthcare performance metrics. Therefore, it is important to rely on a comprehensive understanding of these differences to understand what solutions will be the most effective for Canadians.

⁴ Shahaed, H., Glazier, R. H., Anderson, M., Barbazza, E., Bos, V. L., Saunes, I. S., Auvinen, J., Daneshvarfard, M., & Kiran, T. (2023). Primary care for all: lessons for Canada from peer countries with high primary care attachment. *CMAJ. Canadian Medical Association Journal*, *195*(47), E1628–E1636.

<https://doi.org/10.1503/cmaj.221824>

⁵ Mirror, Mirror 2021: Reflecting Poorly. (2021). *Commonwealth Fund*.

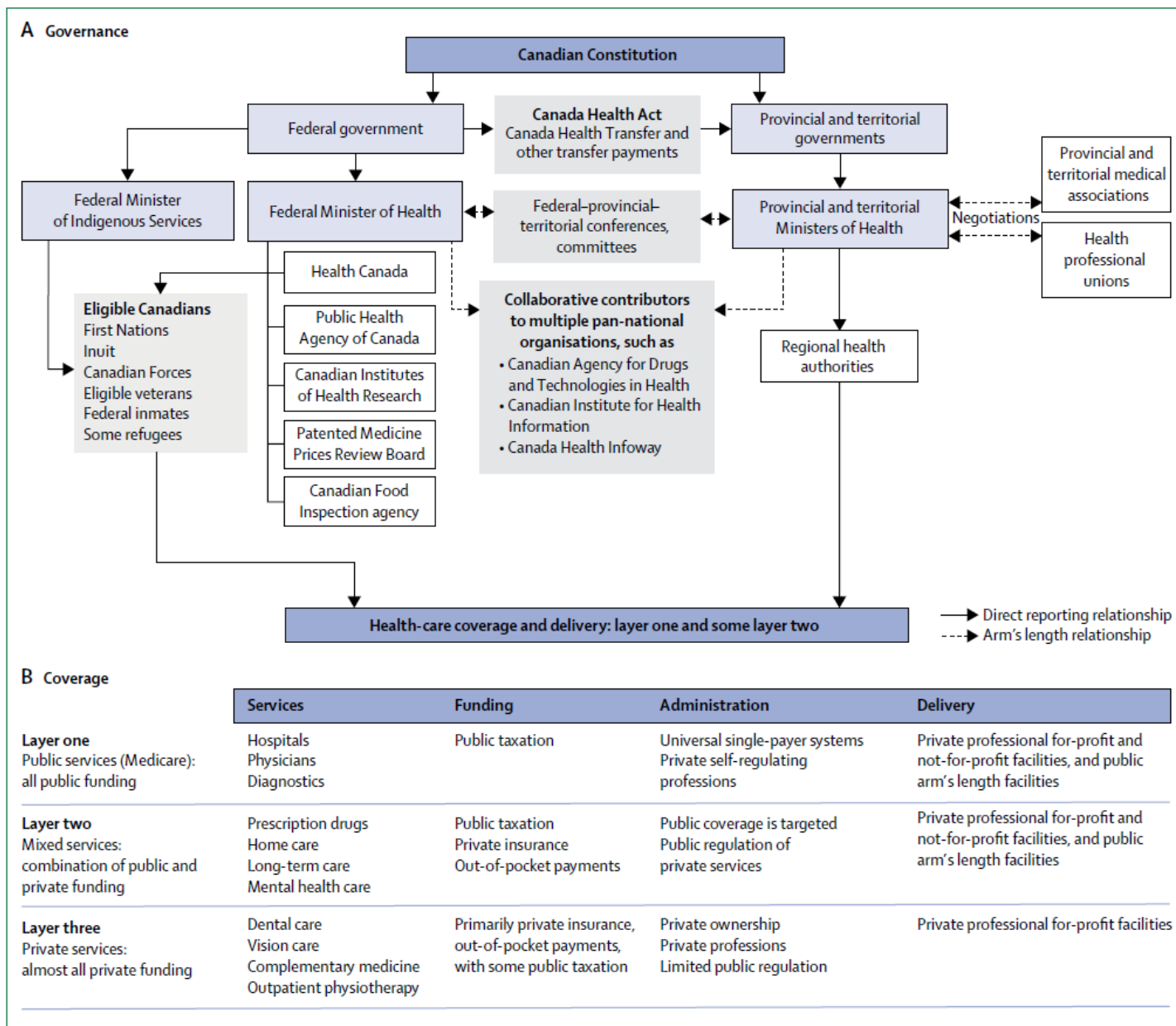
<https://doi.org/10.26099/01dv-h208>

⁶ Flood, C. M., Thomas, B., & McGibbon, E. (2023, September). Canada's primary care crisis: federal government response. In *Healthcare Management Forum* (Vol. 36, No. 5, pp. 327–332). Sage CA: Los Angeles, CA: SAGE Publications.

⁷ Zeitouny, S., Cheung, D. C., Bremner, K. E., Pataky, R. E., Pequeno, P., Matelski, J., ... & Kulkarni, G. S. (2023). The impact of the early COVID-19 pandemic on healthcare system resource use and costs in two provinces in Canada: An interrupted time series analysis. *Plos one*, *18*(9), e0290646.

⁸ Gomez, D., Nantais, J., Telesnicki, T., de Mestral, C., Wilton, A. S., Stukel, T. A., ... & Baxter, N. N. (2022). A population-based analysis of the COVID-19 generated surgical backlog and associated emergency department presentations for inguinal hernias and gallstone disease. *Annals of Surgery*, *275*(5), 836–841.

Exhibit 1. An overview of the Canadian healthcare system with a breakdown based on the layers of funding and eligibility.



Source: Martin *et al.*⁹

⁹ Martin, D., Miller, A. P., Quesnel-Vallée, A., Caron, N. R., Vissandjée, B., & Marchildon, G. P. (2018). Canada's universal health-care system: achieving its potential. *The Lancet*, 391(10131), 1718-1735.

1.3 Objectives and Scope of the Report

This research report aims to consolidate existing literature to assess the state of the Canadian healthcare system in relation to other countries and in light of the COVID-19 pandemic. Primarily, we will dissect Canada's position on an international front through a comparison of health metrics, and financing models. Subsequently, different healthcare models will be compared and benchmarked against global standards. Moreover, we will scrutinize the effectiveness of various funding mechanisms and inherent disparities in healthcare quality among Canadian provinces versus a centralized national approach. We will also explore the expansion of healthcare services and strategies for managing chronic diseases. Additionally, the report will address the impact of the COVID-19 pandemic on the Canadian healthcare system, assessing its strengths and vulnerabilities. By analyzing the system through a critical lens, we aim to shed light on its achievement and areas for improvement with the ultimate goal of fostering informed dialogue and positive change in healthcare delivery across Canada. Ultimately, the report aims to propose solutions and future directions to enhance the overall efficacy and inclusivity of the Canadian healthcare system.

1.4 Methodology

Sources that focused on developing or underdeveloped countries or sources originating from conspiracy websites are excluded [see Table 1].

Table 1. Eligibility Criteria

Inclusion	Exclusion
<ul style="list-style-type: none"> ▪ Source articles, reports, or books ▪ Primary focus on Canadian studies ▪ Data from reputable sources (e.g., government agencies, WHO) ▪ Published in 2011 to present ▪ Primary qualitative, quantitative, or mixed-methods studies ▪ Case studies from countries with well -documented success or innovation in healthcare delivery. 	<ul style="list-style-type: none"> ▪ Developing or underdeveloped countries ▪ Conspiracy websites

Section 2. Canada's Position in Developed Countries

2.1 Comparison of Healthcare Metrics

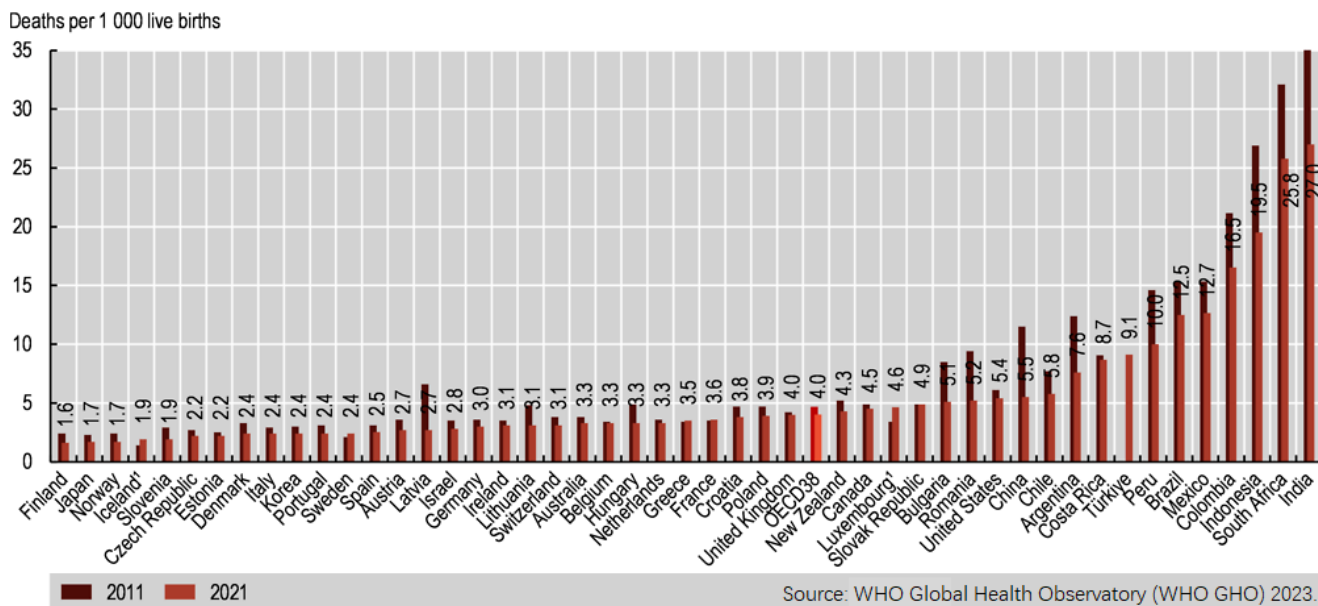
Life Expectancy and Mortality

According to Statistics Canada, the life expectancy at birth of Canadians declined for the third consecutive year in 2022, from 82.3 to 81.3 years. In 2023, this number increased to 81.6 which was 1.3 years older than the OECD average¹⁰. Among these statistics, preventable mortality stood at 113 per 100,000, contrasting with the OECD average of 158, while treatable mortality was 58 per 100,000 lower than the OECD average of 79. These statistics could potentially be attributed to unintentional injuries like substance-related toxicity deaths, suicides and homicides in the younger population

Infant Mortality Rate

According to Statistics Canada, in 2022 the incidence of infant mortality rate rose from 4.3 in 2021 to 4.7 among the population of infants under the age of one¹¹. This number is higher than the average of 4 deaths in OECD countries in 2021¹².

Exhibit 2. Infant mortality rate by country between 2011 and 2021



¹⁰ OECD Health at a Glance 2023 Country Note, Canada. (n.d.). In *OECD*. Retrieved June 4, 2024, from <https://www.oecd.org/canada/health-at-a-glance-Canada-EN.pdf>

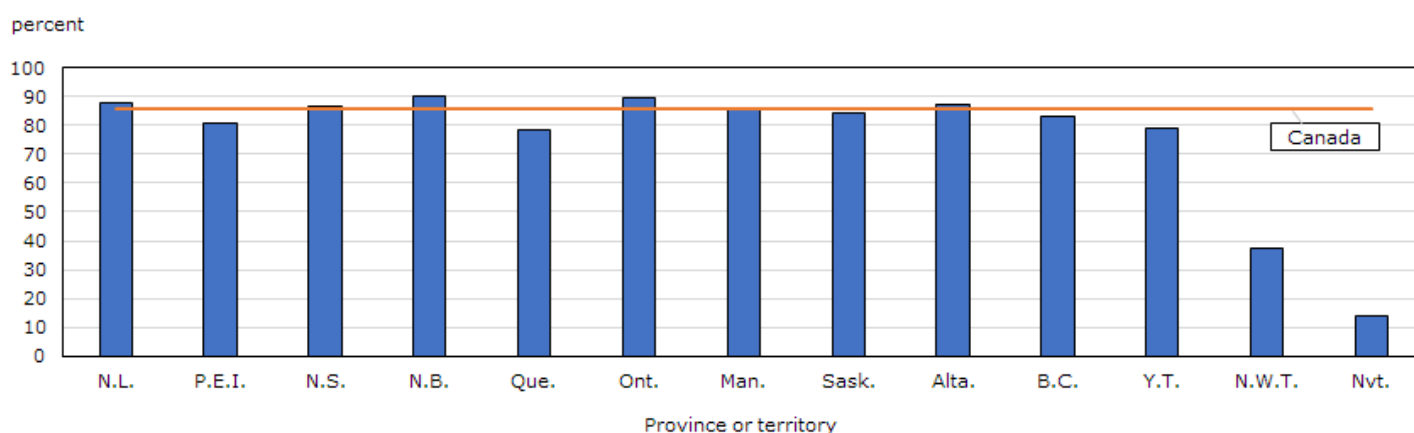
¹¹ *Infant deaths and mortality rates, by age group*. (2023, November 27). <https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310071301>

¹² *Page Rendering Error*. (n.d.). OECD iLibrary. <https://www.oecd-ilibrary.org/sites/1ea5684a-en/index.html?itemId=/content/component/1ea5684a%20-en>

Healthcare Accessibility

In 2021, 85.5% of Canadians had a regular healthcare provider, while 14.4% did not¹³. Among those with a healthcare provider, 58.3% waited three days or less for an appointment, with the remainder waiting longer. Additionally, 7.9% of Canadians, totaling 2 million individuals, reported unmet healthcare needs. In 2023, 56% of Canadians were satisfied with the availability of quality healthcare much lower than the OECD average of 67%¹⁴. 14% of spending was attributed to out-of-pocket spending (lower than the OECD average of 18%) and 73% to mandatory prepayment (lower than the OECD average of 76%)¹⁵.

Exhibit 3. Canadian population divided by province with a regular healthcare physician



Notes: Provincial data are from the 2021 Canadian Community Health Survey (CCHS), and provinces are compared with the 2021 estimate for the rest of Canada, which excludes the province being compared and the territories (shown). Territorial data are from the 2017 and 2018 CCHS, and territories are compared with the 2017 and 2018 estimate for the rest of Canada, which excludes the territory being compared (not shown). Data for the Northwest Territories and Nunavut should be interpreted with caution. The horizontal line at 85.5% represents Canada.

Sources: Statistics Canada, Canadian Community Health Survey (CCHS), 2021, Table 13-10-0096-01 Health characteristics, annual estimates; and CCHS, 2017 and 2018, Table 13-10-0113-01 Health characteristics, two-year period estimates.

Physicians Per Capita

In terms of healthcare personnel, Canada has 2.8 practicing doctors per 1,000 population, lower than the OECD average of 3.7, and 10.3 practicing nurses, exceeding the OECD average of 9.2. Furthermore, Canada possesses 2.6 hospital beds per 1,000 population, falling short of the OECD average of 4.3. In 2022, there were 1280 hospitals in Canada and 2.8 physicians per 1000 residents¹⁶. These numbers indicate a shortage of healthcare personnel and equipment in comparison to other OECD countries.

¹³ *Access to health care*. (2023, September 13).

<https://www150.statcan.gc.ca/n1/pub/82-570-x/2023001/section3-eng.htm>

¹⁴ OECD Health at a Glance 2023 Country Note, Canada. (n.d.). In *OECD*. Retrieved June 4, 2024, from

<https://www.oecd.org/canada/health-at-a-glance-Canada-EN.pdf>

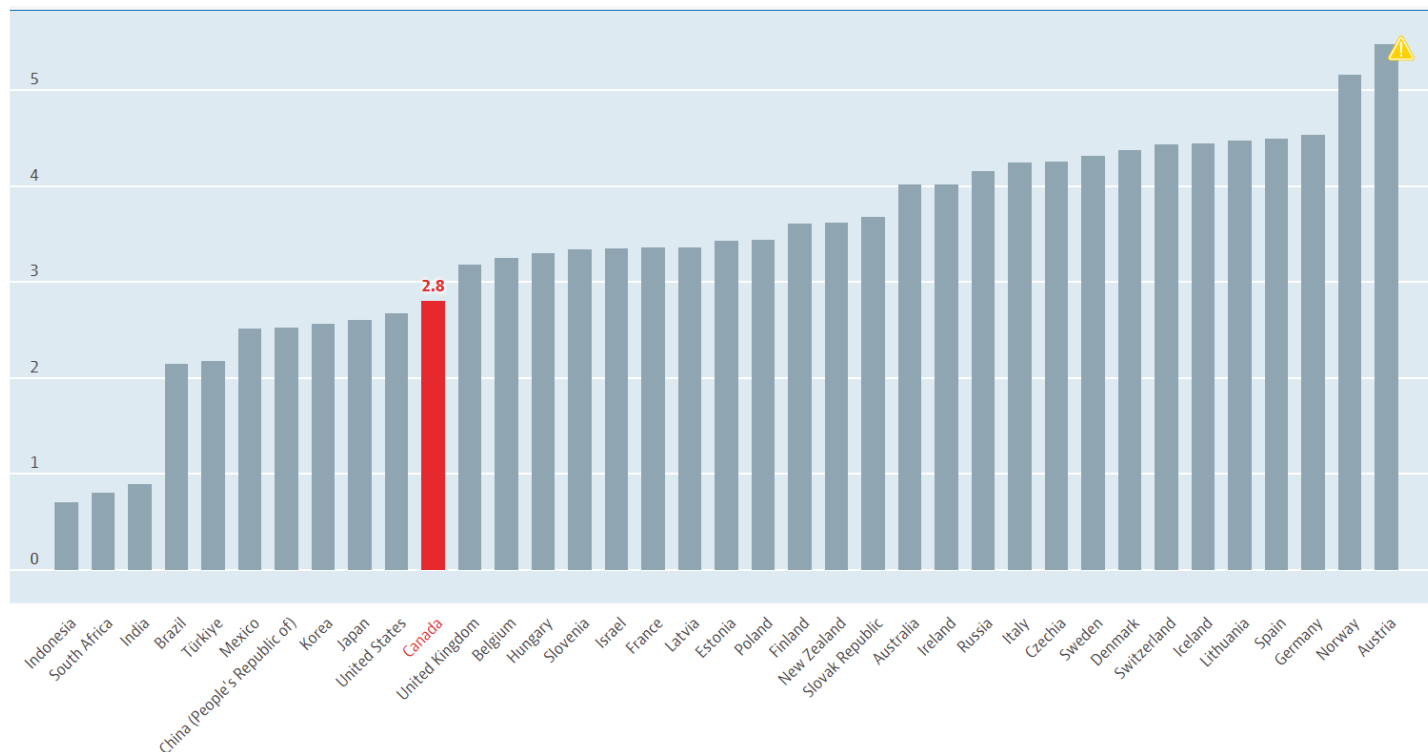
¹⁵ OECD Health at a Glance 2023 Country Note, Canada. (n.d.). In *OECD*. Retrieved June 4, 2024, from

<https://www.oecd.org/canada/health-at-a-glance-Canada-EN.pdf>

¹⁶ *Health resources - Doctors - OECD Data*. (n.d.). theOECD.

<https://data.oecd.org/healthres/doctors.htm>

Exhibit 4. The number of physicians per 100 residents, 2022 or latest available.



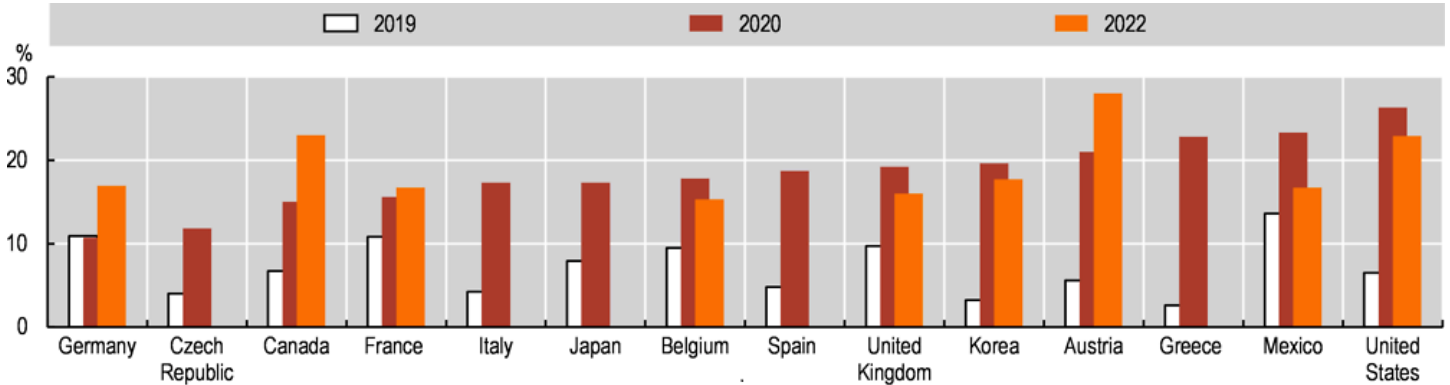
Mental Health

At the onset of the pandemic, the proportion of individuals reporting symptoms of anxiety and depression surged across all OECD countries with accessible data, with some nations experiencing a doubling of these rates¹⁷. While countries like Belgium, Korea, the United Kingdom, and the United States witnessed slight declines in the prevalence of depression symptoms in 2022 compared to 2020, the figures for 2022 persist at least 20% higher than pre-pandemic levels, and in certain instances, surpass double or triple the pre-pandemic rates. In 2021, 1 in 5 Canadians reported moderate to severe symptoms of depression, anxiety or PTSD¹⁸. This statistic was further increased in 2021 to one in four individuals.

¹⁷ Page Rendering Error. (n.d.-b). OECD iLibrary. <https://www.oecd-ilibrary.org/sites/c7a518c0-en/index.html?itemId=/content/component/c7a518c0%20-en>

¹⁸ Page Rendering Error. (n.d.-c). OECD iLibrary. <https://www.oecd-ilibrary.org/sites/c7a518c0-en/index.html?itemId=/content/component/c7a518c0%20-en>

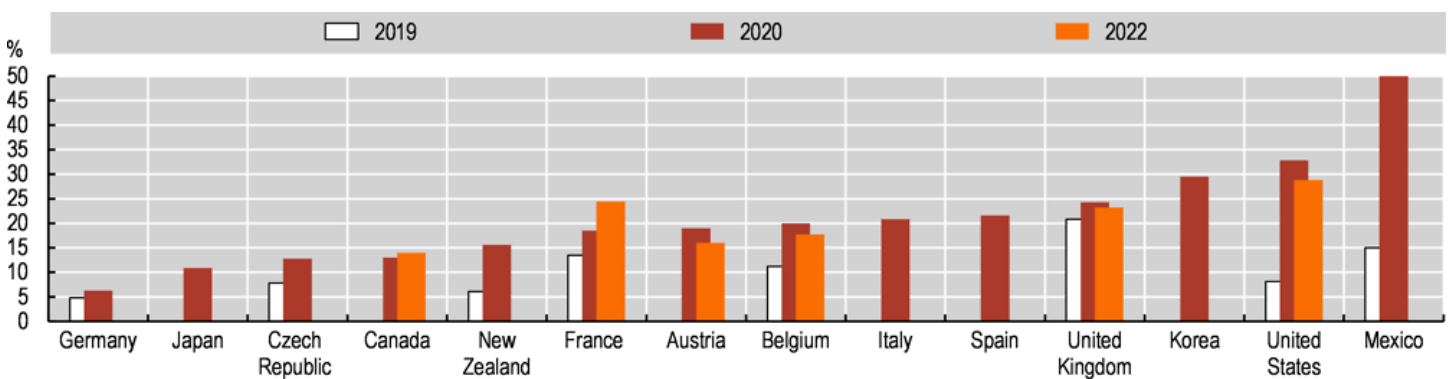
Exhibit 5. Overview of depression or depression symptoms between 2019-2022 according to the OECD



Note: Survey instruments and population samples differ between countries and in some cases across years within countries, which limits direct comparability. Pre-pandemic data for the Czech Republic 2017; Canada 2015-19; Japan 2013; Belgium 2018; United Kingdom 2019-March 2020; Korea 2016-19.

Source: National data sources

Exhibit 6. Overview of anxiety or anxiety symptoms between 2019-2022 according to the OECD



Note: Survey instruments and population samples differ between countries and in some cases across years within countries, which limits direct comparability. Pre-pandemic data for the Czech Republic 2017; New Zealand 2016-17; France 2017; Belgium 2018.

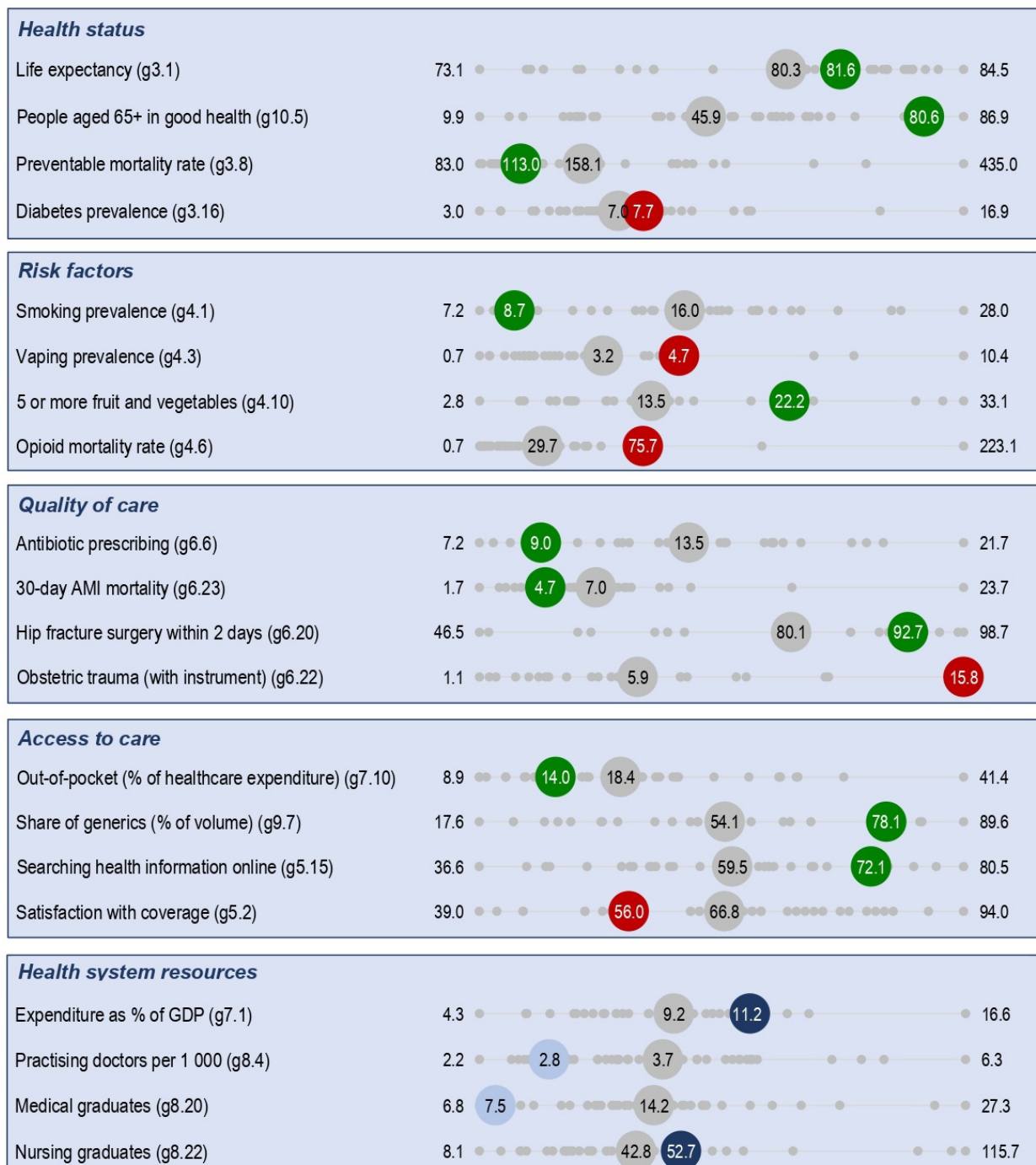
Source: National data sources

Exhibit 7

On which indicators does Canada perform well or badly?

The graphs below show selected indicators from *Health at a Glance 2023* where the performance of Canada deviates markedly from the OECD on average. For more details on the data presented, please refer to the full report, using the graph references provided (e.g. g5.1).

Canada: ● Better ● Worse ● Higher ● Lower ● OECD average ● Other OECD countries

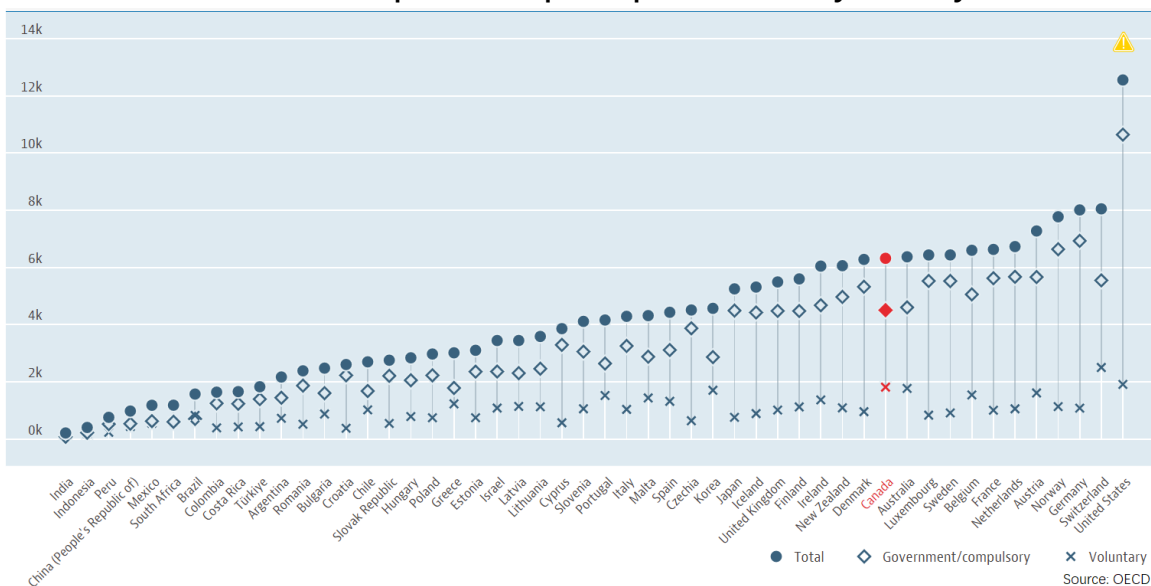


Source: OECD

2.2 Analysis of Healthcare Spending Relative to Developed Nations

According to the 2023 OECD report, Canada allocates \$6319 per capita to healthcare, surpassing the OECD average of \$4986 (USD PPP), as the 8th highest spender after adjusting for age¹⁹. Canada has consistently ranked as the 6th top spender among the other OECD countries, allocating 12.3% of its GDP in 2021 compared to the OECD average of 9.7%^{20, 21}. Additionally, it was ranked. In 2023, Canada is still ranked at 11.2%, compared to the OECD average of 9.2%. These statistics show that Canada has greater healthcare expenditure compared to other high-income OECD countries. The greatest expenditure is on hospitals followed by physicians and other institutions as shown in the following figure²². Despite ranking high on expenditure, this does not translate into the availability of resources. For instance, Canada ranked 23rd out of 28 for hospital beds (2.2 per 1000 people), 26th out of 29 on MRIs (10.3 per million people) and 27th out of 30 for CT scanners (15 per million people). Overall, Canada has fewer physicians, acute-care beds and psychiatric beds per 1000 individuals²³. Despite these statistics, Canada spends less than its OECD counterparts on primary care, 5.3% in relation to 8.1%. It has the lowest spending (70%), among other EU countries.

Exhibit 8. Overview of total health expenditure per capita divided by country.



¹⁹ OECD Health at a Glance 2023 Country Note, Canada. (n.d.). In *OECD*. Retrieved June 4, 2024, from <https://www.oecd.org/canada/health-at-a-glance-Canada-EN.pdf>

²⁰ *National health expenditure trends, 2023 — Snapshot | CIHI*. (n.d.). <https://www.cihi.ca/en/national-health-expenditure-trends-2023-snapshot>

²¹ Comparing Performance of Universal Health Care Countries, 2021. (n.d.). In *Fraser Institute*. Retrieved June 4, 2024, from <https://www.fraserinstitute.org/sites/default/files/comparing-performance-universal-health-care-countries-2021.pdf>

²² *Total health spending in Canada by use of funds 2023*. (2024, May 14). Statista. <https://www.statista.com/statistics/435743/total-health-expenditure-in-canada-by-use-of-funds/>

²³ Comparing Performance of Universal Health Care Countries, 2021. (n.d.). In *Fraser Institute*. Retrieved June 4, 2024, from <https://www.fraserinstitute.org/sites/default/files/comparing-performance-universal-health-care-countries-2021.pdf>

Exhibit 9. Distribution of total Canadian health expenditures by use of funds, 2023.

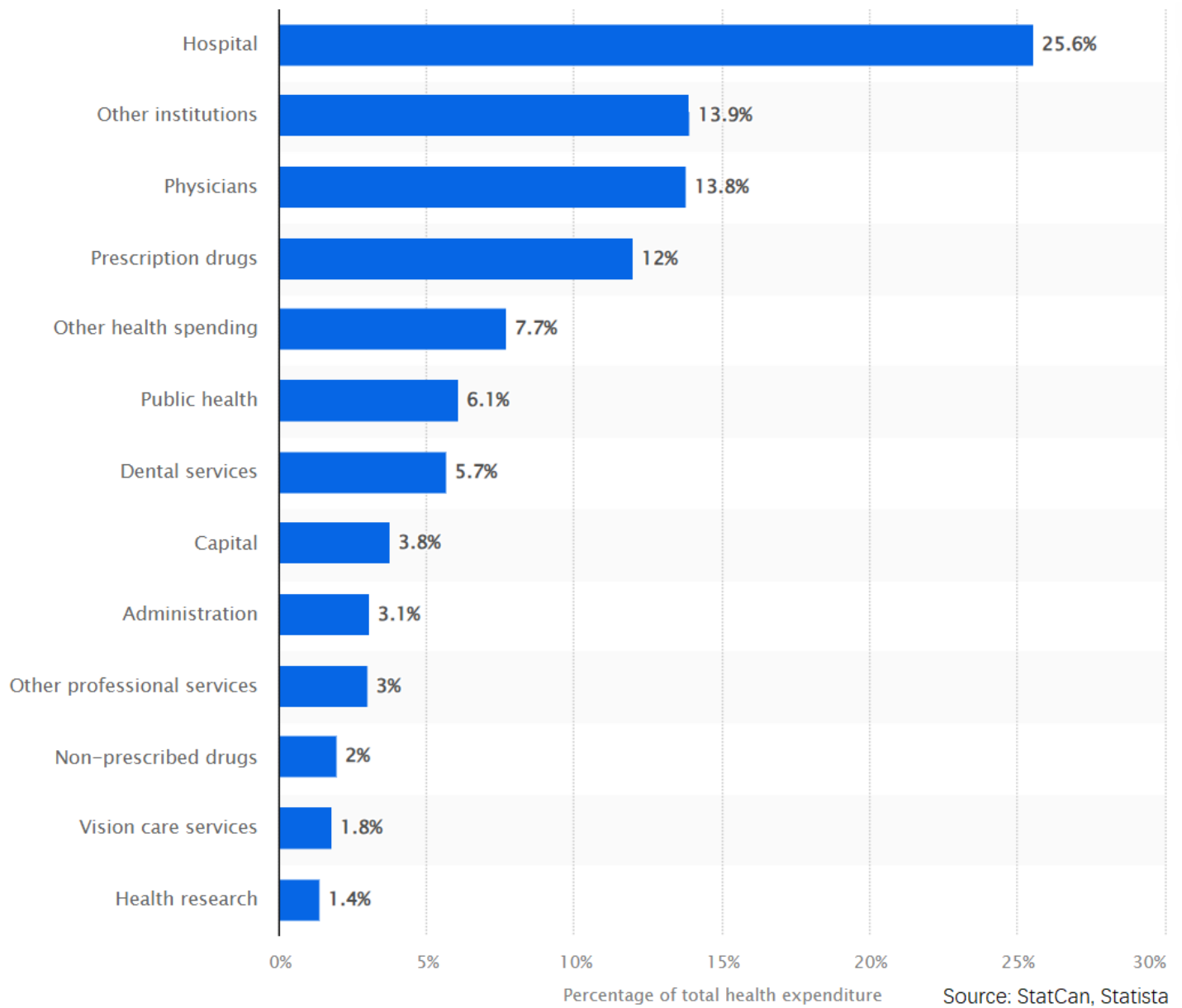
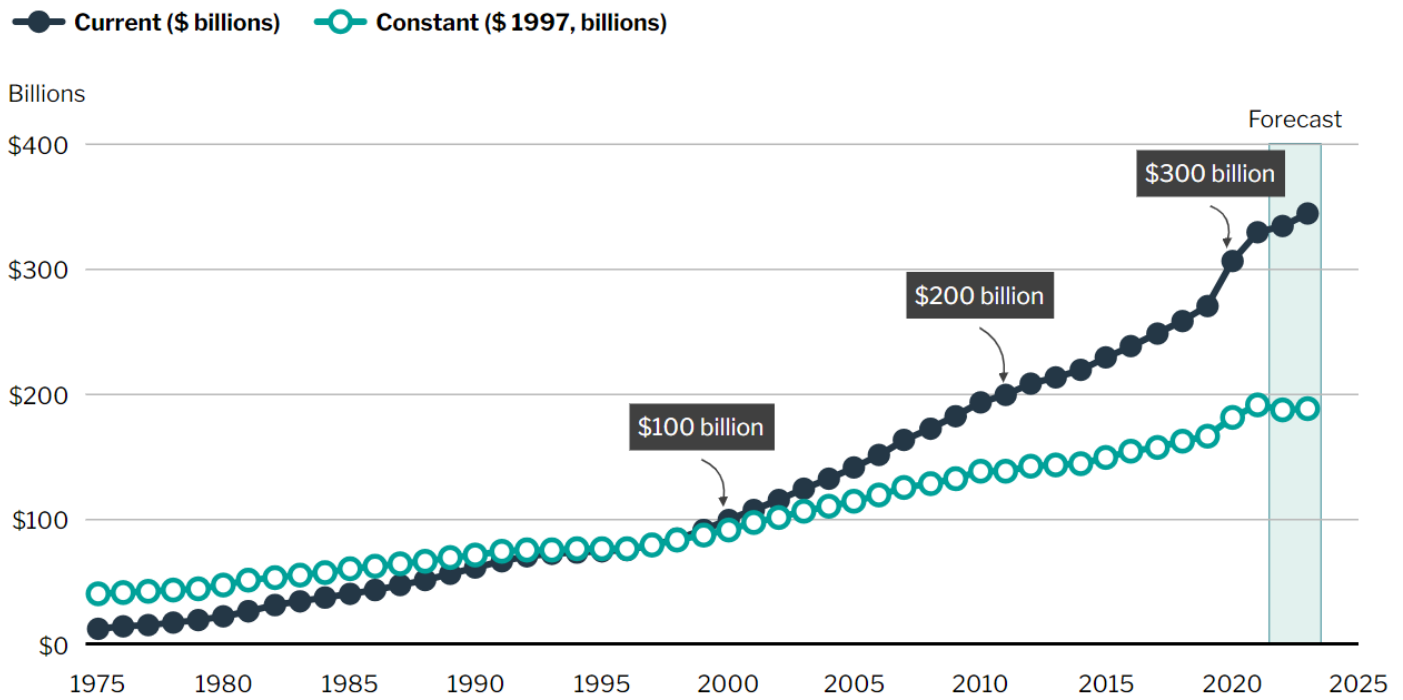


Exhibit 10. Historical and forecasted trends of Canadian health spending in 2023.



Line chart of total health expenditures in current and 1997 constant dollars from 1975 to 2023. It shows the trending of health expenditure in the last 40+ years.

Note

GDP: Gross domestic product.

Source

National Health Expenditure Database, Canadian Institute for Health Information.

Section 3. Global Comparison of Healthcare Systems

3.1 Overview of Healthcare Models Across Different Countries

UK

The UK's National Health System provides public healthcare coverage that is 79% publicly financed from the populations taxes²⁴. While 20% of healthcare is paid for by national insurance, private patients, and copayments local commissioning groups are funded and supervised to provide comprehensive care and fill gaps in accessing healthcare²⁵. Roughly 9% of GDP is spent on healthcare and patient satisfaction weighs in at 61% with only 12% of the population opting for private health care insurance to avoid wait periods. However, the UK does still have a public and private market for healthcare and general practitioner practices are reported as overtaxed leaving the alternative care as free-walk-in centers as private hospitals offer specialized treatments. Furthermore, members of the European Union typically follow the same model as the UK.

USA

The USA does not have a universal free healthcare system comparable to most developed countries rather reflecting a free market. While public finding programs exist, most citizens utilize a combination of public and private funding typically through employment and most hospitals and clinics are owned privately and 60% are non-profit. Despite impressive rates of specialized scans, the USA has one of the least accessible healthcare systems among developed countries leading to the proportionality between the number of physicians and visits per physician being drastically lower than others. This is mostly due to the systemic issues leading to healthcare providers ability to inflate prices, leading to inaccessibility. Despite downfalls, the USA leads in medical innovation, for those who can afford it²⁶.

Australia

Australia has a tax-funded universal free public health insurance program, Medicare. For Citizens or permanent residence healthcare can be very low cost or free covered by this program leading to the recognition and high ranking of healthcare by the World Health Organization²⁷. Residents pay 2% of their

²⁴ *Healthcare Systems Around the World*. (2023, February 25). News-Medical.

<https://www.news-medical.net/health/Healthcare-Systems-Around-the-World.aspx>

²⁵ *Healthcare Systems Around the World*. (2023, February 25). News-Medical.

<https://www.news-medical.net/health/Healthcare-Systems-Around-the-World.aspx>

²⁶ *Healthcare Systems Around the World*. (2023, February 25). News-Medical.

<https://www.news-medical.net/health/Healthcare-Systems-Around-the-World.aspx>

²⁷ *Australia's Healthcare System: How it Works for Expats and Foreigners*. (2024, May 10). International Citizens Insurance.

<https://www.internationalinsurance.com/health/systems/australia.php>

income to the Medicare Levy which results in funding the healthcare system and most patients do not need to pay medical fees for appointments. However, there is an income threshold where a family or individual will have to pay a surcharge on the medical levy if this threshold is met therefore, 50% of citizens take out private insurance to pay for hospital or dental care²⁸. Overall, the total expenditure on healthcare reflects 10% of the GDP with 67% from the public sector²⁹.

India

India spends less than 4% of GDP on healthcare and only a quarter is funded to the public sector, out-of-pocket expenses at private hospitals comprise 75% of the total expenditure. While there is Universal free outpatient and inpatient care at government clinics, it is typically understaffed and not equipped which is leading to out-of-pocket expenses for private healthcare. The National Health Protection Scheme was launched to address concerns and provide hospital care for the population below poverty, roughly 40% of the population. Further, there are very few private healthcare providers however government staff have their own health insurance schemes³⁰.

South America

There are Universal and publicly funded healthcare schemes in Chile and Columbia that are relatively less expensive services leading to medical tourism. In Colombia 97% of the population receives coverage by mandatory universal health insurance with 14% of out-of-pocket spending, reflecting an average lower than many OECD countries³¹. This is financed through taxes and insurance and subsidized for lower-income populations and private and public sectors still present. In Chile, there is statutory health insurance for workers, however there is no employment or government funding. Therefore, funds are managed by the Social Security Health Institutions and the National Health Fund covers healthcare payments. In Brazil the universal comprehensive public healthcare system is run by the Government and funded by federal and municipal taxes with the federal contribution reflecting 43% of the public healthcare expenditure and municipalities a third. The national health expenditure reflects 9% of the GDP and most hospitals are public. However, a lack of access to medication leads to out-of-pocket spending with a quarter of the population

²⁸ *Healthcare Systems Around the World*. (2023, February 25). News-Medical.

<https://www.news-medical.net/health/Healthcare-Systems-Around-the-World.aspx>

²⁹ *Healthcare Systems Around the World*. (2023, February 25). News-Medical.

<https://www.news-medical.net/health/Healthcare-Systems-Around-the-World.aspx>

³⁰ *Healthcare Systems Around the World*. (2023, February 25). News-Medical.

<https://www.news-medical.net/health/Healthcare-Systems-Around-the-World.aspx>

³¹ OECD Health at a Glance 2023 Country Note Colombia. (n.d.). In *OECD*. Retrieved June 4, 2024, from

<https://www.oecd.org/colombia/health-at-a-glance-Colombia-EN.pdf>

needing private health insurance which is typically provided through employment and wait times are unreasonably long in the healthcare that is covered for citizens and visitors³².

3.2 Benchmarking Canada's Healthcare System Against Global Standards.

To benchmark Canada's healthcare system against global standards, this research analyzed Canada's expenditure on healthcare, availability of resources, use of resources, access to resources, and quality and clinical performance as five measures to compare across healthcare systems in high-income countries. Specifically, Canada's expenditure on healthcare reports higher spending on healthcare than the majority of high-income OECD countries with a Universal healthcare system ranking ninth highest for healthcare expenditures per capita and 12% of GDP³³. Despite high spending, Canada reports significant scarcities across crucial medical resource availability compared to peer countries with universal health care models, ranking 28th out of 30 for physician availability, 23rd out of 29 for somatic care bed availability, 25th out of 29 for MRI unite and 2th out of 30 for CT scanners demonstrating diagnostic technology availability, last for wait times and only 2.0 acute care beds per 1,000 population ranking 25th out of 26³⁴.

The data in Exhibit 11 demonstrates there is a clear imbalance between expenditure on health care and the value received in return. Identifying a concern that Canada has significantly fewer physicians and medical resources than peer countries that have comparable health care expenditures. Not only does Canada lack the availability of resources, but research additionally suggests Canada lacks equitable access to resources demonstrated wait times and timeliness of care and cost-related barriers to healthcare. Specifically, Canada was ranked 9th out of 10 for patients able to make same-day appointments, the worst at 10 out of 10 for a percentage of patients who reported waiting four weeks or less for a specialist appointment, the worst at 10 out of 10 for the percentage of patients who reported waiting less than four months for elective surgery, and 8th out of 10 for finding care after hours. Lastly, analyzing primary care and mental health care, Canada reports lower-than-average on clinical and performance quality. For primary Care, Canada ranks 14th out of 24 for performance indicators and for mental health care, Canada ranked 12 out of 18 in evaluating in-patient suicide among patients diagnosed with a mental illness. Therefore, it is clear that Canada's expenditure of healthcare is not necessarily representative of the population's health outcomes or medical care received. A cause for concern is reflected by Canada's

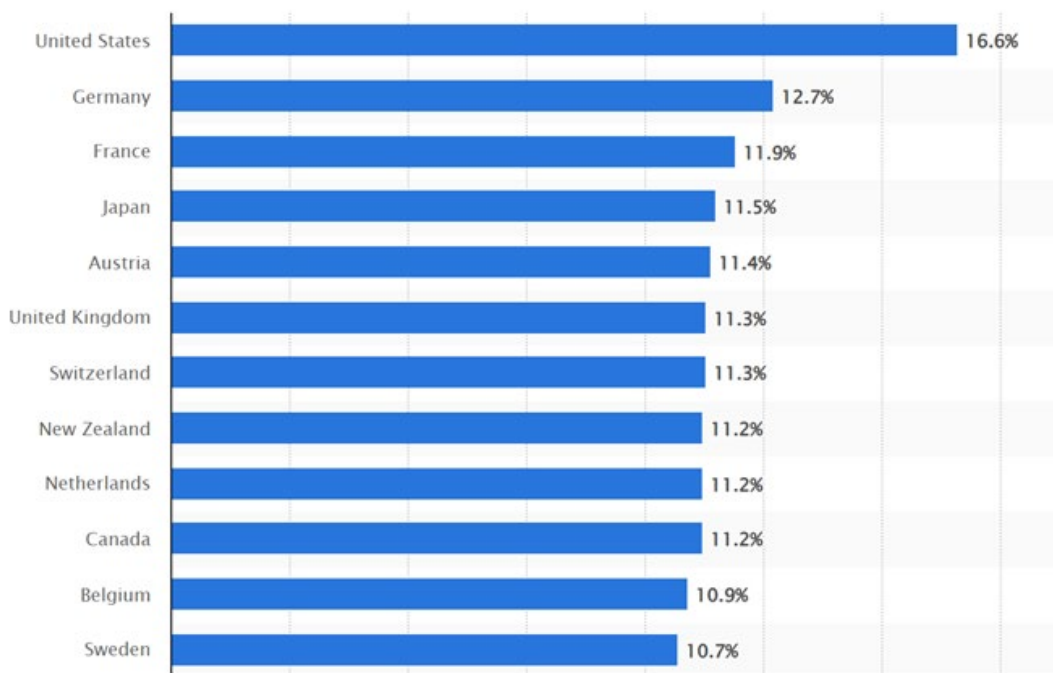
³² Hlafa, B., Sibanda, K., & Hompashe, D. M. (2019). The impact of public health expenditure on health outcomes in South Africa. *International journal of environmental research and public health*, 16(16), 2993.

³³ *Comparing Performance of Universal Health Care Countries, 2023*. (2023, November 16). Fraser Institute. <https://www.fraserinstitute.org/studies/comparing-performance-of-universal-health-care-countries-2023>

³⁴ Jones, K. (2019, October 3). *Canada ranks last on number of hospital beds, wait times - Hospital News*. Hospital News. <https://hospitalnews.com/canada-ranks-last-on-number-of-hospital-beds-wait-times/>

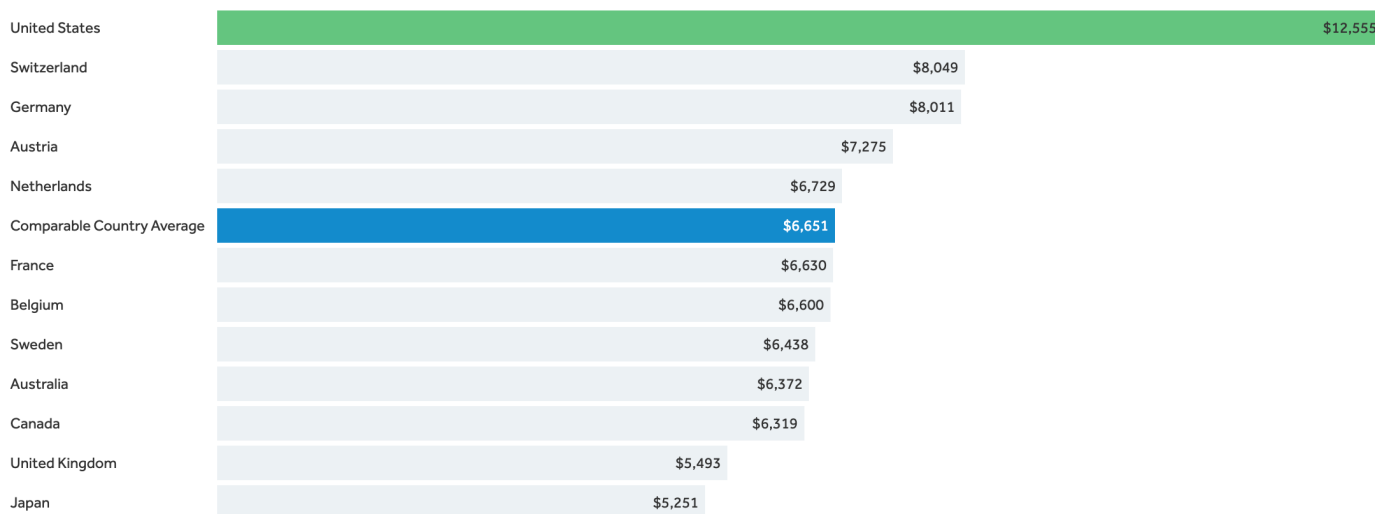
significantly lower numbers of physicians, somatic-care beds, and psychiatric care per thousand compared to average OECD countries. Despite high spending, overall performance, and access to resources in Canada are below the average displaying an imbalance between the value Canadians receiving their healthcare relative to the high cost spent.

Exhibit 11. Health expenditure as a percentage of GDP in selected countries, 2022



Source: Statista

Exhibit 12. Health expenditures per capita, U.S. dollars, 2022 (current prices and PPP adjusted)



Notes: Data from Australia, Belgium, France, Japan, Switzerland, and the U.S. are estimated. Data from Austria, Canada, Germany, the Netherlands, Sweden and the United Kingdom are provisional.

Source: KFF analysis of OECD data • [Get the data](#) • PNG

Exhibit 13. Health spending, total, US dollars/Capita

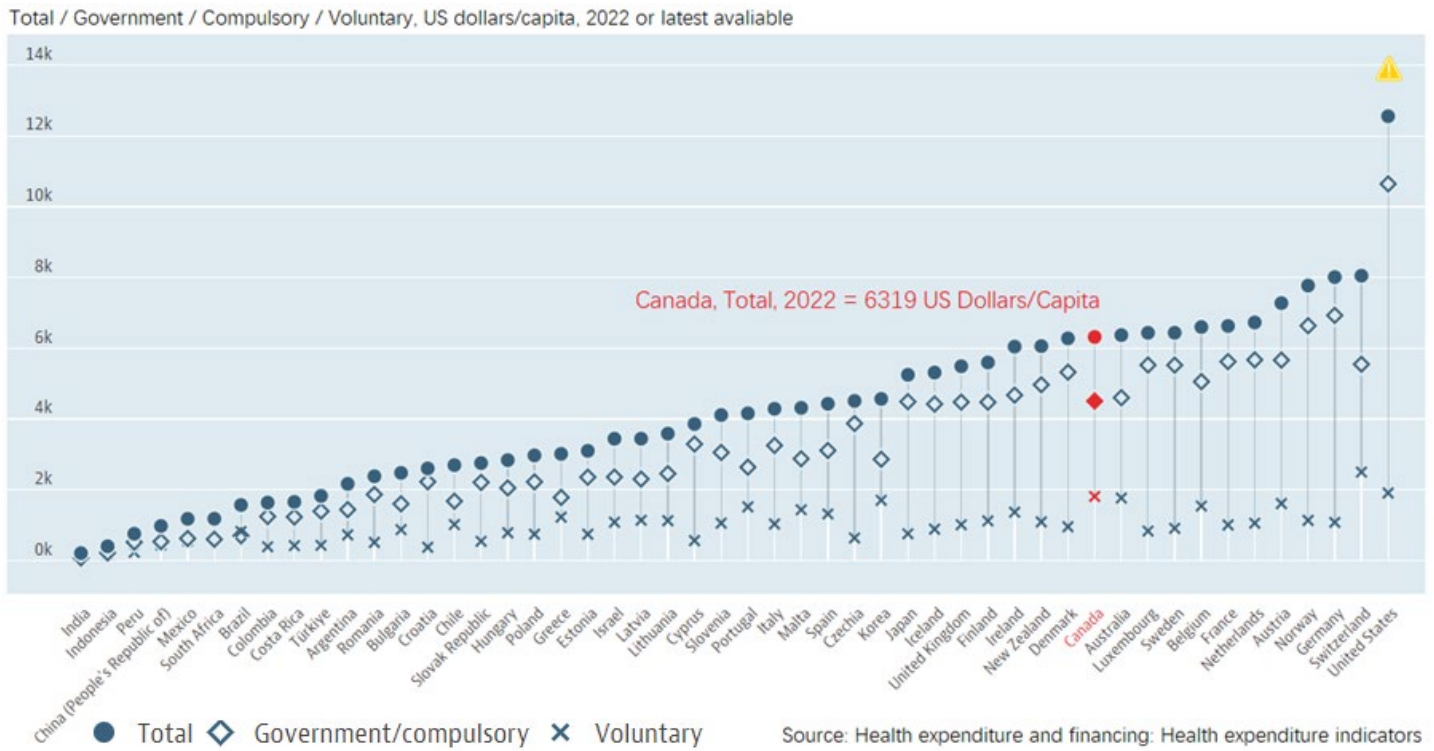
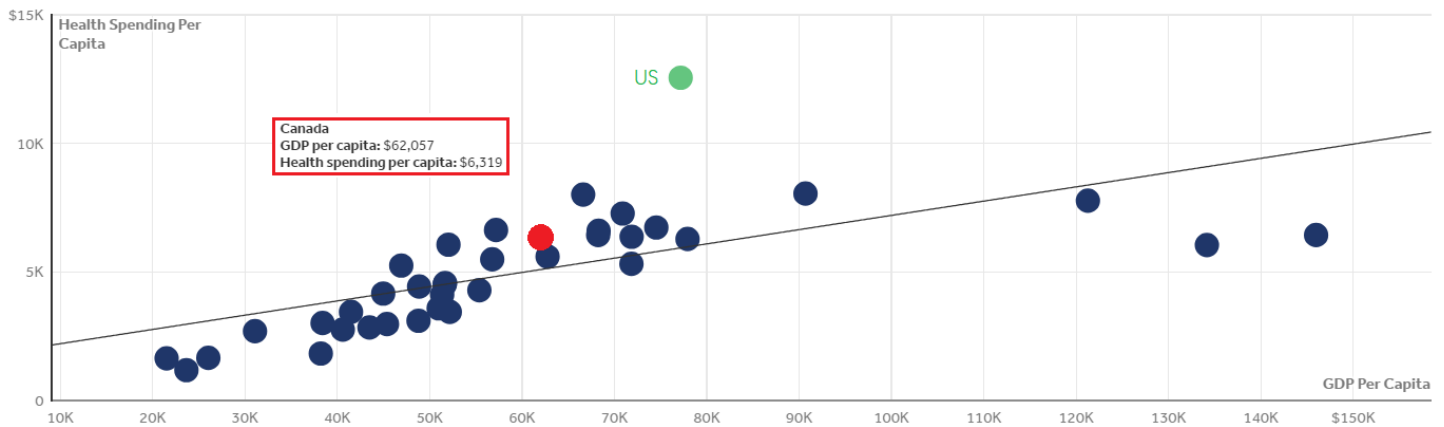


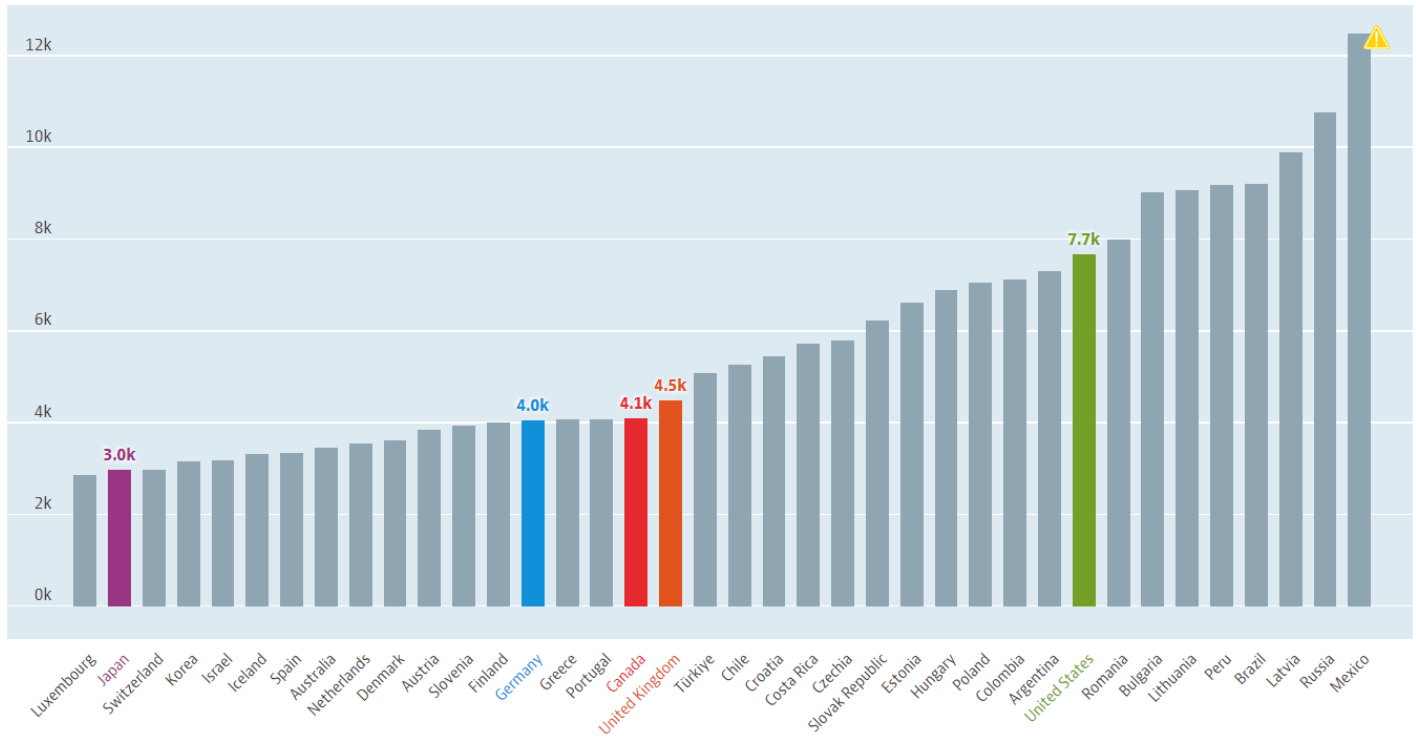
Exhibit 14. GDP per capita and health consumption spending per capita, U.S. dollars, 2022 (current prices and PPP adjusted)



Notes: Health spending per capita for Czech Republic, Denmark, France, and the Slovak Republic are estimated. For all other countries except the United States, health spending per capita is provisional. Health consumption does not include investments in structures, equipment, or research.

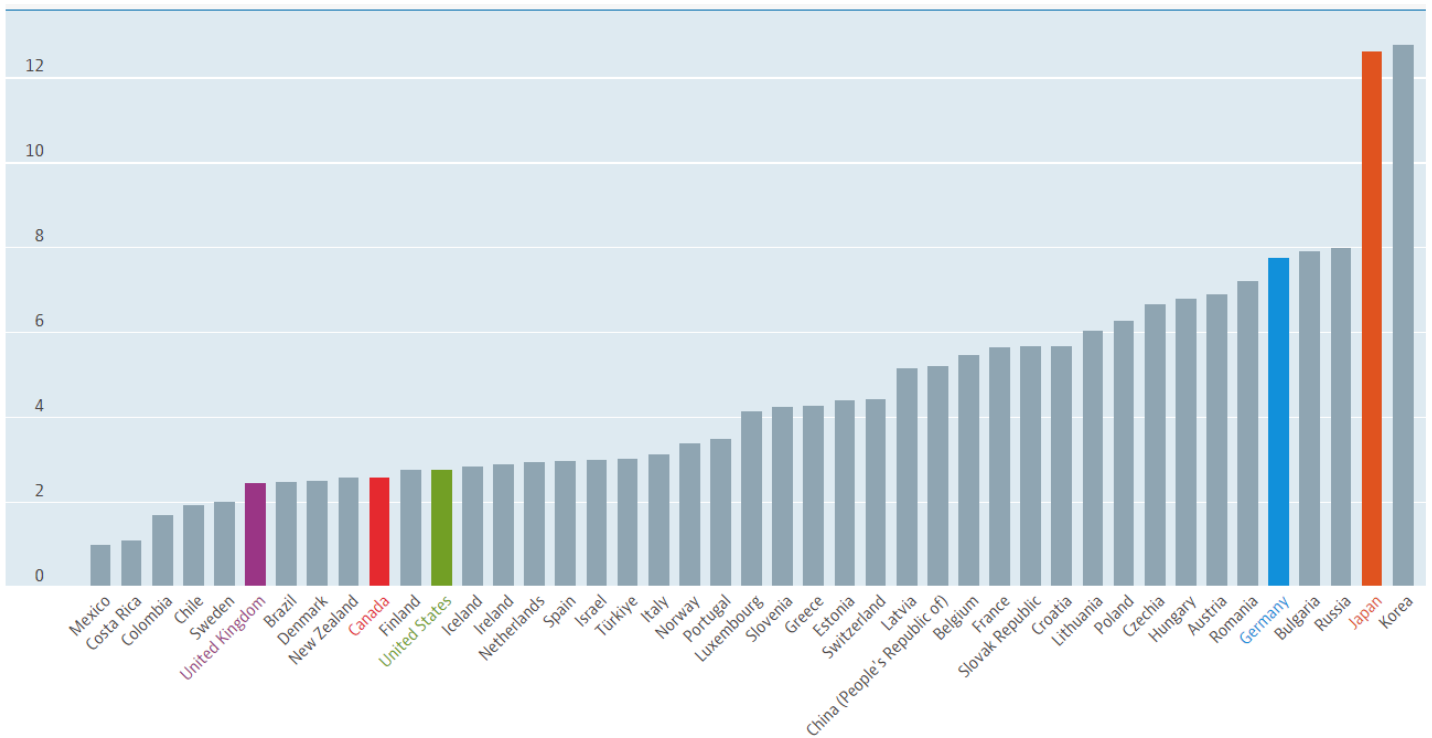
Source: KFF analysis of OECD data • Get the data • PNG

Exhibit 15. Potential years of life lost, Total, per 100 000 inhabitants aged 0-69, 2021



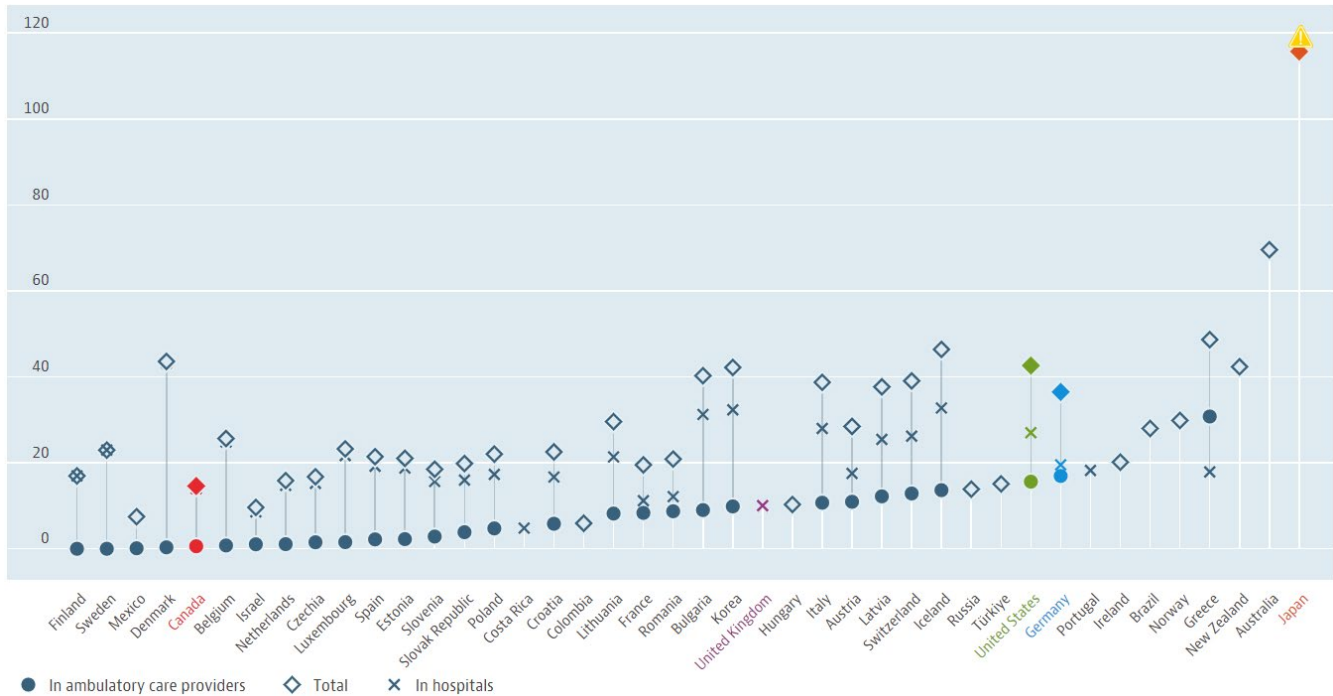
Source: Health Status, OECD

Exhibit 16. Hospital Beds, Total, per 1000 inhabitants, 2022



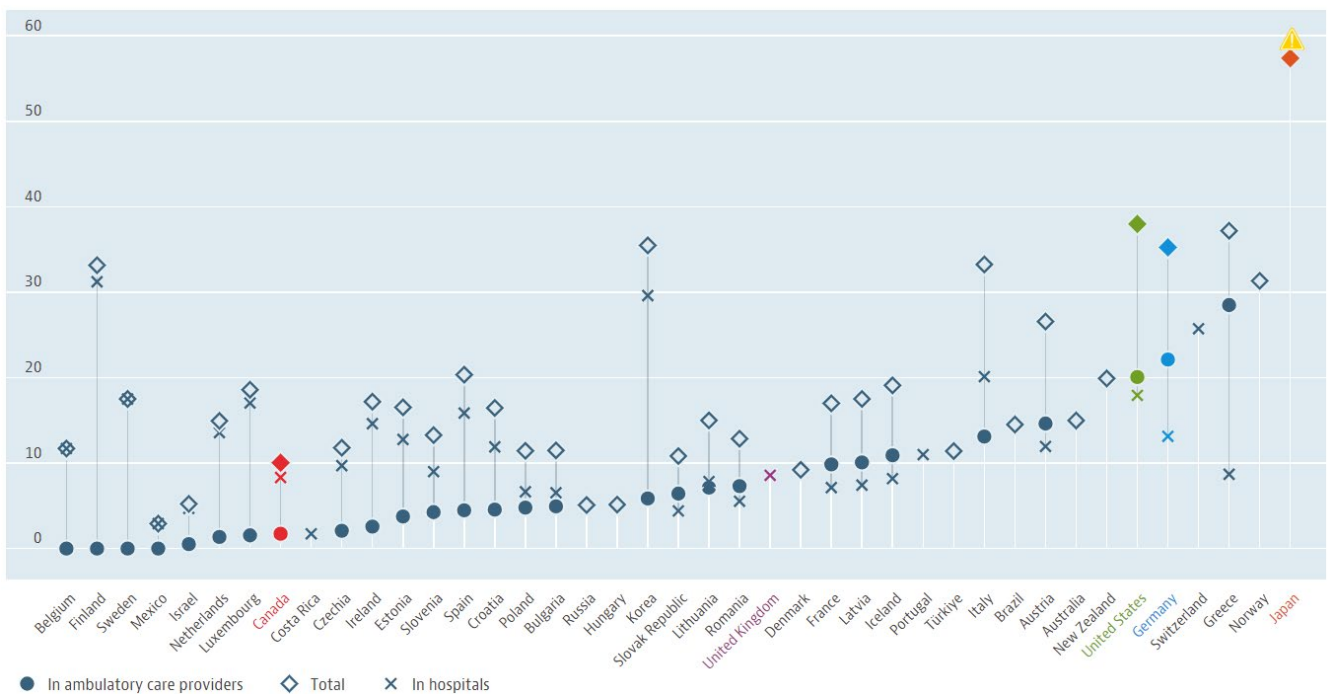
Source: Healthcare Resources, OECD

Exhibit 17. Computed Tomography (CT) Scanners. In ambulatory care providers/Total/In hospitals, per 1 000 000 inhabitants, 2022.



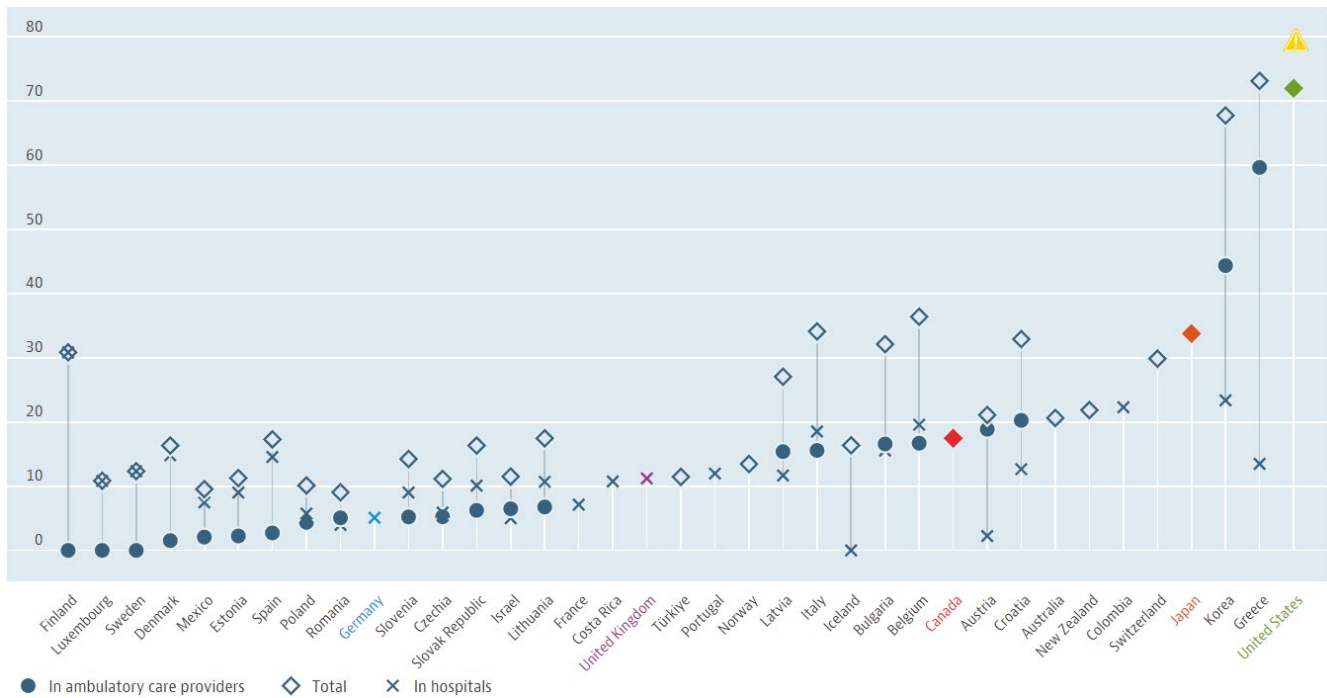
Source: Healthcare Resources, OECD

Exhibit 18. Magnetic resonance imaging (MRI) units. In ambulatory care providers/Total/In hospitals, per 1 000 000 inhabitants, 2022.



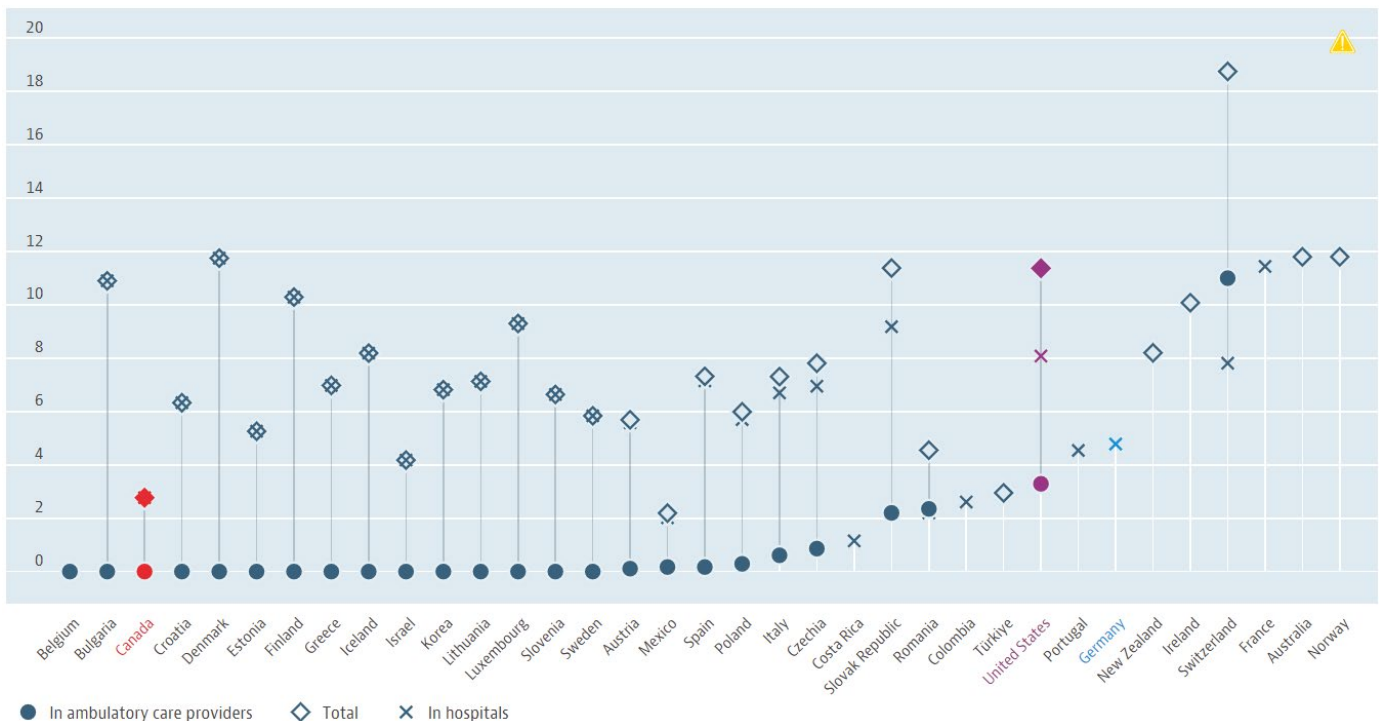
Source: Healthcare Resources, OECD

Exhibit 19. Mammography machines. In ambulatory care providers/Total/In hospitals, per 1 000 000 inhabitants, 2022



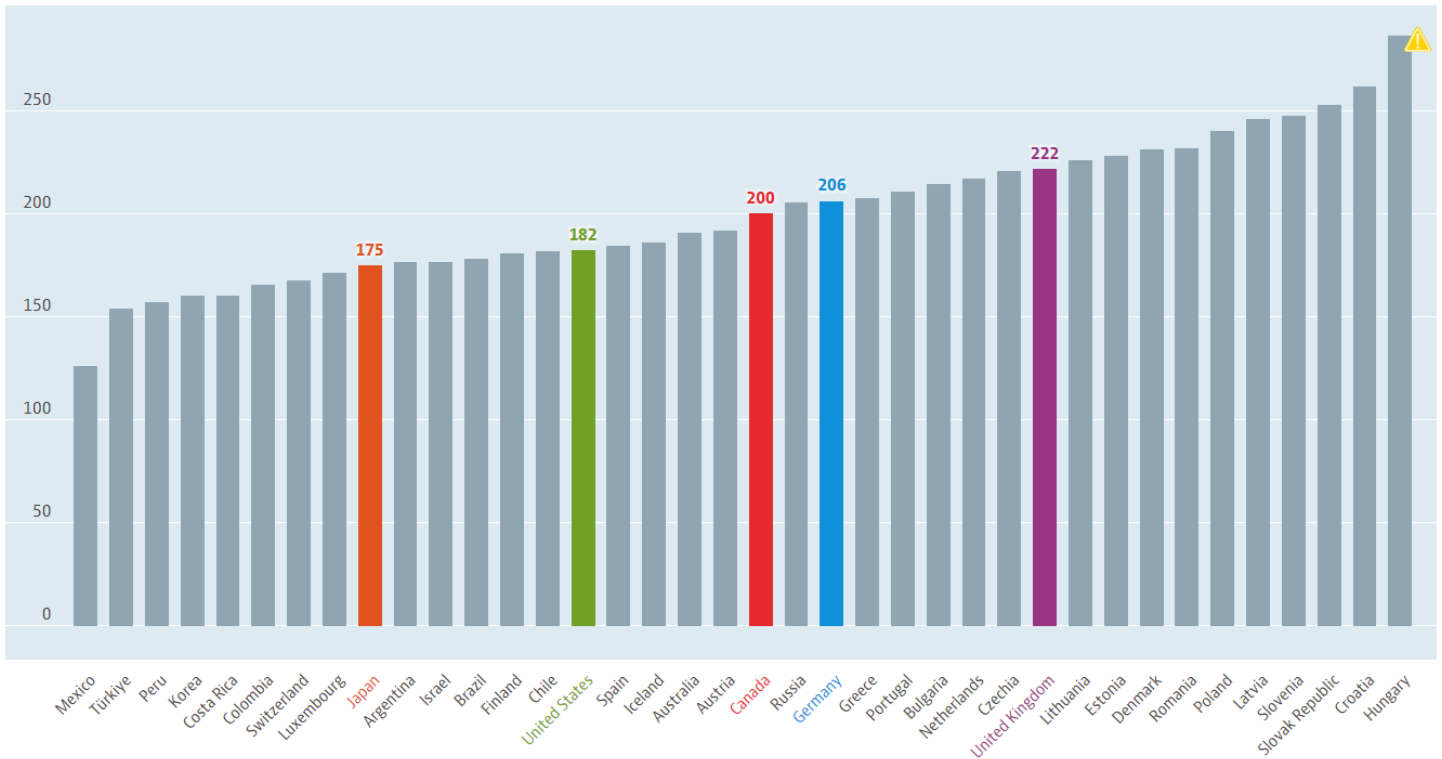
Source: Healthcare Resources, OECD

Exhibit 20. Radiotherapy equipment. In ambulatory care providers/Total/In hospitals, per 1 000 000 inhabitants, 2022



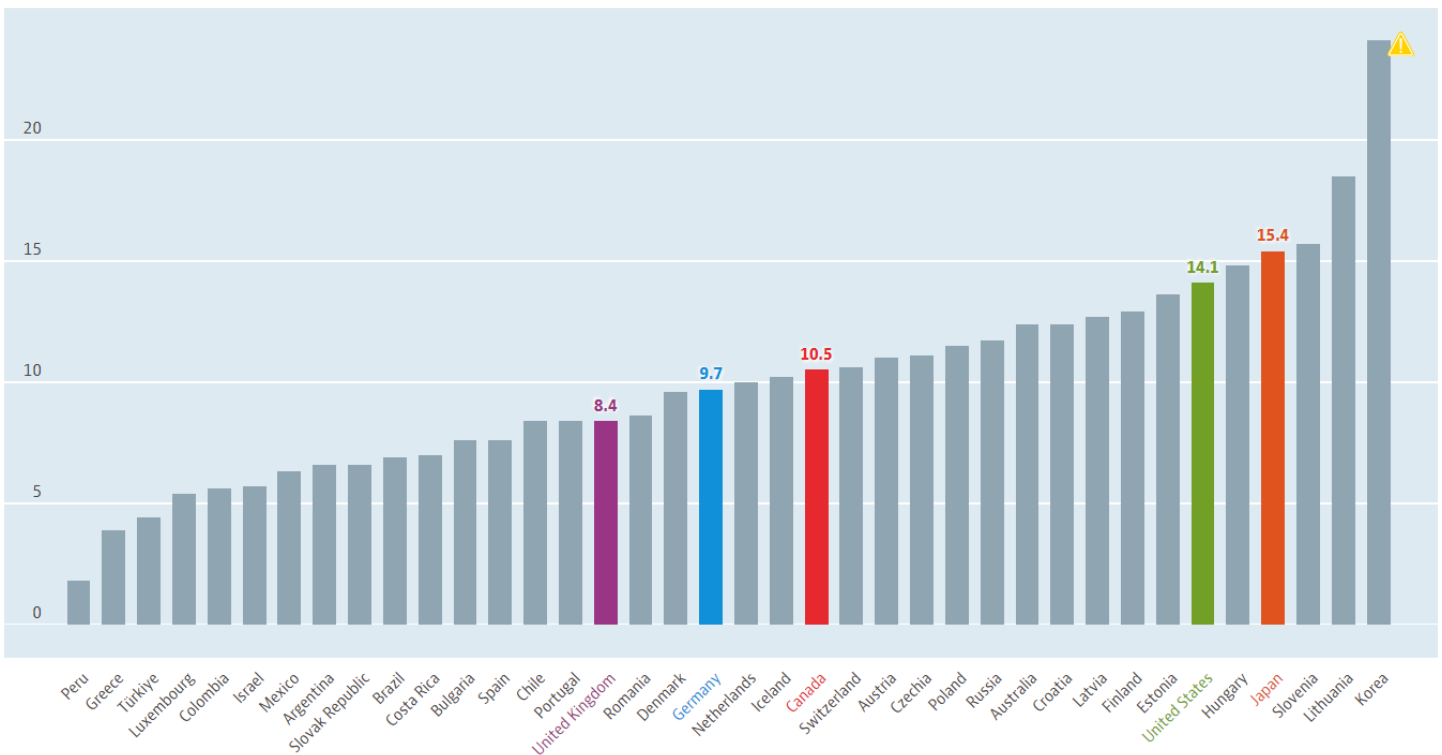
Source: Healthcare Resources, OECD

Exhibit 21. Deaths from cancer. Total, per 100 000 persons, 2021.



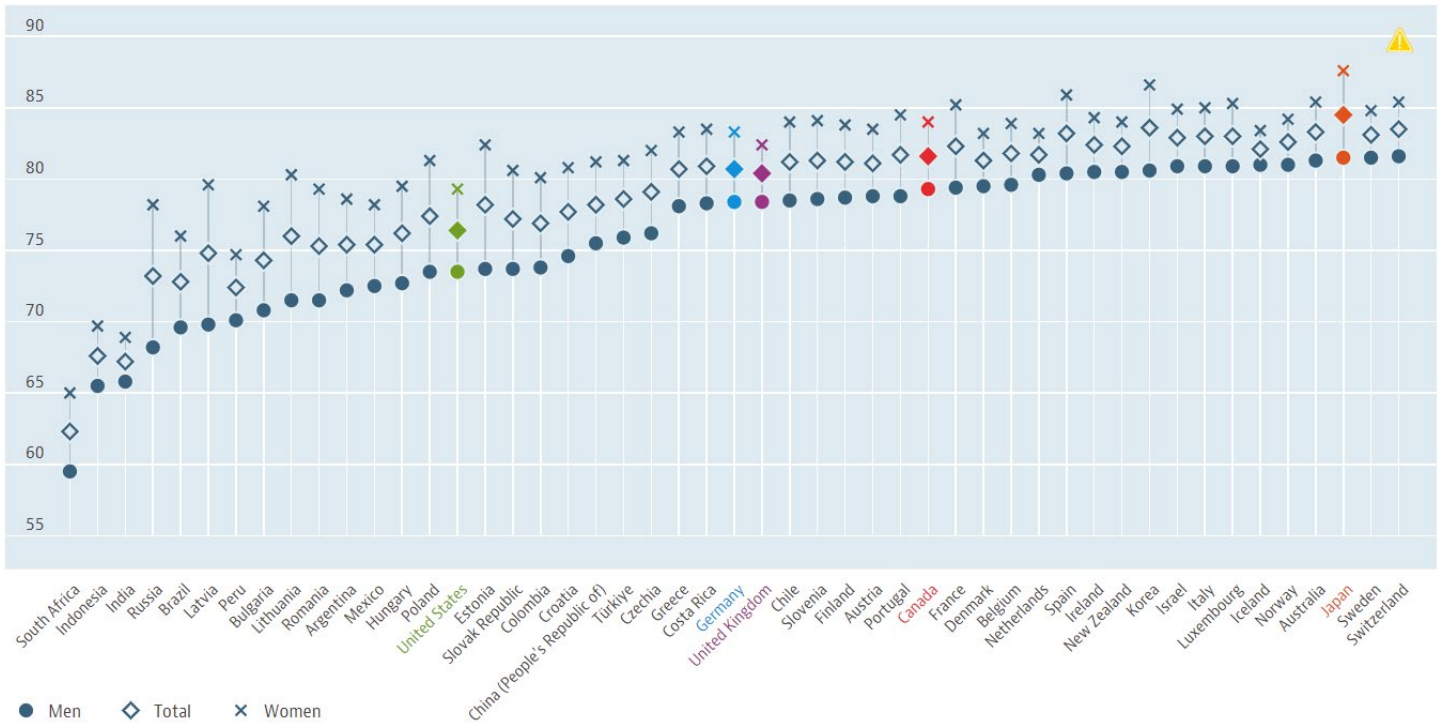
Source: Health Status, OECD

Exhibit 22. Suicide rates. Total, per 100 000 persons, 2021



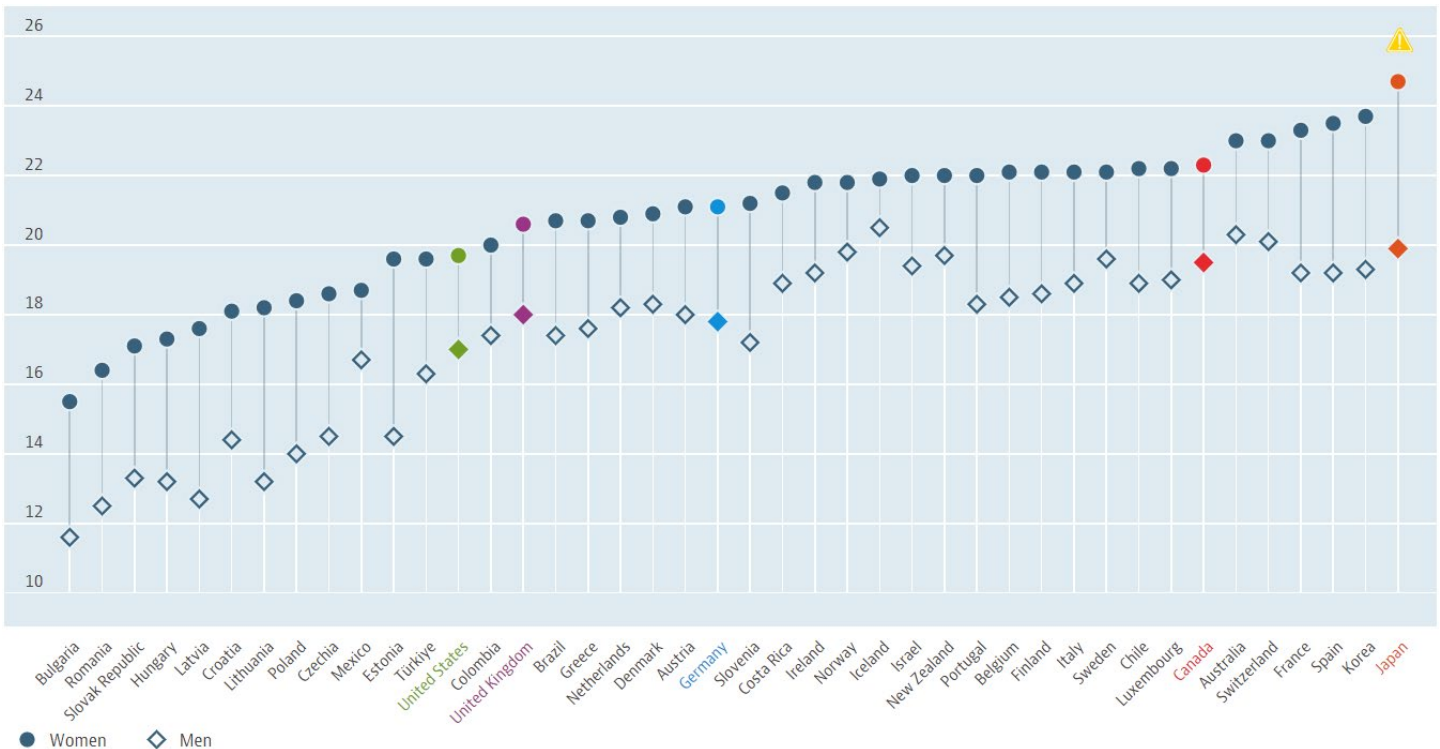
Source: Health Status, OECD

Exhibit 23. Life expectancy at birth. Men/Total/Women, years, 2022.



Source: Health Status, OECD

Exhibit 24. Life expectancy at 65. Women/Men, Years, 2022



Source: Health Status, OECD

3.3 Identifying Best Practices from Other Nations.

Best practices from other Nations in achieving health care coverage reflect a combination of balancing service coverage, population coverage, financial protection, and the quality of care provided. Specifically, balancing the population covered by universal health coverage demonstrated positive results with the enrollment of lower-income socio-economic status families in Health Insurance or Health coverage programs to ensure vulnerable populations had access to healthcare³⁵. Additionally, expanding the coverage to special age groups and special diseases including targeted grounds reduced many barriers accessing healthcare. Furthermore, the services engaged in improving hospital services, community health services, and prioritized delivery of essential health-care services help to ensure proper care for the greater population. Financial protection further reflected reformed payments and highlighted a prepaid system in the form of family grants for health creating an expanded coverage of social health Insurance schemes and community-based health insurance programs and national health insurance to ensure healthcare coverage for all citizens in need.

Reformed health financing through tax and excise tax on harmful products was shown to be a more efficient and effective use of available resources to provide this coverage. Lastly, the quality of health care services provided can be enhanced through the use of information and technology to bridge the gap between lacking access and resources to quality health care. While national licensing examinations help ensure the quality of healthcare physicians, better access and availability of resources can be made available through similar programs as the major initiatives taken such as the no balance-billing (NBB) for government hospitals and the expansion of the Health Facilities Enhancement Program (HFEP) used by the House of Representatives, Congress of the Philippines³⁶.

In most peer countries, health spending per person rose from 2021 to 2022. The only exception was the Netherlands, which saw a 0.1% decrease. In the U.S., per capita health spending increased by 2.9%, a smaller rise compared to many similar nations, yet higher than Australia (2.4%), Canada (0.7%), and the United Kingdom (0.5%). Belgium experienced the largest growth in per capita health spending among countries with accessible data, with a 9.6% increase from 2021 to 2022. This 2.9% rise in per capita health spending surpasses the previous increase from 2020 to 2021 (2.4%) but falls short of the 9.8% surge from 2019 to 2020.

While Canada does well in terms of life expectancy etc, hospital beds, CT scans, MRI, cancer deaths etc. are very low and contributes to our country's wait times for people with grave illnesses.

³⁵ Koohpayehzadeh, J., Azami-Aghdash, S., Derakhshani, N., Rezapour, A., Kalajahi, R. A., Khasraghi, J. S., ... & Soleimanpour, S. (2021). Best practices in achieving universal health coverage: A scoping review. *Medical Journal of the Islamic Republic of Iran*, 35.

³⁶ Koohpayehzadeh, J., Azami-Aghdash, S., Derakhshani, N., Rezapour, A., Kalajahi, R. A., Khasraghi, J. S., ... & Soleimanpour, S. (2021). Best practices in achieving universal health coverage: A scoping review. *Medical Journal of the Islamic Republic of Iran*, 35.

Section 4. Public vs Private Healthcare Models: Risks and Benefits

4.1 Examination of Publicly Funded Healthcare Systems

A public healthcare system is managed by the state and is composed of government-owned facilities, healthcare professionals and regulations³⁷. These models have been implemented in Canada, Norway, Sweden, Italy and the United Kingdom.

Canada ranks as "middle of the road" among Organization for Economic Co-operation and Development (OECD) nations, with healthcare expenditures divided in a 70% to 30% split between public and private sectors, slightly lower than the OECD average of 73% public and 27% private. Over the past 40 years, Canadian public sector spending has decreased from 76% to 70%, marking a notable decline.

The 2021 Commonwealth Fund Report lists Norway as the top-performing healthcare system³⁸. Norway places a strong focus on prevention measures and effective treatment, resulting in Norwegians living longer and healthier lives compared to many other Europeans³⁹. Additionally, the country has a comprehensive, well-developed long-term care system, particularly focusing on addressing mental health issues and developing age-friendly health services. The UK's National Health Service (NHS) stands out as a prominent model of a public healthcare system⁴⁰. Research indicates its greater equity compared to private systems, along with lower costs and similar health outcomes. Praised for prioritizing social equity, the NHS has been extensively compared to the healthcare system in the United States, revealing its cost-effectiveness and equitable nature. Similarly, India operates various public healthcare systems across its states, addressing the imperative of delivering equitable healthcare and cost-effectiveness. These instances underscore the essential role of public healthcare models in providing accessible and affordable healthcare for diverse populations.

Despite these advantages, there are some known disadvantages. Primarily, free healthcare only encompasses a narrow range of unlimited services provided by physicians and hospitals. This approach excludes dental care, pharmaceuticals, and allied health services, leaving individuals to other public or private arrangements. Additionally, the idea behind universal healthcare implies everyone should have access to care without interfering with another's care. However, in practice, demand can exceed supply, leading to market failure. To prevent this, Medicare uses supply-side control by limiting the number of

³⁷ *The public and private hospital systems.* (n.d.). healthdirect.

<https://www.healthdirect.gov.au/understanding-the-public-and-private-hospital-systems#:~:text=to%20the,content%20webpage>.

³⁸ *Norway: health system review.* (2013). PubMed.

<https://pubmed.ncbi.nlm.nih.gov/24434287/>

³⁹ *Norway: health system review.* (2013). PubMed.

<https://pubmed.ncbi.nlm.nih.gov/24434287/>

⁴⁰ Light, D. W. (2003). Universal health care: lessons from the British experience. *American journal of public health*, 93(1), 25-30.

physicians, surgical suites and hospital beds, resulting in prolonged wait times and compromised access to and quality of care. This approach is unsustainable without incorporating demand regulation, as proposed by critics. Unlike Canada and the UK, all OECD countries utilize some form of copayment or user fees for physician and hospital services to manage demand.

4.2 Analysis of Privately Funded Healthcare Systems.

On the other hand, private healthcare entails services funded by individuals or organizations, providing a wider selection of treatment options, shorter wait times, and personalized healthcare experiences⁴¹. However, this model exacerbates pre-existing economic disparities, leading to its characterization as a non-inclusive and inequitable system. Even though US healthcare is often considered private, it is 48% publicly funded, 52% private, and the public share is rising.

Private health insurance can manifest in various forms, serving to duplicate, complement, or supplement public health coverage. Duplicate private insurance competes with public health insurance and is prevalent in systems where a distinction exists between publicly and privately funded providers. Complementary private insurance offers coverage for out-of-pocket expenses that may arise within public systems, while supplementary private insurance covers services not included in public plans.

Supplementary insurance is already present in Canada, with approximately 65% of Canadians having private health insurance from their employers⁴². Any further alterations to private healthcare financing might involve expansion into complementary or duplicate insurance. However, the introduction of duplicate private insurance could pave the way for a "two-tier" system, conflicting with Canadian values regarding Medicare. Progressive tax policies could potentially mitigate the impact of the costs associated with complementary or supplementary plans.

Germany's healthcare model relies on an entirely private financing model and there is very limited government intervention. Statutory health insurance (SHI) is mandatory for everyone and covers 11.5% of the GDP (2017). This insurance entails coverage for inpatient, outpatient, mental health, prescription drugs, dental care, optometry, maternity, sick leave compensation etc. SHI is funded as a co-payment through employees and employers through general wage and supplementary contributions. These funds are allocated to a health fund which is then redistributed to individual sickness funds. If required, additional

⁴¹ *The public and private hospital systems.* (n.d.-b). healthdirect.

<https://www.healthdirect.gov.au/understanding-the-public-and-private-hospital-systems#:~:text=to%20the,content%20webpage>.

⁴² Allin, S., & Hurley, J. (2009). Inequity in publicly funded physician care: what is the role of private prescription drug insurance? *Health Economics*, 18(10), 1218–1232.

<https://doi.org/10.1002/hec.1428>

private insurance can be purchased with employees earning greater than \$68,000. This option may appeal to high-wage earners which covers more services with lower premiums. Regardless of the type of insurance, the healthcare workforce treats all individuals.

The federal government is responsible for overseeing healthcare regulations but not in delivery. Some of the roles include determining the services covered by SHI, population-physician ratios and ambulatory care capacity. However, there are no government subsidies. Unemployed individuals pay in relation to their unemployment entitlements or if unemployment persists long-term, the government pays for them.

In a free market equilibrium, demand and supply are balanced; however, healthcare differs from typical market goods. In an unrestricted healthcare market, affluent individuals would have greater access to expedited healthcare, while those with fewer resources would experience longer wait times and reduced access. During the Great Depression of the early 1930s, many individuals lacked affordable basic healthcare. Consequently, the healthcare system transitioned from a private to a public good, leading to the development of the CHA.

Literature offers additional support for the assertion made in prior international literature reviews that healthcare systems characterized by higher levels of private financing tend to exhibit adverse associations with universality, equity, accessibility, and quality of care. Another study indicates no correlation between HEG and private financing within a healthcare system. Consequently, heightened levels of private financing neither enhance nor deteriorate the sustainability of the healthcare system.

4.3 Case Studies of Countries with Successful Hybrid Models.

Several countries adopt a combination of private and public financing models known as a hybrid model. A hybrid approach is beneficial because it improves the quality and efficiency of care. Examples of countries that have successfully implemented this model include Singapore, Australia, Germany, Netherlands.

Singapore

Singapore is ranked as the country with the highest life expectancy (83 years, 2021), lowest infant mortality rate (2 per 1000) and lowest healthcare spending among developed nations^{43, 44, 45}. Singapore spends 4.2%

⁴³ World Bank Open Data. (n.d.). World Bank Open Data.

<https://data.worldbank.org/indicator/SP.DYN.LE00.IN?locations=SG>

⁴⁴ World Bank Open Data. (n.d.-b). World Bank Open Data.

<https://data.worldbank.org/indicator/SP.DYN.IMRT.IN?locations=SG>

⁴⁵ Hruza, G. J. (2020). A Prescription for world Class Healthcare at Rock Bottom Cost!. *Missouri Medicine*, 117(5), 392.

of its GDP on healthcare annually in comparison to 18% in the United States⁴⁶. The system is based on the fundamental value of personal responsibility for one's health, with strong government control and oversight⁴⁷. They utilize a mixture of both public and private financing models.

The government helps citizens manage their finances through mandatory accounts. The first one is Medisave which is a mandatory medical savings account. This account can be used to pay for out-of-pocket medical services for an individual and family members. Contributions to this tax-free account are made through personal and employer contributions, which also vary by age. This account has an interest rate of 4-5%. MediShield Life is a basic health insurance plan to protect against any large hospital fees. There are also other plans including MediFund which act as a safety net for the underprivileged who cannot cover their bills using the first two funds.

Hospital treatment is based on clinical conditions rather than subsidy status. Patients at public hospitals can choose from four different wards (A, B1, B2 and C). The delivery of care is consistent between the wards with differences in additional amenities such as a private room and TV in the A ward.

Government subsidies cover the following services at different percentages including the C-class ward, primary care at polyclinics (75%), specialist outpatient care (75%), emergency services, intermediate long-term care, and daily assistance for community-dwelling elderly.

Citizens also have the option of purchasing additional private insurance if they have MediShield life. Private insurance would cover inpatient treatment and care, surgery, radiosurgery, bone marrow transplants, psychiatric hospital stays, day surgeries, selected outpatient services (dialysis, radiotherapy, chemotherapy) and immunosuppressants after an organ transplant.

Australia

The 2021 Commonwealth Fund report lists Australia as the top third-performing healthcare system. Among Belgium, France and Canada, Australia has the lowest total healthcare expenditure. This financing model encompasses both public and private financing.

There is strong government intervention in the system at federal, provincial and local levels. The federal government oversees the Medicare Benefits Scheme (MBS), the Pharmaceutical Benefits Scheme, regulation of private insurance, pharmaceuticals and therapeutic goods. Individual states are responsible

⁴⁶ Hruza, G. J. (2020). A Prescription for world Class Healthcare at Rock Bottom Cost!. *Missouri Medicine*, 117(5), 392.

⁴⁷ *Singapore*. (n.d.). International Health Care System Profiles | Commonwealth Fund.

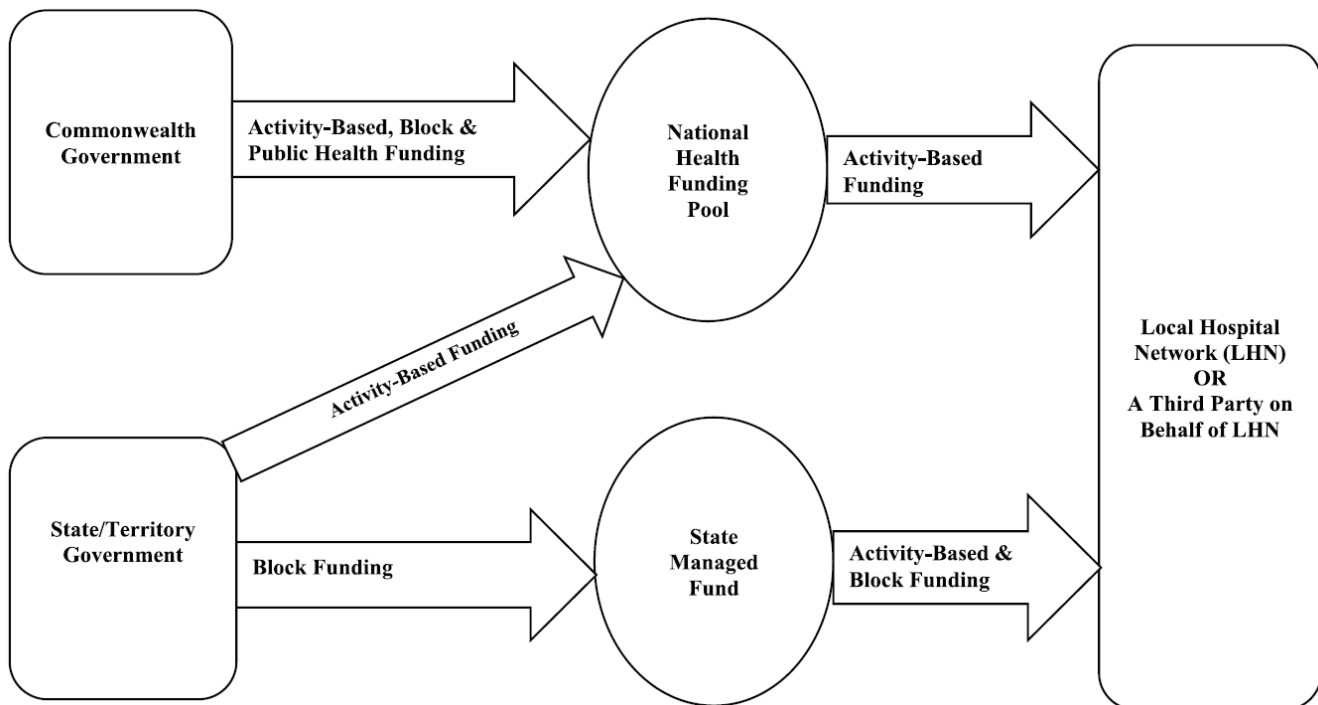
<https://www.commonwealthfund.org/international-health-policy-center/countries/singapore>

for managing service delivery through public hospitals, ambulances, dental care, community health and mental health. They also play a role in the private sector through hospital regulation, pharmacy location and healthcare workers. Local governments must support community and preventive health programs.

Medicare, funded through national taxes and government levies, offers free public hospital care for citizens. However, citizens, permanent residents and refugees can buy additional private insurance coverage, which offloads services onto the private sector. Coverage can include a range of services from hospital care, ambulance, dental, physiotherapy, chiropractic etc. Approximately 46% (2016) of the population had purchased additional coverage. Policymakers have the flexibility to enhance spending by redesigning incentives for healthcare providers, potentially improving efficiency. Specifically, using a tax rebate (8.5%-33.9%) for purchasing private insurance, dependent on socioeconomic status and age. The use of Activity-Based Funding (ABF) allows for a shift towards bundled payment systems, incentivizing efficiency, quality, and patient outcomes.

To alleviate out-of-pocket expenses, the Australian government has instituted two safety nets: Original Medicare and Extended Medicare. The Original Medicare Safety Net ensures coverage of all MBS fees up to a maximum of \$322. Meanwhile, the Extended Medicare Safety Net covers 80% of out-of-pocket costs, up to \$467 for government-issued cardholders and \$1,464 for others.

Exhibit 25. Flowchart examining the funding sources of the Australian healthcare system.



Source: Dexit *et al.* A review of the Australian healthcare system: A policy perspective, 2018

Netherlands

The healthcare system in the Netherlands is characterized by its hybrid model, drawing funding from a combination of premiums, tax revenues, and government grants. Under this system, every citizen is required to obtain private statutory insurance, with a few exceptions such as those who contribute to a health savings account or serve actively in the armed forces. Notably, family coverage isn't offered; however, children under the age of 18 are automatically covered.

This mandatory insurance provides comprehensive coverage, encompassing general practitioner services, specialty care, hospitalization, maternal care, dental services, prescription drugs, physiotherapy, and home nursing, among other essential medical needs. To address additional healthcare needs, individuals have the option to purchase supplemental insurance, which extends coverage to services such as dental care, alternative medicine, physiotherapy, optometry, and contraceptives.

The federal government assumes a pivotal role in both regulating and delivering healthcare services. It sets priorities, establishes cost controls, and ensures equitable access to healthcare facilities and treatments. Moreover, the government is directly involved in healthcare delivery, overseeing hospitals, physicians, home nursing services, and mental health programs.

To mitigate financial barriers to healthcare access, the government provides subsidies that offset insurance premiums for low-income households. This measure aims to promote universal access to healthcare services and reduce disparities in healthcare utilization based on socioeconomic status. Overall, the Netherlands' healthcare system reflects a commitment to providing comprehensive, accessible, and high-quality healthcare for all its residents.

In addition to its financing and coverage structure, this healthcare system also emphasizes preventive care and patient-centered approaches. General practitioners (GPs) act as the primary point of contact for patients and play a crucial role in coordinating care and referrals to specialists when necessary. This emphasis on primary care helps to ensure early detection and management of health issues, contributing to better health outcomes and cost-effectiveness in the long term.

Summary

The cornerstone of sustainability lies not in debating private versus public funding models, but in effectively managing the annual Health Expenditure Growth (HEG), also known as health inflation. HEG factors include population growth, aging, inefficiency, labor and drug price inflation, and technological change. When

HEG consistently outpaces the economy's growth rate, regardless of private or public financing, the system becomes unsustainable. This imbalance leads to escalating healthcare costs consuming available resources, ultimately squeezing out other forms of consumption. Overall, the literature suggests that improving health outcomes may be more correlated to social determinants of health and health behaviors rather than how it is financed^{48, 49, 50}.

4.4 Canada's Public and Private Healthcare Sectors to Benefit From 2024 Budget⁵¹

Healthcare expenditure will benefit from increased government spending despite projected below-trend GDP growth in 2024. Increased digital health investment aims to create a more integrated and efficient health information system that will deepen collaboration between healthcare providers.

Private healthcare expenditure will benefit from increasing public-private partnerships. The Pharmacare Act will be a major focus of Canada's healthcare investment over the next five years supporting both public and private sectors.

Healthcare expenditure will benefit from increased government spending despite projected below-trend GDP growth in 2024. We have increased our forecast compound annual growth rate (CAGR) in local currency terms and project that public health expenditure in Canada will expand by 4.1%, reaching CAD283.5bn by 2028. This upward revision is a direct reflection of Canada's 2024 federal budget. While an explicit value for healthcare expenditures has not been stated, an increase in the federal government's health transfers has increased y-o-y to reach CAD52bn in 2024. Our macro team anticipates that Canada's economy will stagnate over 2024 which will temper future federal budget spending growth, although we believe that healthcare spending will remain a priority for the government. This is underscored by the steady rise in federal health transfers, signaling a commitment to bolster the healthcare system irrespective of broader economic pressures. As a result, despite the projected economic headwinds, the healthcare

⁴⁸ Dutton, D. J., Forest, P. G., Kneebone, R. D., & Zwicker, J. D. (2018). Effect of provincial spending on social services and health care on health outcomes in Canada: an observational longitudinal study. *CMAJ. Canadian Medical Association Journal*, 190(3), E66–E71. <https://doi.org/10.1503/cmaj.170132>

⁴⁹ Lee, S. K., Rowe, B. H., & Mahl, S. K. (2021). Increased private healthcare for Canada: is that the right solution?. *Healthcare Policy*, 16(3), 30.

⁵⁰ Dodge, D. A., & Dion, R. (2011, April 6). *Chronic Healthcare Spending Disease: A Macro Diagnosis and Prognosis*. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1825363

⁵¹ *Canada's Public And Private Healthcare Sectors To Benefit From 2024 Budget*. (n.d.). Fitch Solutions.

<https://www.fitchsolutions.com/bmi/healthcare/canadas-public-and-private-healthcare-sectors-benefit-2024-budget-08-05-2024>

sector in Canada is poised for continued investment and development, underpinned by a robust government spending strategy.

Health Transfers Increase to Support Healthcare System Expansion

Canada – Federal Government Health Transfer Amount, 2015/2016-2024/2025, CAD bn

Increased digital health investment aims to create a more integrated and efficient health information system that will deepen collaboration between healthcare providers. One key area of the budget allocation is digital health, where an investment of CAD2bn over the next five years is set to develop and implement virtual care platforms and expand electronic health records. Initiatives such as the expansion of telehealth services are designed to reduce the burden on physical healthcare facilities, enabling remote consultations and monitoring, which are particularly critical in addressing the healthcare needs of Canadians living in rural and remote areas. By facilitating these advancements, the government's budget allocation for digital health is expected to be a major driver of the growth in public healthcare spending.

Private healthcare expenditure will benefit from increasing public-private partnerships. We have also increased our forecast CAGR for private healthcare expenditure to 4.6%, expected to reach CAD116.4bn by 2028. This forecasted growth is supported by the government initiatives that encourage private sector innovation and investment in healthcare. One example is the allocation of CAD500mn for the next-generation medical technology fund within the 2024 healthcare budget. This fund is designed to foster private-public partnerships in areas such as diagnostics, robotic surgery and personalized medicine. The private sector is expected to leverage these investments to develop medical devices and applications that utilize artificial intelligence and big data analytics. The government's budgetary support for such initiatives is indicative of a broader trend in Canada towards fostering a synergistic relationship between the public and private sectors to reduce the burden on public healthcare systems, which underpins our projection of a robust growth trajectory for private healthcare expenditure.

Positive Outlook for Both Public and Private Healthcare Expenditures

Canada – Health Expenditure by Payor Types, CAD bn

The Pharmacare Act will be a major focus of Canada's healthcare investment over the next five years, offering significant benefits to healthcare providers and institutions within both the public and private sectors. The Act aims to alleviate existing financial pressures on healthcare providers associated with the

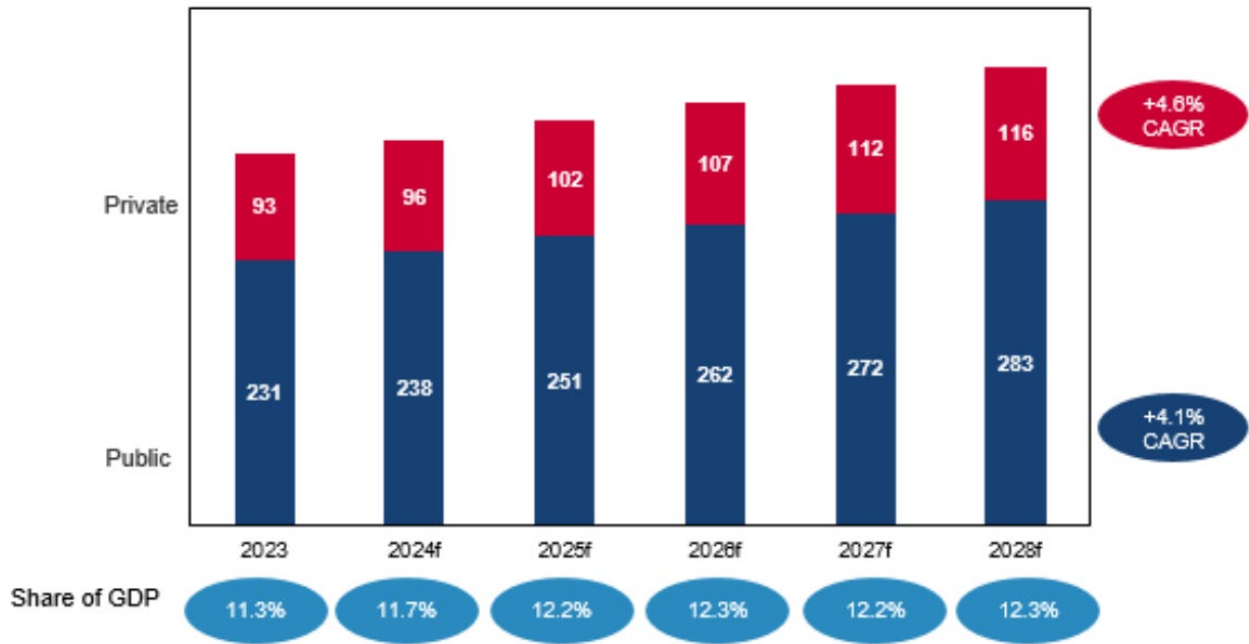
cost of drugs through the creation of a national formulary of essential prescription drugs and related products, which will establish a consistent scope of medications accessible to all Canadians under the national universal pharmacare program. The Act will therefore allow for a more efficient allocation of resources towards patient care and service expansion. Hospitals are poised to see a decrease in admissions and readmissions associated with medication non-adherence, given that patients are expected to gain improved access to pharmaceuticals. The creation of a national drug agency, a key component of the Pharmacare Act, is intended to expedite the drug approval process and enhance the efficiency of medication procurement. This agency should assist healthcare providers by shortening the duration before new treatments are accessible and by securing a steady availability of crucial medications.

There are also several barriers to the implementation of the new Act. Transitioning to a streamlined approval and procurement system would create initial bureaucratic obstacles, potentially delaying the anticipated advantages. Ensuring an uninterrupted supply chain for a wide range of pharmaceuticals will prove challenging and there may be concerns regarding the impact of the Act on the incentive for pharmaceutical innovation, particularly in light of negotiations on drug pricing and cost management. Despite the aim of universal coverage, discrepancies in the formulary could leave certain treatments inaccessible through the program, necessitating alternative funding or insurance for those medications.

The CAD1bn investment earmarked for the treatment of rare diseases will be impactful for healthcare institutions as it will enable providers to offer therapies that were previously unaffordable or unavailable. For private sector healthcare providers, the focus on rare diseases represents an opportunity to diversify and expand services and promote innovation in personalized medicine. The act's funding allocation to bolster family health services, with a focus on mental health, is also poised to benefit healthcare providers. The CAD3bn budget allocation will expand the market for private practitioners and clinics and supplement existing demand for mental health services. Improved mental health services in the public sector will help to integrate care, resulting in a more holistic approach to health and potentially reducing the incidence of comorbidities.

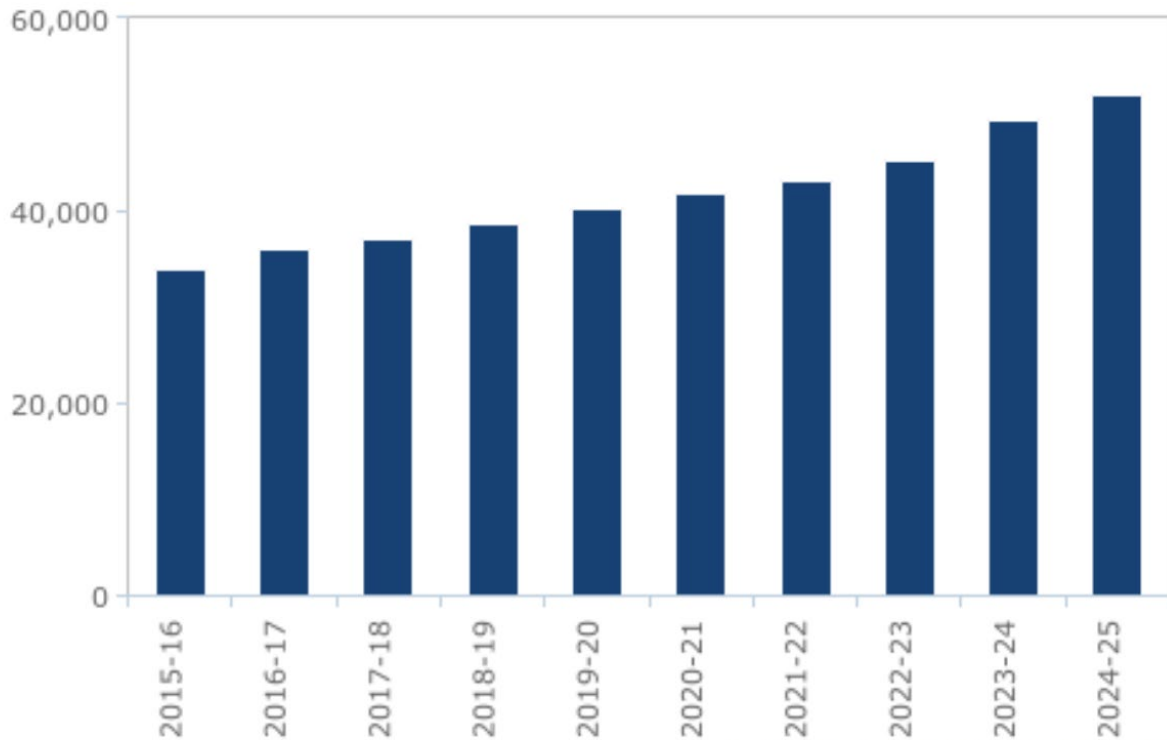
Exhibit 26. Positive Outlook for Both Public and Private Healthcare Expenditures

Canada – Health Expenditure by Payor Types, CAD bn



f=BMI forecast. Source: WHO, BMI

Exhibit 27. Canada, federal government health transfer amount, 2015/2016-2024/2025, CAD bn.



Source: Department of Finance Canada, BMI

Section 5. Efficiency and Bureaucracy in Canadian Healthcare

5.1 Impact of Bureaucracy on Healthcare Delivery

Bureaucracy plays a crucial role in the administration of Canada's healthcare system, but it also introduces several inefficiencies. As of 2023, health expenditures are expected to account for 12.1% of Canada's GDP, indicating significant financial investment and potential bureaucratic inefficiency following a peak of 13.8% in 2020 during the global health crisis⁵². The layered bureaucratic structure can often lead to duplicative processes, delayed decision-making, and increased operational costs, all of which may detract from direct patient care quality and access.

The system's complexity is exacerbated by the federal structure of governance, where responsibilities are divided between provincial, territorial, and federal governments, each with their own sets of rules and regulatory frameworks. This often results in redundant administrative tasks and can cause delays in policy implementation and healthcare delivery.

For instance, administrative overheads are responsible for a substantial portion of healthcare costs. Studies indicate that simplifying these systems could significantly reduce expenses without impacting the quality of care⁵³. Furthermore, the bureaucratic approach can impede the adoption of innovative healthcare technologies and methodologies, thereby affecting overall system responsiveness and adaptability to patient needs.

5.2 Identification of Inefficiencies in the Canadian Healthcare System

The Canadian healthcare system exhibits several inefficiencies that can be primarily attributed to its bureaucratic nature. One of the most significant issues is the lengthy wait times for medical services, which are among the highest in the OECD countries. These wait times reflect an underlying inefficiency in resource allocation and scheduling within the healthcare bureaucracy⁵⁴.

Resource mismanagement is another critical inefficiency. There is often an underutilization of available resources such as medical equipment and personnel, which results from stringent but outdated regulatory controls that do not align with current technological advancements or healthcare practices.

⁵² *National health expenditure trends, 2023 — Snapshot* | CIHI. (n.d.-b).

<https://www.cihi.ca/en/national-health-expenditure-trends-2023-snapshot>

⁵³ Papanicolas, I., Woskie, L. R., & Jha, A. K. (2018). Health care spending in the United States and other high-income countries. *Jama*, 319(10), 1024-1039.

⁵⁴ *Waiting Your Turn: Wait Times for Health Care in Canada, 2023 Report*. (2023, December 7). Fraser Institute.

<https://www.fraserinstitute.org/studies/waiting-your-turn-wait-times-for-health-care-in-canada-2023>

Additionally, the lack of a unified digital health records system across provinces leads to significant inefficiencies in patient data management. This not only affects the quality and speed of healthcare delivery but also increases the risk of errors⁵⁵. The absence of interoperability in health information systems across different jurisdictions complicates comprehensive care delivery and continuity of care.

5.3 Strategies to Streamline Bureaucratic Processes

Addressing the inefficiencies in the Canadian healthcare system requires a multi-faceted approach, focused on streamlining bureaucratic processes and enhancing system responsiveness:

Enhancing Interoperability of Health Information Systems

Implementing a unified electronic health record (EHR) system would enable seamless sharing of patient data across provinces and healthcare providers, reducing redundancies and improving care coordination⁵⁶. This strategy is supported by evidence from other countries that have successfully implemented national EHR systems, showing improvements in patient outcomes and system efficiency⁵⁷.

Simplifying Regulatory Processes

Streamlining the approval processes for new medical technologies and pharmaceuticals can reduce the time and cost associated with bringing these innovations to market. For instance, adopting a risk-based approach to regulation can expedite the approval of low-risk innovations while maintaining rigorous standards for more critical interventions

Decentralizing Decision-Making

Empowering local health authorities and providers to make decisions based on their specific regional needs can improve responsiveness and resource allocation. This approach has been effective in other federal systems like Australia, where local health districts manage resources to meet community-specific health needs effectively⁵⁸.

⁵⁵ Home | Canada Health Infoway. (n.d.).

<https://www.infoway-inforoute.ca/en/>

⁵⁶ Electronic Health Record | Canada Health Infoway. (n.d.).

<https://www.infoway-inforoute.ca/en/component/tags/tag/electronic-health-record>

⁵⁷ Bates, D. W., Saria, S., Ohno-Machado, L., Shah, A., & Escobar, G. (2014). Big data in health care: using analytics to identify and manage high-risk and high-cost patients. *Health affairs*, 33(7), 1123-1131.

⁵⁸ Philippon, D. J., & Braithwaite, J. (2008). Health system organization and governance in Canada and Australia: a comparison of historical developments, recent policy changes and future implications. *Healthcare Policy*, 4(1), e168.

Implementing Lean Management Principles

Adopting lean principles from the manufacturing industry could help healthcare facilities reduce waste, improve patient flow, and optimize resource use. This has been successfully demonstrated in multiple healthcare settings, where lean methodologies have led to shorter wait times and lower costs without compromising care quality⁵⁹.

Performance Benchmarking

Regularly evaluating performance against national and international best practices can help identify areas for improvement and foster a culture of continuous improvement. Benchmarking initiatives can be facilitated through collaborations with international health organizations to learn from global best practices.

The analysis in Section 6 highlights how bureaucracy contributes to inefficiencies that increase healthcare costs, delay access to services, and hinder the adoption of innovative care models in Canada. With health expenditures accounting for a significant portion of GDP, inefficiencies such as duplicative administrative processes, long wait times, and a lack of integrated health information systems directly impact the quality and accessibility of patient care. By addressing these issues, the Canadian healthcare system can not only save costs but also deliver more

⁵⁹ Tlapa, D., Zepeda-Lugo, C. A., Tortorella, G. L., Baez-Lopez, Y. A., Limon-Romero, J., Alvarado-Iniesta, A., & Rodriguez-Borbon, M. I. (2020). Effects of lean healthcare on patient flow: a systematic review. *Value in Health, 23*(2), 260-273.

Section 6. Nationalization of Healthcare: Feasibility and Implications

6.1 Accessing the Role of Federal Government in Healthcare

The responsibilities of the federal government include establishing and managing national standards for the healthcare system under the Canada Health Act (CHA), offering financial assistance for provincial and territorial healthcare services, aiding in the delivery of healthcare services to particular demographics, and undertaking various other health-related duties.

Parliament has asserted its authority over health affairs through its jurisdiction under the criminal law power [section 91(27)], as well as through the federal spending power, which is derived from its control over public debt and property [section 91(1A)], and its broad taxing authority [section 91(3)].

Canada Health Act

The Canada Health Act (CHA) states that:

The primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers⁶⁰.

This legislation, coupled with the Canada Health Transfer (CHT), serves as the mechanism through which the federal government can impact healthcare, despite its primary jurisdiction lying within the provinces and territories. The CHA mandates that healthcare insurance plans must adhere to specific criteria and conditions for provincial and territorial governments to receive the complete financial support outlined in the CHT.

6.2 Potential Benefits of Nationalizing Healthcare

The prospect of nationalizing healthcare in Canada is a topic of considerable debate, with proponents highlighting potential benefits such as streamlined administration and improved accessibility, while opponents express concerns about increased government intervention and potential inefficiencies.

⁶⁰ *Canada Health Act*, RSC 1985, c C-6.

Benefits

1. Streamlined Administration

- A unified, federally managed healthcare system would alleviate the administrative burden on provincial governments, allowing them to focus on other critical areas.
- This approach could appeal to proponents of smaller governments and lower taxes, potentially garnering support from provincial leaders who have advocated for healthcare privatization.

2. Improved Accessibility

- A federal system could ensure consistent healthcare access across the country, irrespective of provincial boundaries, addressing disparities and better serving diverse populations.
- Nationalizing healthcare could strengthen the federal government's incentive to enhance healthcare access nationwide, particularly in underserved areas or major cities with unique healthcare needs.

3. Coordination and Efficiency

- Centralized coordination of healthcare services at the federal level could lead to more efficient resource allocation and better integration with national public health policies and disaster assistance initiatives.
- A nationalized system would facilitate the production of essential pharmaceuticals, vaccines, and protective equipment, potentially leading to cost savings and improved preparedness for future health crises.

Section 7. Expansion of Healthcare Services: Pharmacare and Mental Health.

7.1 Evaluation of Federal Initiatives on Pharmacare

Evaluation of Federal Initiatives on Pharmacare

For decades, Canadians have taken great pride in their comprehensive and inclusive health insurance system, known as, "Canadian Medicare." This system, governed by the Canada Health Act and jointly administered by provinces and the federal government, provides a sense of security to citizens by guaranteeing access to medically necessary services like physician consultations, diagnostic tests, and hospital stays, regardless of factors such as age, income level, or geographic location.

Despite its strengths, Canada's universal public health insurance system presents a unique challenge when it comes to accessing prescription medications. Unlike other high-income countries with similar systems, Canada does not extend its coverage to include prescription drugs dispensed at community pharmacies⁶¹. Instead, drug coverage is administered through a fragmented system consisting of more than a hundred public plans and an estimated 100 000 private insurance plans⁶². Consequently, many Canadians face significant financial burdens due to the uninsured costs associated with necessary medications.

The Case for Pharmacare

There are both significant social and economic incentives for the implementation of a universal pharmaceutical drug plan in Canada. A report titled "Body Count," commissioned by the Canadian Federation of Nurses Unions in 2018, projected that the financial burden of prescription drugs may be linked to an estimated 370 to 640 premature deaths annually from heart disease and 270 to 420 premature deaths each year among working-age Canadians with diabetes⁶³. From an economic lens, according to Steve Morgan, health economist at the University of British Columbia, universal public drug coverage has the potential of⁶⁴:

- Decreasing total Canadian spending on prescription drugs by \$7.3 billion

⁶¹ Morgan SG, Martin D, Gagnon MA, et al. Pharmacare 2020: The future of drug coverage in Canada. Vancouver, Pharmaceutical Policy Research Collaboration, University of British Columbia, 15 July 2015

https://static1.squarespace.com/static/5d4364837cb2650001cd7e1b/t/5d4dc0e3ae5c1700019ae116/1565376740550/2015_Pharmacare2020_MorganEtAl_Report.pdf

⁶² Kratzer J, McGrail K, Strumpf E, Law MR. Cost-control mechanisms in Canadian private drug plans. *Healthc Policy* 2013;9(1):35–43.

⁶³ Lopert R, Docteur E, Morgan S. Body count: The human cost of financial barriers to prescription medications. Canadian Federation of Nurses Unions; 2018.

⁶⁴ Morgan S, Law M, Daw J, Abraham L, Martin D. Estimated cost of universal public coverage of prescription drugs in Canada. *CMAJ*. 2015;187(7):491–497.

- Saving the private sector \$8.2 billion whereas government spending would increase by approximately \$1 billion, with a worst-case estimate of a \$5.4 billion increase 2024, the Pharmacare Act, the legislative framework for this program, was formally introduced and is now publicly available for review.

The Arrival of Canadian Pharmacare Legislation

In early March, an agreement between the New Democratic Party (NDP) and Liberals led to the unveiling of a plan for the initial phase of a national pharmacare initiative. This plan involves the provision of federal support for medications for Canadian citizens. On February 29, 2024, the Pharmacare Act, the legislative framework for this program, was formally introduced and is now publicly available for review.

Limited Scope

Currently, the scope of coverage under the legislation is limited to specific drugs for diabetes and contraception. The Minister of Health is empowered to offer financial support to provinces or territories to enhance their existing public pharmacare coverage for these drugs, provided there is a formal agreement in place between the Minister and province/territory. However, the coverage offered by the province or territory must adhere to the principles of being universal, single-payer, and covering costs from the first dollar. This means that any province or territory seeking funding must ensure that beneficiaries do not incur any out-of-pocket expenses.

The latest federal budget allocated \$1.5 billion toward the implementation of pharmacare, representing a substantial financial commitment that could have broad implications for the country's healthcare system. Interestingly, a recent survey indicated that pharmacare is not a top priority for Canadians. Only 18% of survey respondents indicated that the government should prioritize creating a new, universal, single-payer drug plan. However, among voters with the intention to vote for the Conservative party, only 23% were directly opposed to pharmacare⁶⁵.

⁶⁵ Osman, L. (n.d.). *Pharmacare not the top health priority for most Canadians: survey*. CTV News.

The Potential to Prioritize Children and Youth

Approximately 50% of Canadian children need at least one prescription medication annually, with the average child receiving four prescriptions per year⁶⁶. While prescription drug usage is widespread among young individuals, it notably differs from patterns observed in adults⁶⁷. While many adults, particularly seniors, depend on multiple prescription medications to manage chronic illnesses, children predominantly receive antibiotics for short-term treatment⁶⁸. The medication usage patterns for young individuals with chronic conditions exhibit a greater diversity compared to adults. For example, the most frequently prescribed medication for a chronic condition in pediatric patients, such as an inhaler for asthma treatment, is utilized by only 6% of children⁶⁹. In contrast, nearly half of patients aged 65 and older use statins, the most common prescription drug for treating high cholesterol⁷⁰.

7.2 Importance of Mental Health Services in Canadian Healthcare

The World Health Organization reports that around 450 million people currently struggle with mental health concerns reflecting the current crisis state. In Canada, more than 6.7 million people, roughly 1 in two Canadians, have or have had experiences with mental health concerns displaying alarming statistics that highlight the need for mental health services in Canadian Healthcare. The prevalence of mental illness in Canada has negative impacts and has been identified as a leading comorbidity and cause of disability in the country preventing close to 500,000 employees from working and increasing the disability cost of leave as a result of mental illness. This economic burden reflects an estimated \$51 Billion including the cost of health care and loss of productivity. Despite roughly 1 in 5 Canadians experiencing a mental illness each year, many are forced to wait for the care they need or don't receive services at all. Due to the high prevalence of individuals suffering from mental health concerns and or diagnosed mental illness, the current mental health epidemic reflects the importance of mental health services in Canadian healthcare. One case for concern is a lack of accessibility for mental health services, specifically nearly 75% of children with mental illnesses do not have access to specialized treatment services. Despite accounting for 10% of the burden of disease in Ontario, mental illnesses only receive 7% of health care funding widening the gap

⁶⁶ Canadian Institute for Health Information. National Health Expenditure Trends, 1975 to 2018. November 2018.

www.cihi.ca/en/health-spending/2018/national-health-expenditure-trends

⁶⁷ Canadian Institute for Health Information. Prescribed Drug Spending in Canada, 2018.

<https://www.cihi.ca/en/health-spending/2018/prescribed-drug-spending-in-canada>

⁶⁸ Chai G, Governale L, McMahon AW, Trinidad JP, Staffa J, Murphy D. Trends of outpatient prescription drug utilization in US children, 2002-2010. *Pediatrics* 2012;130(1):23-31.

⁶⁹ Hales CM, Kit BK, Gu Q, Ogden CL. Trends in prescription medication use among children and adolescents-United States, 1999-2014. *JAMA* 2018;319(19):2009-20.

⁷⁰ Canadian Institute for Health Information. Prescribed Drug Spending in Canada, 2018.

<https://www.cihi.ca/en/health-spending/2018/prescribed-drug-spending-in-canada>

to access even further⁷¹. However, meeting the mental health needs of children and youth in Canada can effectively help build a foundation for the health and well-being of the growing population. With troubling statistics for youth and adolescents, Canadians 18 and older reporting a diagnosis of depression, anxiety, or other mental health condition, from 20% in 2016 (CMWF average: 14%) to 29% in 2023 (CMWF average: 25%). Mental health issues will directly impact 43% of Canadians over their lifetime, therefore, mental health services are of crucial importance for all age groups. Despite the knowledge, statistics, and information surrounding the prevalence of mental health concerns and the importance of mental health care services in Canada, many individuals struggle with barriers to accessing mental health services if even accessing them at all⁷².

7.3 Strategies for Enhancing Access to Mental Health Support

Barriers to accessing services across Canada include patients' lack of knowledge on access to these services, long wait times, shortage of accessible mental health professionals, a lack of mental health services integrated into government oversight, cultural and language barriers, concern of stigma, inequities due to geographical demographics, and cost of services not covered by private insurance plans⁷³. One of the larger barriers Canadians reportedly face when accessing mental health care services is due to financial barriers related to costs and a lack of knowledge and awareness on how to find or access services appropriately.

Mental health services are not currently fully covered by public health insurance leading to Canadians predominantly paying out-of-pocket to access mental health services such as counselling. Despite the desire, Canadians cite cost as their barrier to accessing mental services in need. The Commonwealth Fund average reflects a proportion of 11% of adults who don't get mental health services when needed cite cost as their barrier while Canada reports the third highest need at 15% of adults. While the cost of mental health services poses a crucial barrier for Canadians accessing equitable care, a large portion of the individuals who do not receive mental health services additionally report the experience of other forms of economic stress reflecting high stressors in the cost of housing and stable income. With nearly 71% of these Canadians diagnosed with mental health concerns, nearly half report a household income lower than \$60,000. However, virtual health care presents a potential avenue to access mental health services at

⁷¹ *The Crisis is Real*. (n.d.). CAMH.

<https://www.camh.ca/en/driving-change/the-crisis-is-real>

⁷² CHANGING DIRECTIONS, CHANGING LIVES: THE MENTAL HEALTH STRATEGY FOR CANADA. (n.d.). In *The Mental Health Commission of Canada*. Retrieved June 4, 2024, from

https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/MHStrategy_StrategyText_ENG_0_1.pdf

⁷³ Moroz, N., Moroz, I., & D'Angelo, M. S. (2020, November). Mental health services in Canada: barriers and cost-effective solutions to increase access. In *Healthcare management forum* (Vol. 33, No. 6, pp. 282-287). Sage CA: Los Angeles, CA: SAGE Publications.

a lower cost⁷⁴. Moreover, both uptake of and satisfaction with virtual mental health services were significantly higher among Canadian adults than among adults in other countries surveyed, therefore leading to a possible solution for Canadians struggling with mental health concerns.

⁷⁴ *Canadian Institute for Health Information*. (2024, May 2). CIHI.
<https://www.cihi.ca/en>

Section 8. Provincial Healthcare Performance Analysis

8.1 A Comparison of Healthcare Outcomes Across Provinces

The Conference Board of Canada has curated a provincial health report card that summarizes several health indicators including life expectancy, self-reported health, and mortality due to various health-related diseases⁷⁵. Canada achieves an overall "B" grade on the health report card, ranking 8th out of 16 comparable countries. The only "A" grades Canada earns are in self-reported health indicators. For most metrics, Canada receives "B" grades, placing it in the middle tier among peer nations. The areas of greatest concern are infant mortality and diabetes-related mortality, where Canada scores "C"s.

Exhibit 28. Report card for Canada published by The Conference Board of Canada.

REPORT CARD														
Health Indicators														
	Canada	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Yukon	N.W.T.	Nunavut
Life expectancy	B	C	C	C	B	B	A	C	D	B	A	D-	D-	D-
Premature mortality	B	B	B	B	B	A	A	D	D	B	A	C	D-	D-
Infant mortality	C	D	B	C	B	C	C	D-	D-	D	B	C	D-	D-
Self-reported health	A	A	A	A	A	A+	A+	A+	A	A+	A	A	A+	A
Self-reported mental health	A	A	B	B	B	A	A	A	A	A	B	B	B	D
Mortality due to cancer	B	D	C	D	C	C	B	C	B	A	A	D-	D-	D-
Mortality due to heart disease and stroke	B	C	C	B	B	A	B	B	B	C	B	B	C	A
Mortality due to respiratory diseases	B	C	C	C	C	B	B	B	B	B	B	D	D	D-
Mortality due to diabetes	C	D-	B	C	C	B	C	D	D	B	C	D-	A	A+
Mortality due to nervous system diseases	B	B	B	B	B	B	B	B	B	B	B	B	A	A
Suicides	B	B	A	B	B	B	A	B	C	B	B	A	C	D-

Note: Data for the most recent year available were used. For details on methodology and data sources, see the "Methodology & Data" section of this website.
Source: The Conference Board of Canada.

Source: The Conference Board of Canada

⁷⁵ Health. (n.d.). The Conference Board of Canada. Retrieved June 4, 2024, from <https://www.conferenceboard.ca/hcp/health-asp/>

Health Spending

Canada got a B overall and several territories received a failing grade.

Health spending per person varies among the provinces and territories, and it is highest in the territories.

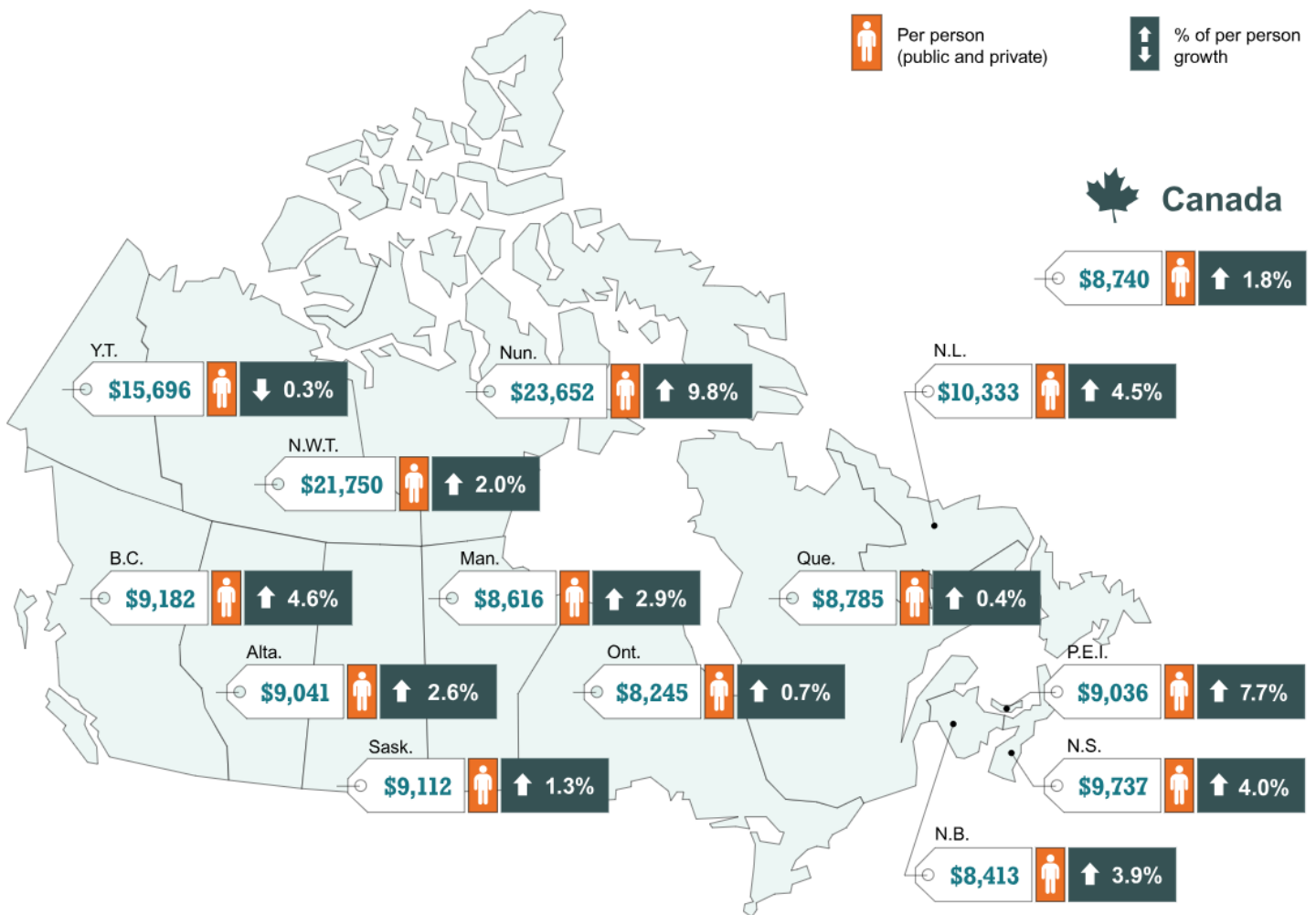
Here are the 2023 forecasts for per-person spending and the corresponding growth rates for Canada as a whole and for each province and territory [see Exhibit 16].

- Canada: \$8,740 per person; 1.8% increase
- Newfoundland and Labrador: \$10,333 per person; 4.5% increase
- Prince Edward Island: \$9,036 per person; 7.7% increase
- Nova Scotia: \$9,737 per person; 4.0% increase
- New Brunswick: \$8,413 per person; 3.9% increase
- Quebec: \$8,785 per person; 0.4% increase
- Ontario: \$8,245 per person; 0.7% increase
- Manitoba: \$8,616 per person; 2.9% increase
- Saskatchewan: \$9,112 per person; 1.3% increase
- Alberta: \$9,041 per person; 2.6% increase
- British Columbia: \$9,182 per person; 4.6% increase
- Yukon: \$15,696 per person; 0.3% decrease
- Northwest Territories: \$21,750 per person; 2.0% increase
- Nunavut: \$23,652 per person; 9.8% increase

Cardiovascular Disease Related Mortality Rates

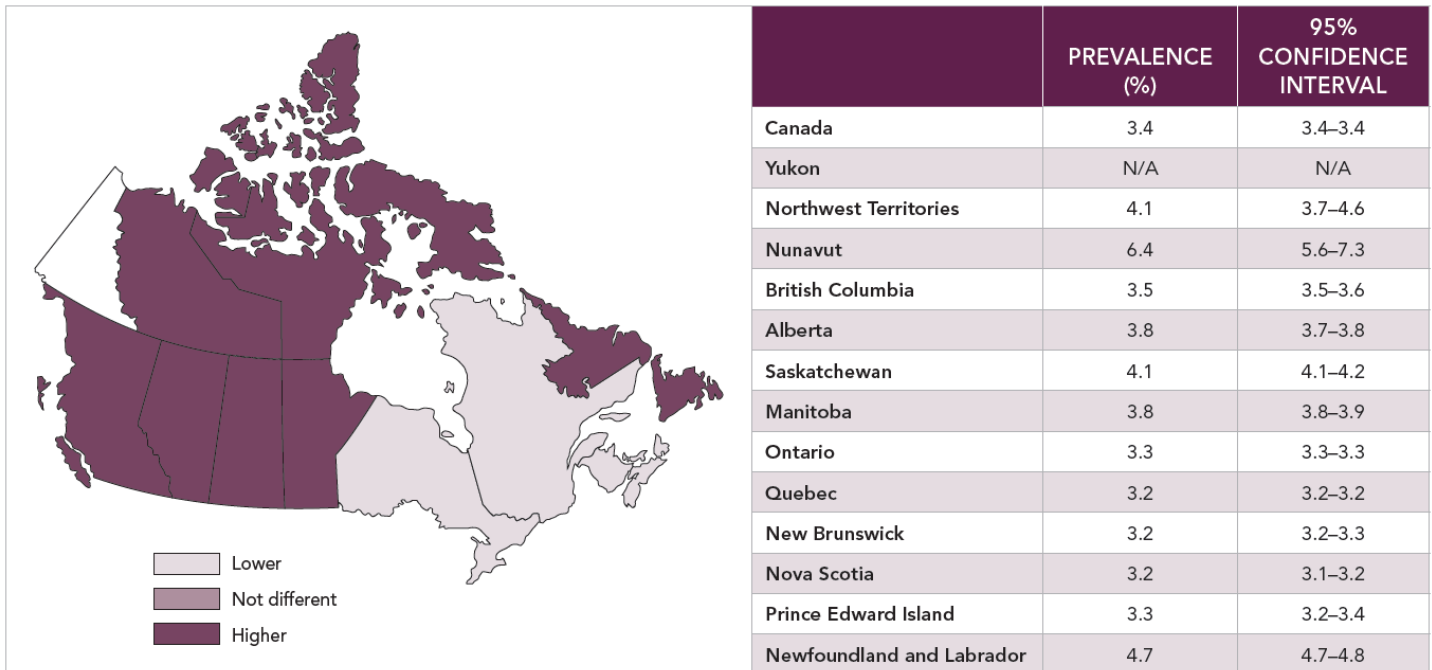
Cardiovascular disease (CVD) is the leading cause of death in Canada and is associated with significant regional variations in its mortality rates across Canada. A report from the Canadian Chronic Disease Surveillance System: Heart Disease in Canada found that age-standardized heart failure prevalence ranged from a low of 3.2% in Quebec, New Brunswick and Nova Scotia to a high of 6.4% in Nunavut.

Exhibit 29. Health spending in Canada, how do the provinces and territories compare?⁷⁶



⁷⁶ How do the provinces and territories compare? | CIHI. (n.d.). <https://www.cihi.ca/en/how-do-the-provinces-and-territories-compare>

Exhibit 30. Age standardized prevalence of diagnosed heart failure, among Canadians ages 40 years and older, by province or territory, 2012-2013.



† Age-standardized to the 2011 Canadian population.

* Data from Yukon were not available.

NOTES: The 95% confidence interval shows an estimated range of values which is likely to include the true value 19 times out of 20.

SOURCE: Public Health Agency of Canada, using Canadian Chronic Disease Surveillance System data files contributed by provinces and territories, May 2016.

Substance Related Disorders

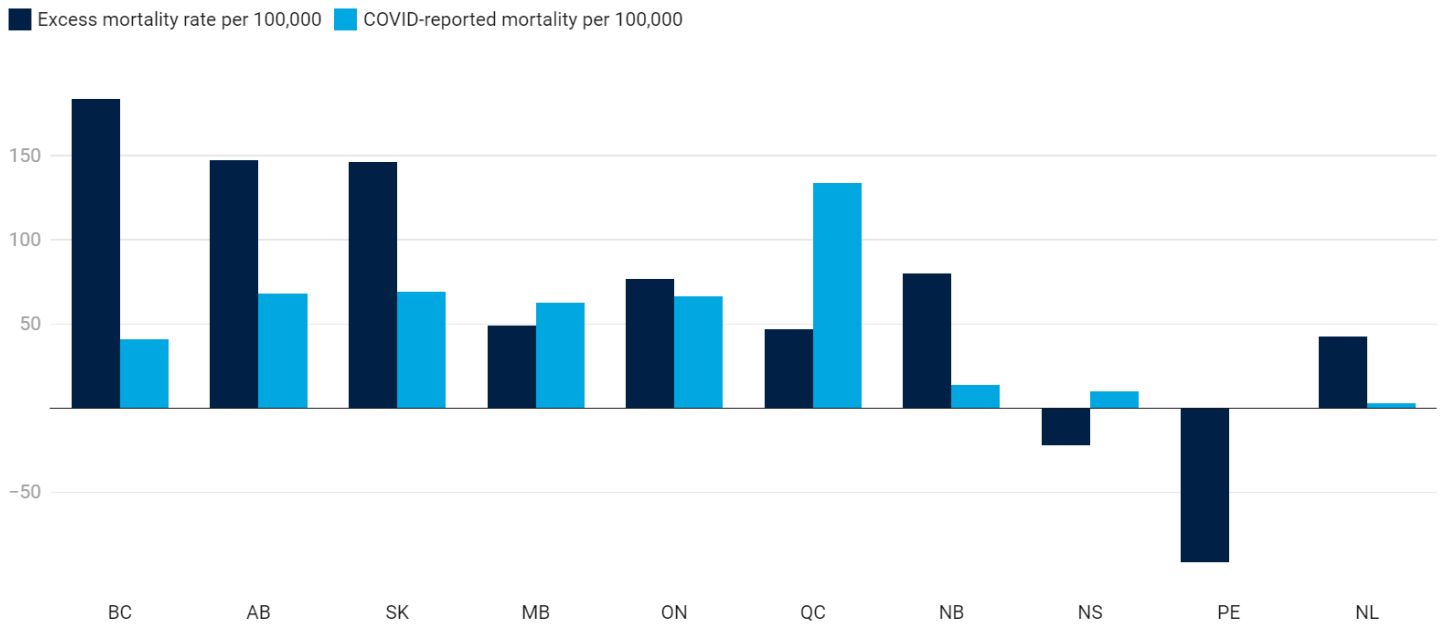
Found an increase in annual recorded substance-related disorders (SRD) diagnostic rates in Alberta, Ontario, and Nova Scotia but a stable rate in Manitoba and Québec. However, cumulative recorded SRD diagnostic rates increased steadily for all provinces.

Excess and COVID-19 Deaths

Excess deaths are defined as “deaths above and beyond what would have been expected under normal circumstances.”⁷⁷

⁷⁷ Dcc. (2022, August 31). A province-by-province look at excess deaths in Canada during the pandemic. *UBC Faculty of Medicine*. <https://www.med.ubc.ca/news/a-province-by-province-look-at-excess-deaths-in-canada-during-the-pandemic/>

Exhibit 31. Excess deaths and COVID-19 deaths by province.



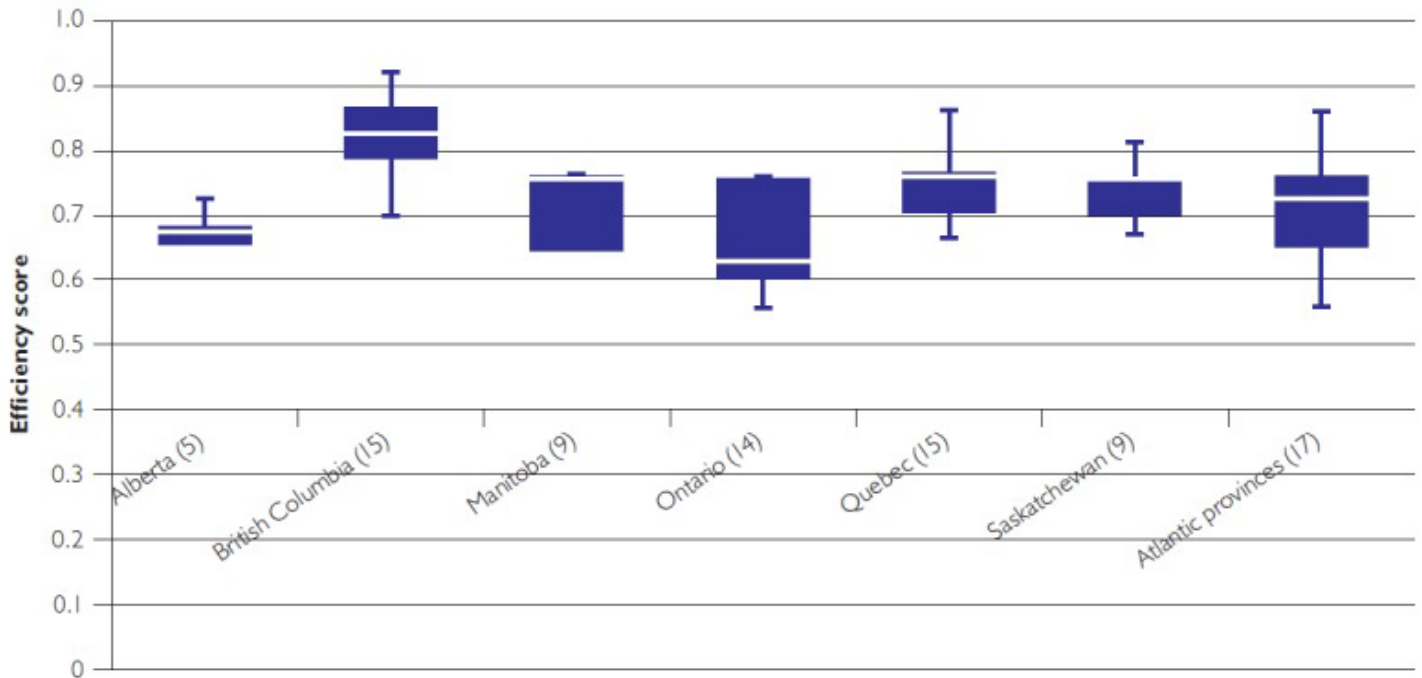
Excess mortality and COVID-reported mortality per 100,000 population, Mar. 14, 2020 to Oct. 23, 2021 (Manitoba only: Mar. 14 2020 to Feb 13, 2021)
 Chart: UBC Media Relations • Source: [Canadian Medical Association Journal](#) • [Embed](#) • [Download image](#) • Created with [Datawrapper](#)

Health System Efficiency

Allin et al. (2015) found significant variations in health system efficiency, as evidenced by the erratic efficiency scores, across the provinces, with British Columbia exhibiting relatively higher scores than the other provinces⁷⁸.

⁷⁸ Allin, S., Veillard, J., Wang, L., & Grignon, M. (2015). How can health system efficiency be improved in Canada?. *Healthcare Policy*, 11(1), 33.

Exhibit 32. Summary of efficiency scores by province, including median, 25th and 27th percentiles (the number of regions in parentheses).



Note: Atlantic provinces include Newfoundland, New Brunswick, Nova Scotia and Prince Edward Island

8.2 Case Study: Quebec’s Healthcare Model and Private Insurance for Medicare

In Canada, the debate over healthcare privatization is significantly influenced by the prohibition of private health insurance for medically necessary services⁷⁹. Traditionally, private health insurance in Canada is restricted to services not covered under provincial public health plans, as mandated by the 1984 Canada Health Act⁸⁰. Six provinces, including Quebec, explicitly ban the purchase of duplicate private health insurance for services already publicly insured⁸¹.

⁷⁹ Flood C. M, Haugan A. Is Canada odd? A comparison of European and Canadian approaches to choice and regulation of the public/private divide in health care. *Health Economics, Policy and Law*. 2010;5:319–341.

⁸⁰ Hurley J. E, Guindon E. G. Private health insurance in Canada [CHEPA working paper 08-04] Hamilton, ON: Centre for Health Economics and Policy Analysis; 2008.

⁸¹ Flood C. M. Chaoulli’s legacy for the future of Canadian health care policy. *Osgoode Hall Law Journal*. 2006;44(2):274–309.

The Chaoulli vs Quebec Case

The pivotal case of *Chaoulli v Quebec* in 2005 marked a significant challenge to these restrictions. Dr. Jacques Chaoulli, a physician from Quebec, alongside his patient, Mr. George Zeliotis, contested the provincial ban on duplicate private health insurance. Mr. Zeliotis, who endured a year-long wait for a hip replacement, argued that his inability to purchase private insurance for expedited treatment infringed upon his rights⁸². The Supreme Court of Canada (SCC), in a narrow 4-3 decision, ruled in favor of Chaoulli and Zeliotis, stating that Quebec's laws preventing the purchase of private insurance violated the Quebec Charter of Human Rights and Freedoms⁸³.

Legislative Response and Market Impact

In response to the SCC's decision, the Quebec National Assembly passed Bill 33 in December 2006. This legislation lifted the ban on private health insurance for three specific surgical procedures: 1) hip replacements, 2) knee replacements, and 3) cataract removals⁸⁴. Concurrently, Quebec implemented a wait time guarantee in 2005, ensuring that if a patient had to wait more than six months for these surgeries, the government would fund their treatment in a private clinic⁸⁵. This guarantee aimed to mitigate equity concerns, as not all residents could afford private insurance. However, it also rendered Bill 33 largely redundant since the publicly funded alternative was available⁸⁶.

Outcomes and Analysis

Despite the legislative changes, the market for duplicate private health insurance did not significantly expand in Quebec or elsewhere in Canada⁸⁷. The wait time guarantee appeared effective in maintaining treatment timelines, with 55% of patients receiving hip replacements within three months and 85% within six months⁸⁸. Data from the Canadian Institute for Health Information in 2010 indicated no substantial

⁸² Tiedemann M. Health Care at the Supreme Court of Canada – II: *Chaoulli v. Quebec* [Report No. PRB 05-31E. Ottawa: Parliamentary Information and Research service; 2005. Oct 05, [April 21, 2024].

⁸³ Flood C. M, Xavier S. Health care rights in Canada: The Chaoulli legacy. *Medicine and Law*. 2008;27(3):617-644.

⁸⁴ Mehra N. Eroding public Medicare: Lessons and consequences of for-profit health care across Canada. 2008.

<http://medicare.ca/wp-content/uploads/2009/05/private-clinics-ohc.pdf>

⁸⁵ Services Quebec. Access to specialized medical services. 2011a. [June 29, 2011]. [Online] Available:

<http://wpp01.msss.gouv.qc.ca/appl/g74web/default.asp>.

⁸⁶ Flood C. M, Xavier S. Health care rights in Canada: The Chaoulli legacy. *Medicine and Law*. 2008;27(3):617-644.

⁸⁷ Hurley J. E, Guindon E. G. Private health insurance in Canada [CHEPA working paper 08-04] Hamilton, ON: Centre for Health Economics and Policy Analysis; 2008.

⁸⁸ Services Quebec. Access to specialized medical services. 2011a. [June 29, 2011]. [Online] Available:

<http://wpp01.msss.gouv.qc.ca/appl/g74web/default.asp>.

change in wait times for hip replacement surgeries from 2006 to 2009, with 88% of patients treated within six months⁸⁹.

The healthcare system in Quebec, and Canada more broadly, operates on a triage basis, prioritizing patients based on the severity of their symptoms rather than the duration of their wait⁹⁰. This approach aims to optimize cost-effectiveness and maximize health service utilization.

The case study of Quebec illustrates the complexities and impacts of lifting bans on private health insurance within a publicly funded healthcare system. While the decision in *Chaoulli v Quebec* prompted legislative changes, these did not significantly alter the landscape of private health insurance due to existing public guarantees and a triage-based healthcare system. Future considerations should focus on ensuring that public guarantees continue to function effectively to maintain equitable access to timely medical care.

8.3 Factors Contributing to Variations in Provincial Performance.

A cross-sectional study by Sibley and Glazier (2009) found that the leading reasons for self-perceived unmet health service needs include problems of availability of services (54.9%) and acceptability (42.8%).⁷⁹ The most prevalent reason associated with service availability was long waiting times. However, this reason was not correlated with the supply of family physicians.

Excess and COVID-19 Deaths

Quebec, Ontario, Alberta, and British Columbia reported the higher number of COVID-19-related mortalities in comparison to the other Canadian provinces. In Quebec and Ontario, neighborhoods with the highest proportions of population groups identified as visible minorities exhibited an age-standardized mortality rate over three times higher than that of neighborhoods with the lowest proportions of such groups.

⁸⁹ Canadian Institute for Health Information. Provincial reporting of wait times in priority areas. 2010. Mar.

http://secure.cihi.ca/cihiweb/products/wait_times_tables_2010_e.pdf

⁹⁰ Gaudet M. -C, Feldmann D. E, Rossignol M, et al. The wait for total hip replacements in patients with osteoarthritis. *Canadian Journal of Surgery*. 2007;50(2):101–109.

Provincial Populations' Lifestyle Habits

The disparity in life expectancy between the easternmost Canadian provinces, specifically the Atlantic provinces of New Brunswick, Nova Scotia, Prince Edward Island, and Newfoundland and Labrador, compared to other provinces, is evident in their elevated rates of smoking, lack of physical activity, hypertension, and obesity⁹¹. Conversely, British Columbia, positioned as Canada's westernmost province, consistently exhibits the lowest prevalence of these factors⁹².

Immigration Status

The demographic composition of each province's population also provides insight into regional mortality differences in Canada. Previous research using Canadian data has shown that immigrants typically have lower mortality rates compared to those born in Canada. Therefore, the larger proportion of immigrants in the total population of Western provinces, particularly British Columbia, compared to Atlantic provinces, is likely to contribute to better overall mortality outcomes in the former. Moreover, immigrants in Western provinces, particularly those originating from non-European countries like Asia, may experience even lower mortality rates than their counterparts in Atlantic provinces.

Public Home Care Services

Home Care Service Eligibility Criteria

Each Canadian province or territory is responsible for establishing their own eligibility criteria for public home care services⁹³. Hence, there are varied client characteristics and care needs once older adults begin seeking or using home care services⁹⁴. One study found that Nova Scotian clients had significantly greater care and service requirements upon admission to home care relative to clients in Manitoban clients⁹⁵.

⁹¹ *Life expectancy and other elements of the complete life table, single-year estimates, Canada, all provinces except Prince Edward Island.* (2023, November 27).

<https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310083701>

⁹² *Life expectancy and other elements of the complete life table, single-year estimates, Canada, all provinces except Prince Edward Island.* (2023b, November 27).

<https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310083701>

⁹³ Hébert PC, Morinville A, Costa A, Heckman G, Hirdes J. Regional variations of care in home care and long-term care: a retrospective cohort study. *CMAJ Open*. 2019;7(2):E341–50.

⁹⁴ Canadian Institute for Health Information. Quick stats. Available from:

https://www.cihi.ca/en/quick-stats?field_type_of_quick_stats_tid=All&field_topic_tid=All&items_per_page=10&or%20der=field_type_of_quick_stats&sort=desc

⁹⁵ Hébert PC, Morinville A, Costa A, Heckman G, Hirdes J. Regional variations of care in home care and long-term care: a retrospective cohort study. *CMAJ Open*. 2019;7(2):E341–50.

Moreover, accessibility to home care programs may be varied due to insufficient services to meet the demand.

Home Support Service Delivery Method

In Nova Scotia, the delivery of home support services is outsourced to private agencies, whereas the Winnipeg Regional Health Authority (WRHA) utilizes internal health authority staff for this purpose. In Nova Scotia, where private agencies handle service delivery, the connection between waiting for home support services and higher care needs is not well-established. Nonetheless, it's conceivable that waitlists have contributed to a decline in clients' functional capacity and could partially account for the higher rates of discharge to long-term care (LTC) facilities among the Nova Scotia cohort after the first year of receiving home care⁹⁶.

Free Structure

Although nursing services are provided to both jurisdictions' home care clients at no cost, Nova Scotian clients must pay a fee for services based on their net household income up to a monthly maximum whereas Manitoban clients do not⁹⁷.

Poor Health Outcomes Among Indigenous Peoples Populations

The disproportionate health impacts on Indigenous Peoples may influence the overall health outcome results for the territories, particularly in the Northwest Territories and Nunavut. According to the 2021 Census by Statistic Canada, there are 20,035 Indigenous people, accounting for 49.6% of the total Northwest Territories population⁹⁸. Indigenous communities often face higher levels of poverty, unemployment, and inadequate housing compared to non-Indigenous populations. These socioeconomic determinants are closely linked to health, influencing access to nutritious food, healthcare services, and clean water.

⁹⁶ Young, Calvin, Melissa Walter, and Francesca Brundisini. "CADTH Health Technology Review Telephone Triage Services in Canada."

⁹⁷ Young, Calvin, Melissa Walter, and Francesca Brundisini. "CADTH Health Technology Review Telephone Triage Services in Canada."

⁹⁸ Indigenous Peoples 2021 Census. (2022). In *Newstats NWT Bureau of Statistics Released*. Retrieved June 5, 2024, from https://www.statsnwt.ca/census/2021/Census_IndigenousPeoples.pdf

Section 9. Improving Healthcare Delivery and Access

9.1 Summary of Key Challenges

According to a 2022 survey, the most notable challenges which hindered healthcare delivery in Canada were the shortage of healthcare workers (63%), lengthy waiting times (47%), aging population (29%) and bureaucracy (20%)⁹⁹. A report published in December 2023, showed that Canada also had low primary care attachment in comparison with other EU countries¹⁰⁰.

9.2 Addressing Primary Care Attachment

Primary care is the sector comprising family physicians and nurse practitioners, covering a range of integrated healthcare services for families and communities¹⁰¹. Studies show that high primary care attachment is associated with better health outcomes and reduced inequities¹⁰². In terms of primary care, Canada is the worst among other EU countries, with only 80% of the population access to a primary care provider.

One particular study looked at the differences in primary care models between Canada and the EU (Finland, Netherlands, Norway and United Kingdom).⁹² In all of these systems, primary care goals are established and funded by the national government. Whereas in Canada, primary care is a private practice not accountable for population needs, location, timings, services offered and types of staff. By increasing government international and contractual agreements, this would ensure that the population's needs are being met.

The next step in this process is to increase government spending with a greater budget for primary care operations and physicians. Simultaneously, this would allow for the recruitment of more physicians and

⁹⁹ *Problems with national health care system in Canada 2022*. (2023, September 28). Statista.

<https://www.statista.com/statistics/736176/top-healthcare-system-issues-in-canada/>

¹⁰⁰ Shahaed, H., Glazier, R. H., Anderson, M., Barbazza, E., Bos, V. L., Saunes, I. S., Auvinen, J., Daneshvarfard, M., & Kiran, T. (2023b). Primary care for all: lessons for Canada from peer countries with high primary care attachment. *CMAJ. Canadian Medical Association Journal*, 195(47), E1628–E1636.

<https://doi.org/10.1503/cmaj.221824>

¹⁰¹ Donaldson, M. S., Yordy, K. D., Lohr, K. N., & Vanselow, N. A. (1996). *Defining Primary Care*. Primary Care - NCBI Bookshelf.

<https://www.ncbi.nlm.nih.gov/books/NBK232631/>

¹⁰² Shahaed, H., Glazier, R. H., Anderson, M., Barbazza, E., Bos, V. L., Saunes, I. S., Auvinen, J., Daneshvarfard, M., & Kiran, T. (2023c). Primary care for all: lessons for Canada from peer countries with high primary care attachment. *CMAJ. Canadian Medical Association Journal*, 195(47), E1628–E1636.

<https://doi.org/10.1503/cmaj.221824>

increase the overall number of physicians per capita. More spending would also mean greater interest and budget

Lastly, improved organization is required in all aspects of the healthcare model from both macro and micro perspectives. A central management system for all healthcare information would allow for continued care if an individual moves to a new location. This would improve patient-physician communication and integration between different healthcare components. The next part of organization comes directly from the primary care setting through an interprofessional team consisting of nurses, general practitioners, physiotherapists and psychologists. In Finland and Norway, patients are first triaged by a nurse over phone call who then recommends appropriate next steps. Typically, there is a strong practice of gatekeeping specialty and emergency services, alleviating burden on the system. Additionally, there is a comprehensive system to provide 24-hour and after-hours care service. Many of these above-mentioned practices are nonexistent in Canada.

Advancing primary care systems in Canada will not only address current challenges such as lengthy wait times and emergency department overcrowding but also reduce health disparities and improve overall healthcare accessibility for all Canadians.

9.3 Addressing Wait Times

The biggest concern about the Canadian healthcare system is the lengthy wait times, often up to 27.4 weeks for a medical procedure¹⁰³. Additionally, 18% of Canadians wait more than four months for elective non-urgent surgery and 30% wait more than two months for specialist referrals¹⁰⁴. The reasons may vary including limited specialty care, staff shortages, high patient volumes and financial limits¹⁰⁵.

Some literature suggests that a lack of primary care access can help reduce waiting times in the emergency department¹⁰⁶. 5 million or one in six Canadians lack access to a family doctor, forcing them to depend on walk-in clinics and emergency services for care, subsequently increasing patient flow in emergency

¹⁰³ *Waiting Your Turn: Wait Times for Health Care in Canada, 2022 Report*. (2023, November 23). Fraser Institute. <https://www.fraserinstitute.org/studies/waiting-your-turn-wait-times-for-health-care-in-canada-2022>

¹⁰⁴ Martin, D., Miller, A. P., Quesnel-Vallée, A., Caron, N. R., Vissandjée, B., & Marchildon, G. P. (2018). Canada's universal health-care system: achieving its potential. *Lancet*, *391*(10131), 1718–1735. [https://doi.org/10.1016/s0140-6736\(18\)30181-8](https://doi.org/10.1016/s0140-6736(18)30181-8)

¹⁰⁵ *Waiting Your Turn: Wait Times for Health Care in Canada, 2022 Report*. (2023b, November 23). Fraser Institute. <https://www.fraserinstitute.org/studies/waiting-your-turn-wait-times-for-health-care-in-canada-2022>

¹⁰⁶ Flood, C. M., Thomas, B., & McGibbon, E. (2023, September). Canada's primary care crisis: federal government response. In *Healthcare Management Forum* (Vol. 36, No. 5, pp. 327–332). Sage CA: Los Angeles, CA: SAGE Publications.

rooms¹⁰⁷. The situation is further exacerbated by the slow growth rate of family physicians, partly due to economic incentives favoring specializations. Moreover, a single physician retirement leads to 1000 people losing a family doctor. Therefore, increasing primary care physicians may provide one solution to reducing hospital wait times.

Some people propose that diverting services to private clinics can decrease surgical wait times, by reducing demand on the public system¹⁰⁸. However, this approach would favor individuals who can afford private services. Physicians would also distribute their time between private and public sectors, increasing their workload and spending less time on the publicly funded side. Overall, this would provide only temporary relief in wait times, and increase physician workload, before resources are saturated again.

Instead, promoting preventative care and healthy lifestyles can be implemented as a demand-side measure to reduce wait times. For instance, education on healthier lifestyles can reduce demand for medical procedures and treatments, reducing strain on the system. Knowledge dissemination of available healthcare services can help direct individuals towards appropriate care and discourage unnecessary visits. This strategy should be designed to be accessible to a diverse population by taking ethnic, linguistic and cultural factors into account.

9.4 Facilitating Fast-Track Processes for Foreign Healthcare Professionals.

By expediting the recognition of foreign credentials, Canada stands to bolster its economy, foster quality employment opportunities, and ensure a sustainable healthcare workforce. Presently, even individuals with bachelor's degrees often struggle to secure employment commensurate with their skills due to existing barriers.

Canadian-born foreign-trained doctors find it very difficult to practice in Canada. The process for receiving the appropriate credentials include: a medical school degree, residency training, write a licentiate from the Medical Council of Canada and be certified either through the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College of Family Physicians of Canada (CFPC)¹⁰⁹. Cumulatively, this process can span several years, presenting a significant barrier and deterrence to entry for foreign-trained doctors seeking to practice in Canada.

¹⁰⁷ Glazier, R. H. (2023). Our role in making the Canadian health care system one of the world's best: how family medicine and primary care can transform—and bring the rest of the system with us. *Canadian Family Physician*, 69(1), 11.

¹⁰⁸ Lee, S. K., Rowe, B. H., & Mahl, S. K. (2021). Increased private healthcare for Canada: is that the right solution?. *Healthcare Policy*, 16(3), 30.

¹⁰⁹ Helmi, F., & Helmi, F. (2024, March 27). *How to Immigrate to Canada as a Doctor | Arrive*. Arrive.

<https://arrivein.com/career-ca/how-to-immigrate-to-canada-as-a-doctor/>

In the 2022 budget, Canada proposed a \$30 million investment in the foreign credential recognition program, signaling a commitment to addressing this issue. As part of this initiative, the Canadian government has devised a plan to accelerate accreditation for internationally educated health professionals (IEHPs), prompted by labor shortages and protracted wait times. This funding encompasses \$86 million allocated to 15 organizations nationwide, aimed at expanding the capacity for foreign credential recognition. Specifically, the program targets highly educated health professionals, such as midwives, facilitating their ability to undertake virtual examinations. The overarching objective of these projects is to enhance accessibility to credential recognition, furnish relevant work experiences, and enhance labor mobility across jurisdictions. Various healthcare departments, including nursing, pharmacy, dentistry, laboratory technicians, and respiratory therapy, will benefit from this funding, underpinning a comprehensive approach to addressing workforce shortages and ensuring the seamless integration of internationally trained professionals into Canada's healthcare system.

9.5 Examining Compensation Gaps Among Healthcare Providers.

According to Canada's Human Rights Act, all physicians deserve equal pay for the same work¹¹⁰. Despite these principles, there is a compensation gap between female and male healthcare workers, which persists after factoring hours and patients¹¹¹. Canadian physicians are paid through a fee-for-service model where physicians are paid for specific services or medical procedures.

Approximately 70% of compensation for physicians occurs through a fee-for-service model. At first glance, there may not be any evident disparities. However, with a closer examination of individual procedures, the disparity becomes clearer. For instance gynecologic procedures are typically performed by female doctors and urologic procedures by male doctors. One particular study found that gynecologic procedures were paid 28% less than urologic procedures. The solution to this issue would be to implement a uniform billing distribution between male and female procedures.

¹¹⁰ Ruzycki, S. M., Sunba, S., Ejaredar, M., Yanchar, N., & Daodu, O. (2024). Addressing the root causes of the sex-based pay gap in medicine in Canada. *CMAJ. Canadian Medical Association Journal*, 196(12), E416–E418.

<https://doi.org/10.1503/cmaj.231518>

¹¹¹ *New study reveals doctors in Canada are paid less for surgeries on women.* (n.d.). Sinai Health. Retrieved June 5, 2024, from

<https://www.sinaihealth.ca/news/new-mount-sinai-study-draws-attention-to-surgical-sexism-across-canada/>

9.6 Implementation of Physician Assistant Funding Model

The variability in provincial funding models for Physician Assistants (PAs) poses a significant obstacle to their integration, expansion, and sustainability within Canada's healthcare systems. Opportunities for provincially funded positions are limited, and employer-remunerated models can be financially burdensome if the role is not effectively integrated. This inconsistency in funding approaches often leads to short-term contracts, job insecurity, and limited practice opportunities for PAs within provincial healthcare systems. PAs have the unique opportunity to “supplement physician care, increase patient access to care, and improve efficiencies.”¹¹² Therefore, establishing a funding model that aligns with existing healthcare remuneration structures and supports the employment of PAs across Canada is essential for further integrating this profession into the country's health and care ecosystem.

Delegation of Administrative Tasks

Previous literature has found that entrusting qualified healthcare professionals like Physician Assistants with tasks such as electronic medical records (EMR) documentation and administrative duties, including reviewing and responding to patient laboratory results, can lead to increased satisfaction in their roles and greater effectiveness in practice. Moreover, this delegation has been associated with improved interactions with patients and decreased wait times for patients. However, we argue that in the present landscape, the outlook and potential for PAs are considerably broader.

The primary focus for both PAs and physicians should be patient-facing roles, while administrative duties remain necessary but secondary. Although PAs possess skills and knowledge in administrative tasks, such duties do not fully utilize their extensive clinical training. Instead, administrative responsibilities can be shared with physicians to enhance practice efficiency, while medical scribes are ideally suited for this role. Medical scribes document healthcare professionals' assessments without direct patient care responsibilities or formal training in clinical care. Additionally, with the advancement of AI technology in medical scribing, it is expected to further support PAs in their patient-facing care roles, crucial for realizing the aforementioned benefits.

¹¹² Jones and others, “A Perspective on the Economic Sustainability of the Physician Assistant Profession in Canada.”

Section 10. Canada's COVID-19 Response in Comparison to Global Standards

The onset of the COVID-19 pandemic has especially evoked discussions in both the scientific and public policy spaces surrounding the inequitable distribution of resources in both the developed and developing world. It has also required the international community to recognize how their measures for emergency public health responses have succeeded or failed in response to the pandemic. Prior to the onset of the pandemic, countries were already varied in their levels of pre-existing universal health coverage, preparedness for pandemic situations, and the degree of governmental and public backing for public health initiatives. As the effects of Covid-19 persistently influence societies across various sociopolitical dimensions, it is important to examine how diverse governance systems tackled the complexities of this pandemic could offer insights for policymakers navigating the ongoing management of its economic, physical, mental, and behavioral health repercussions, relying on an ever-evolving body of evidence. In this section, we will be observing Canada's COVID-19 response compared to different nations as well as the strengths and weaknesses demonstrated by certain administrations of governance. In this comparison of Canada to five other Western countries (Italy, Australia, New Zealand, the UK, and the US), this study will evaluate how pandemic responses during COVID-19 have evolved into new pandemic-related protocols and whether these countries are going to be prepared in the event of another global public health catastrophe.

10.1 General Overview of Pre-Pandemic and Pandemic Responses

According to a retrospective study conducted by Poirier et al. (2023) on international conduct during the pandemic, a country's success in their response to COVID-19 was largely dependent on the existing state of their healthcare systems as well as efficiency in national governance structure when it came to mobilizing emergency policy. The robust availability of medical workers and facilities, particularly when paired with universal healthcare, indicated stronger health outcomes and more trust in accessing health facilities when experiencing poor health. Countries such as Canada and the UK operate as single-payer, universal healthcare systems funded by general taxation. Australia similarly relies on comprehensive health services funded primarily through taxation, although approximately 70% of Australia's population also opt for private health insurance either as an employee or as a constituent of an employee,

resulting in a dual-tier healthcare system. This allows privately insured individuals quicker access to hospital care and diagnostic tests, though all citizens still hold a degree of access to fundamental health facilities. In Italy, while the Servizio Sanitario Nazionale (SSN) offers universal coverage, there is also a private healthcare sector in Italy, which provides additional medical services for those who choose to pay for them

out of pocket or through private insurance. However, the majority of Italians rely on the public healthcare system for their medical needs. In contrast, the United States maintains a mixed system of public and private healthcare coverage without guaranteeing universal access. Variations in responses to COVID-19 are influenced by these differences in healthcare systems and governance structures.

In addition to health administration, governance and foreign policy also played a key role in the infection patterns demonstrated between regions. Additionally, before the onset of the COVID-19 pandemic, selective border closures had not demonstrated effectiveness in curbing the spread of emerging infectious diseases like influenza, Ebola, and other coronaviruses. Comprehensive border closures - which focused on restricting

non-essential entry from all countries - were rarely implemented prior to COVID-19, thus yielding limited evidence on their efficacy. However, the rapid global dissemination of COVID-19 sparked renewed discussions regarding the potential of targeted and/or comprehensive border closures in mitigating international pandemic transmission.

10.2 Canada and the Pandemic

COVID-19 cases first appeared in Canada, the UK and the US in late January but lockdowns did not occur until the end of March. Compared with the other G10 countries, Canada performed better than most in terms of percentage of the population receiving 2 doses of a SARS-CoV-2 vaccine, and on measures assessing the direct effect of the pandemic: number of people infected, number who died from COVID-19 and total excess deaths¹¹³. However, the country still faced obstacles during the initial wave of the pandemic. According to Yu et al¹¹⁴, Canada's approach to addressing the challenges posed by COVID-19 revealed shortcomings across various critical domains. These included inadequate attention to long-term care (LTC) facilities, a lack of robust testing strategies, limited medical resources, ineffective public communications, and insufficient funding for biomedical research. These deficiencies, coupled with delayed implementation of pandemic containment measures, potentially hindered Canada's ability to curtail the virus's spread during its initial stages. Moreover, concerns have been raised regarding the mental well-being of healthcare workers and vulnerable populations, underscoring the need for further

¹¹³ Razak, F., Shin, S., Naylor, C. D., & Slutsky, A. S. (2022). Canada's response to the initial 2 years of the COVID-19 pandemic: a comparison with peer countries. *CMAJ*, 194(25), E870-E877

¹¹⁴ Yu, A., Prasad, S., Akande, A., Murariu, A., Yuan, S., Kathirkamanathan, S., ... & Ladha, S. (2020). COVID-19 in Canada: A self-assessment and review of preparedness and response. *Journal of global health*, 10(2).

exploration of mental health interventions. Yu et al. further suggest that the Canadian government may not have been adequately prepared for the pandemic, prompting calls for additional research on early response plans and their impact. Key areas for investigation include the effectiveness of measures such as widespread school closures and international border restrictions in mitigating viral transmission, tailored pandemic control strategies for different regions, and the optimal timing for testing and contact tracing initiatives. Given the potential cost and time efficiencies associated with early intervention, understanding the efficacy of such measures is crucial for minimizing the pandemic's impact.

In Canada, information management efforts faced significant obstacles due to the relatively weaker public health infrastructure at the federal level compared to the country's provincial counterparts. Although the federal government did release an online dashboard providing basic statistics such as case numbers and deaths, national-level epidemiological data suffered from significant delays, with minimal improvement observed until late 2020 June¹¹⁵. For instance, on May 25, 2020, Canada reported 85,679 confirmed cases of Covid-19, but the federal government had comprehensive data for only 40,660 cases¹¹⁶. This lack of comprehensive data reporting can largely be attributed to the autonomy of the provinces; the federal government relied on provincial health authorities for data reporting, and federal agencies historically demonstrated limited expertise in public health¹¹⁷.

¹¹⁵ Public Health Agency of Canada, Epidemiological summary of COVID-19 cases in Canada. AEM 2020.

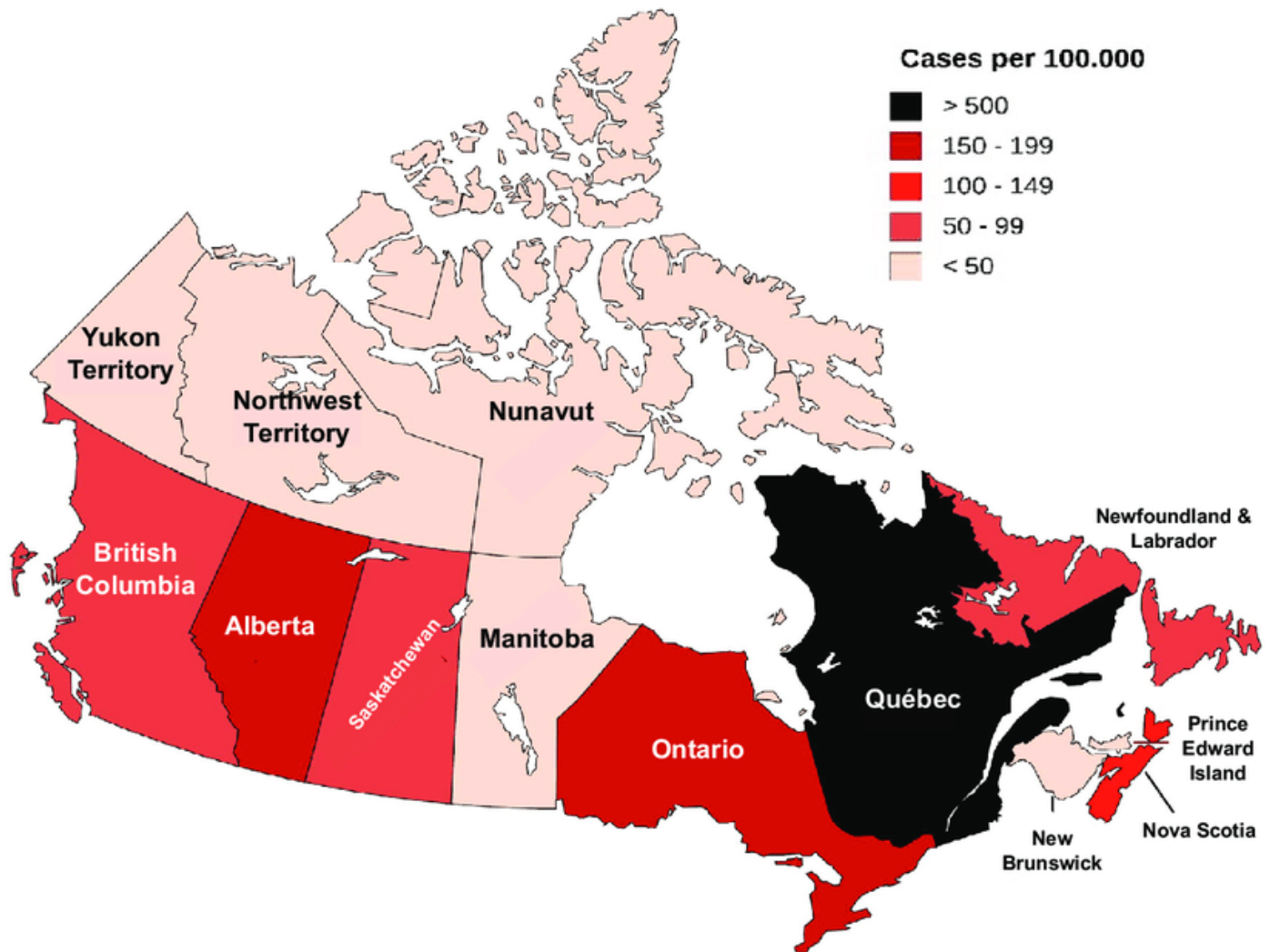
<https://health-infobase.canada.ca/covid-19/epidemiological-summary-covid-19-cases.html>

¹¹⁶ COVID-19 - Situation épidémiologique | Coronavirus Covid-19 n.d.

<https://covid-19.sciensano.be/fr/covid-19-situation-epidemiologique>

¹¹⁷ Razak, F., Shin, S., Naylor, C. D., & Slutsky, A. S. (2022). Canada's response to the initial 2 years of the COVID-19 pandemic: a comparison with peer countries. *CMAJ*, 194(25), E870-E877

Exhibit 33. Heat map showing the regional distribution of COVID-19 cases in Canada.



Source: Des chercheurs dénoncent un «manque criant de données sur la pandémie.

10.3 The United States and the Pandemic

Independent scientists in both the UK and US have voiced concerns regarding the excessive governmental influence exerted on public health organizations and their ability to both contribute to COVID-19 response protocol as well as the dissemination of scientific knowledge¹¹⁸. In the US, the Trump administration even

¹¹⁸ Unruh, L., Allin, S., Marchildon, G., Burke, S., Barry, S., Siersbaek, R., ... & Williams, G. A. (2022). A comparison of 2020 health policy responses to the COVID-19 pandemic in Canada, Ireland, the United Kingdom and the United States of America. *Health Policy*, 126(5), 427-437.

went to the extent of altering scientific guidelines to align more closely with its own perspective, offering advice that directly contradicted the recommendations of scientific experts. In the United States, the greatest contributing factor to COVID-19 pressure came from noncompliance with public health measures such as mask-wearing, social distancing, and lockdowns. This was particularly of concern due to the political divisiveness of the Trump regime wherein the belief held by some individuals was that these measures impinge upon their personal freedoms and rights. This perspective, while understandable given the significant lifestyle changes associated with pandemic containment efforts, has in part been reinforced by certain political factions, resulting in a politicization of adherence to containment measures¹¹⁹.

For instance, following the example of pandemic denial and China scapegoating set by President Trump, a portion of the population continues to question the severity of the pandemic as portrayed by scientists, exhibit racism against the country's AAPI population and perceive the measures as unwarranted infringements on their liberties and rights despite the dissolution of all COVID-19 related policies¹²⁰. Addressing this type of noncompliance may benefit from approaches similar to those employed to combat pandemic fatigue, alongside concerted efforts by public health authorities, communities, and businesses to underscore the importance of adherence to containment measures, potentially reinforced by national or regional mandates¹²¹.

According to Valley, "New York City, with its field hospital in Central Park resembling a scene from a disaster movie, is another testament to the power of uncontrolled virus spread to overwhelm the health system." Figure 2 shows the spread of the COVID-19 virus in a community against response measures (Reff). Its Reff peaked at a staggeringly high value of 8, before the city put a sudden stop to economic activity and went into complete lockdown, which drastically decreased the rate of infection but notably had a severe impact on city's economy in tandem. It took a prolonged and perilous policy battle to finally bring the Reff below 1. Perhaps more than any other city, New York will feel the economic shock of this epidemic for many years to come.

¹¹⁹ Gollwitzer, A., Martel, C., Brady, W. J., Pärnamets, P., Freedman, I. G., Knowles, E. D., & Van Bavel, J. J. (2020). Partisan differences in physical distancing are linked to health outcomes during the COVID-19 pandemic. *Nature human behaviour*, 4(11), 1186-1197.

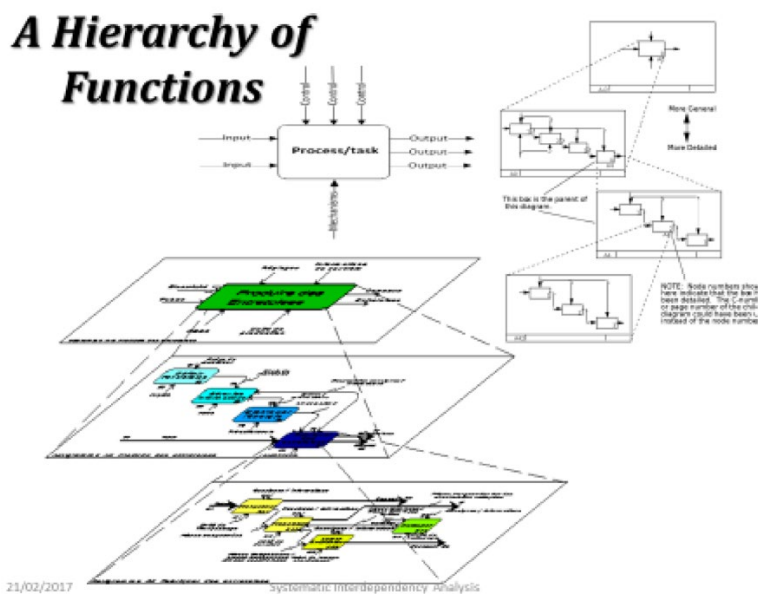
¹²⁰ Arantani L. How did face masks become a political issue in America? *Guardian* 2020. June 29, 2020
<https://www.theguardian.com/world/2020/jun/29/face-masks-us-politics-coronavirus>

¹²¹ Betsch, C., Korn, L., Sprengholz, P., Felgendreff, L., Eitze, S., Schmid, P., & Böhm, R. (2020). Social and behavioral consequences of mask policies during the COVID-19 pandemic. *Proceedings of the National Academy of Sciences*, 117(36), 21851-21853

10.4 The United Kingdom and the Pandemic

The Coronavirus Act granted emergency powers to the government of the United Kingdom to implement non-pharmaceutical interventions (NPIs) and policies to contain the spread of COVID-19 which can slow the rates of transmissions, incidence and prevalence of cases, hospitalizations and deaths as well as ease the burden on resources in the National Health Service (NHS). As COVID-19 spread rapidly throughout the UK in March 2020, all of Northern Ireland, Scotland, Wales and England swiftly implemented similar policies, characterized by comparable levels of strictness in order to protect its citizenship despite the economic and social tension the region was experiencing due to the Brexit issue¹²². These initial measures remained largely consistent throughout April before divergent approaches emerged in May 2020. Scotland consistently maintained the strictest policies and restrictions for much of the pandemic, while Wales and Northern Ireland adopted intermediate measures. In contrast, England began easing restrictions in mid-May and subsequently maintained relatively lower levels of strictness. By late 2020, the UK witnessed a resurgence in cases, prompting England to reinstate stringent policies in alignment with those enforced by the Scottish government. Other parts of the UK also chose implementations of "circuit breaker" style restrictions which is shown in Figure 3 below and which have resulted in both Northern Ireland and Wales surpassing Scotland in terms of stringency.

Exhibit 34. The Structured Analysis and Design Technique (SADT) schematic of nested functional boxes



¹²² Cameron-Blake, E., Tatlow, H., Wood, A., Hale, T., Kira, B., Petherick, A., & Phillips, T. (2020). Variation in the response to COVID 19 across the four nations of the United Kingdom. Blavatnik School of Government, University of Oxford, 2020-10

Within this framework Slater et al¹²³. explain that the following functions were meant to be performed:

- Infection control in the University Hospital for Wales Emergency Department during the pandemic and its recovery
- Responding to the intensive care challenges of COVID-19 in Man- Chester¹²⁴
- The management of team performance - the prolonged effects of crisis on the responders – Epsom and St. Hillier
- The specification, adaptation and supply of personal protective equipment – Business School - Cardiff
- The Development of guidance for rapidly manufactured ventilators - CIEHF
- The primary care outcomes – Glasgow

10.5 Italy and the Pandemic

Italy had experienced a slow rise but intense sudden onset of the COVID-19 crisis by the end of 2020, well into 2021 and it was overall slow to respond to the pandemic as well. This led to an explosion of cases which overwhelmed the health system, particularly in the country's north. Italy's death toll of over 27,000 serves to demonstrate what can happen if viruses are allowed to spread unchecked and if public health officials neglect their duties to the citizens from the get-go, even if strict measures are brought in later. According to Sanfelici, Italy followed different stages of the crisis management cycle: disaster mitigation (risk assessment, prevention, preparedness) and disaster response (relief, rehabilitation, reconstruction) when they had begun to mobilize against the virus, though this framework did have regional differences that accounted for the various geographical differences in the area. They particularly chose to address protections for vulnerable populations such as older persons, children and low SES individuals who were at a significantly higher risk of mortality and severe diseases following COVID-19 infection¹²⁵. Budget reductions have predominantly targeted public hygiene services, according to Signorelli et al.¹²⁶. The primary care sector had received limited attention from reform efforts and policy initiatives because the

¹²³Slater, D., Hollnagel, E., MacKinnon, R., Sujana, M., Carson-Stevens, A., Ross, A., & Bowie, P. (2022). A systems analysis of the COVID-19 pandemic response in the United Kingdom—Part 1—The overall context. *Safety Science*, 146, 105525.

¹²⁵Sanfelici, M. (2020). The Italian response to the COVID-19 crisis: lessons learned and future direction in social development. *The International Journal of Community and Social Development*, 2(2), 191-210.

¹²⁶Signorelli, C., Odone, A., Bianco, D., Di Vivo, N., & Beveri, F. (2016). Health expenditure for prevention in Italy (2006-2013): descriptive analysis, regional trends and international comparisons. *Epidemiologia e prevenzione*, 40(5), 374-380.

NHS was already a robust source of medical administration¹²⁷. Nevertheless, these sectors still proved crucial during the response phase of the pandemic; particularly in regions where community-centered healthcare approaches were well-established. These regions which have more public access to healthcare services demonstrated greater efficacy in pandemic response¹²⁸. In some regions, pandemic response prioritized extensive testing of both symptomatic and asymptomatic cases, proactive tracing of potential positives, and enhanced emphasis on home diagnosis and care. Such policies are believed to have significantly alleviated the strain on hospitals and reduced the risk of COVID-19 transmission within medical facilities, a challenge more prevalent in other parts of the country, where a hospital-centric approach was adopted.

10.6 Australia and the Pandemic

Australia's response to the COVID-19 pandemic has been widely regarded as effective, marked by swift and decisive measures to contain the spread of the virus. Particularly, being an island nation, Australia was able to swiftly implement strict border controls early in the pandemic, restricting entry for non-citizens and non-residents, and enforcing mandatory quarantine for returning travellers. A study by MacIntyre et al.¹²⁹ highlights the effectiveness of border closures in preventing widespread transmission. When these closures were enacted in March 2020, they served to restrict entry into the country for non-citizens and non-residents, effectively limiting the potential importation of the virus from overseas.

Additionally, Australia was one of the first non-Asian countries to mandate that returning Australian citizens and residents were required to undergo a 14-day mandatory quarantine upon arrival in government-managed facilities. This approach aimed to prevent community transmission by ensuring that individuals arriving from high-risk regions did not introduce the virus to the local population. Furthermore, the border closures were periodically adjusted in response to evolving epidemiological conditions and emerging variants of concern. Australia also managed to successfully implement social distancing measures during the pandemic with little population dissidence. The following Reff chart demonstrates

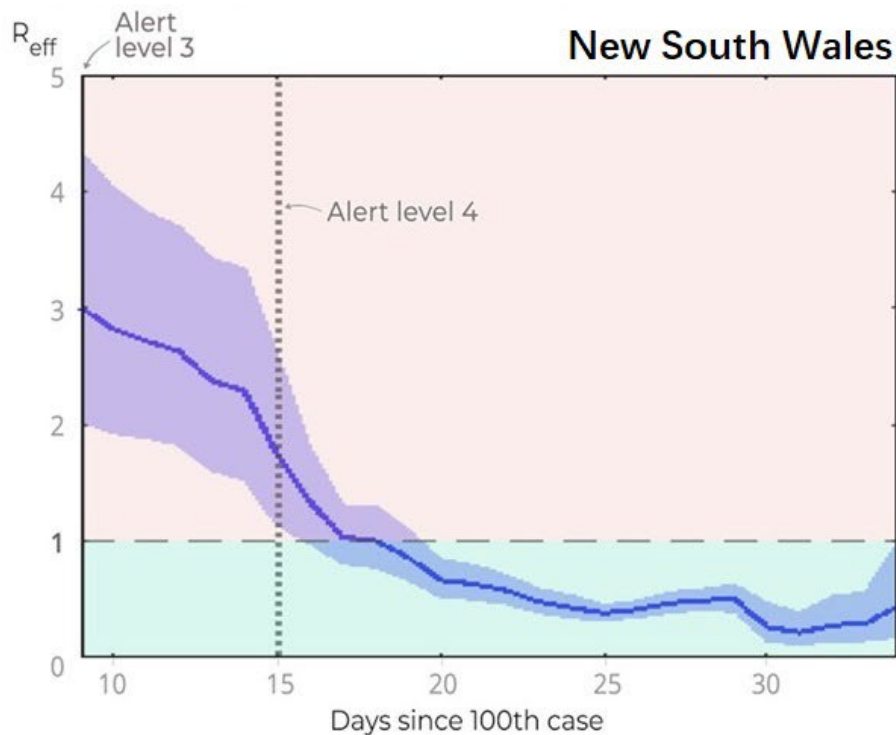
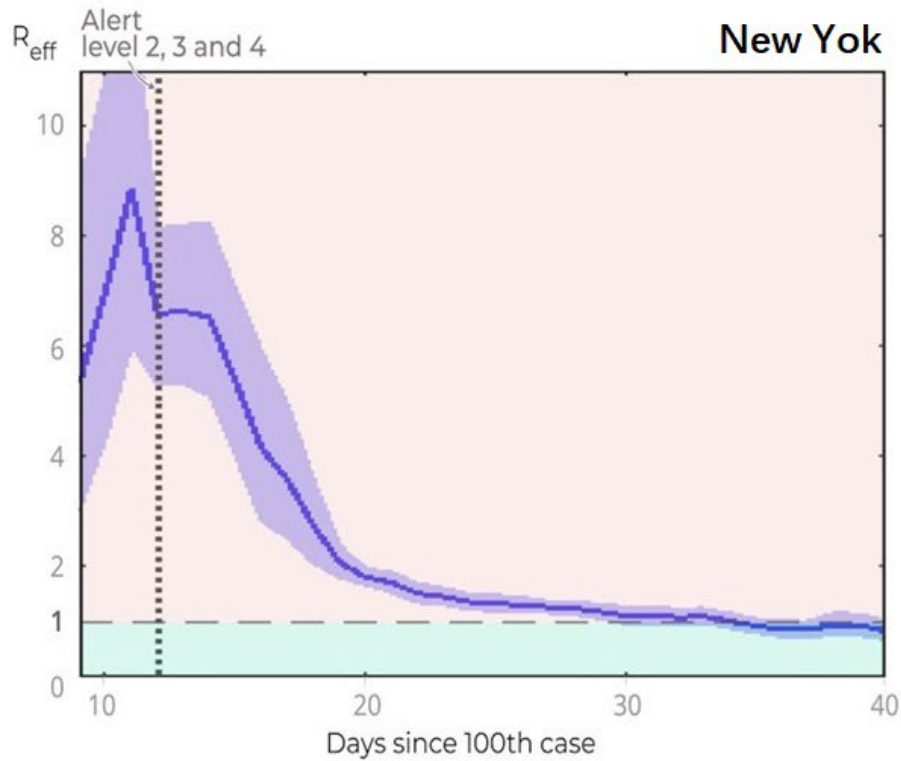
¹²⁷ Ferré, F., de Belvis, A. G., Valeria, L., Longhi, S., Lazzari, A., Fattore, G., ... & Maresso, A. (2014). Italy: health system review. *Health systems in transition*, 16.

¹²⁸ Nacoti, M., Ciocca, A., Giupponi, A., Brambillasca, P., Lussana, F., Pisano, M., ... & Montaguti, C. (2020). At the epicenter of the Covid-19 pandemic and humanitarian crises in Italy: changing perspectives on preparation and mitigation. *NEJM Catalyst innovations in care delivery*, 1(2).

¹²⁹ MacIntyre, C. R., Nguyen, P. Y., Chughtai, A. A., Trent, M., Gerber, B., Steinhofel, K., & Seale, H. (2021). Mask use, risk-mitigation behaviours and pandemic fatigue during the COVID-19 pandemic in five cities in Australia, the UK and USA: A cross-sectional survey. *International Journal of Infectious Diseases*, 106, 199-207.

how the high number of early outbreaks in the country was swiftly mitigated due to government action, which allows Australia to be regarded as a success story in its ability to control the COVID-19 pandemic.

Exhibit 35. When $R_{eff} < 1$ it means that the virus has been largely eliminated from the community.



10.7 New Zealand and the Pandemic

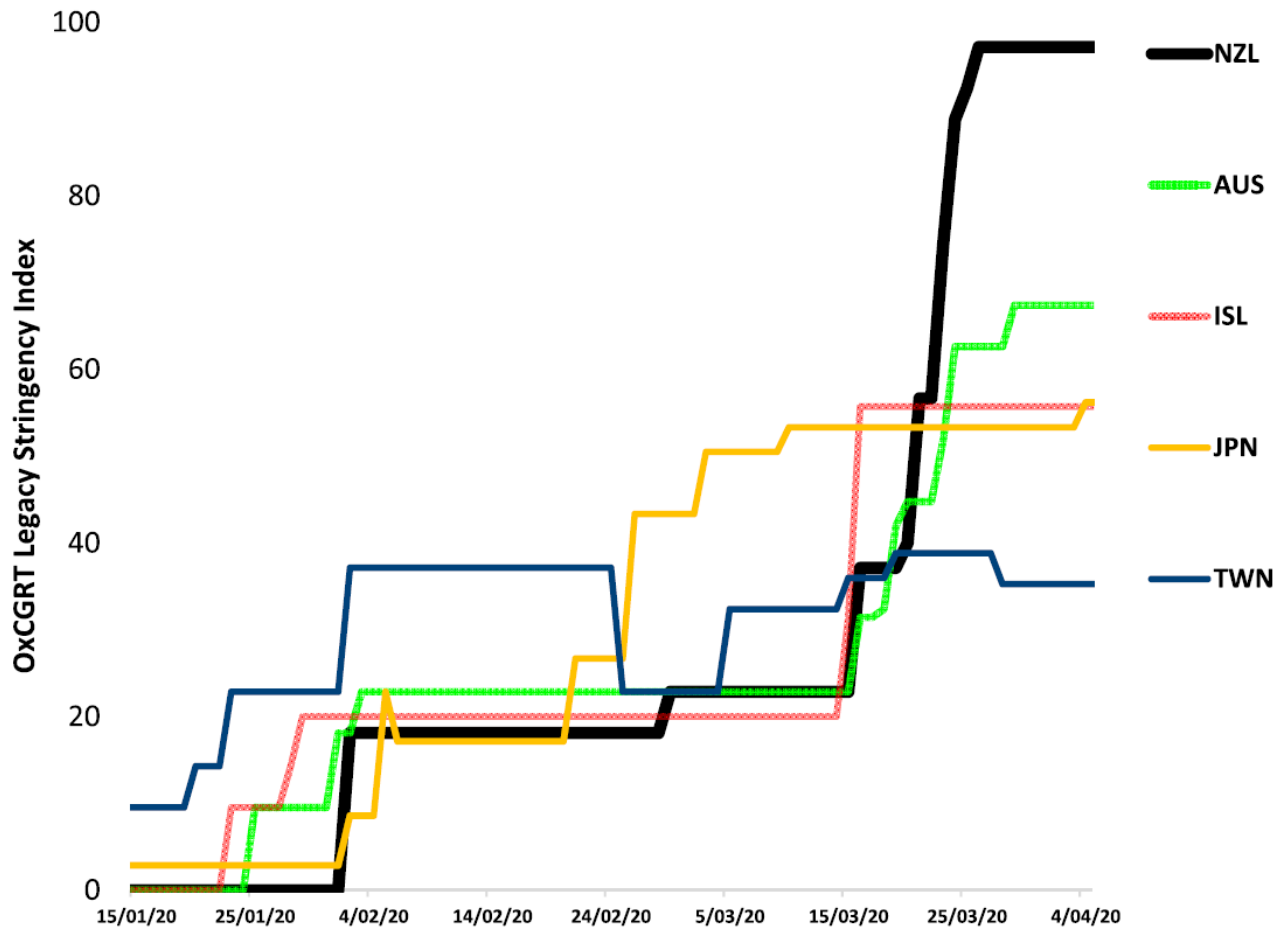
By far, New Zealand had demonstrated the greatest and most efficient response to the COVID-19 pandemic, having managed to mitigate the outbreak within less than a year of the start of the outbreaks due to high levels of population compliance and stringent government public health initiatives. In fact, while most governments were negatively impacted by their performance during the COVID-19 pandemic, New Zealand, as well as Australia, experienced an increase in government trust following their conduct during the pandemic. Goldfinch et al.¹³⁰ found that trust in government had increased dramatically, with around 80% of respondents agreeing that their local and federal governments were generally trustworthy and were pillars of support during the pandemic. Around three-quarters also agreed that management of the pandemic had increased their trust in the government as well as over 85% of respondents stated that they had confidence that public health scientists who worked in the public interest during the pandemic. Gibson¹³¹ explains that while this success did not come from an immediate implementation of the pandemic lockdown protocol, an intensely strict implementation during Wave 4 of the pandemic in specific during which new infection rates were peaking did contribute to the success of the country's response. Figure 5 shows that while New Zealand's implementation was not particularly early in comparison to other countries, it was leagues more stringent and allowed the country to be able to curb infection rates and continue to function without greatly impacting the internal economy. New Zealand implemented strict border controls, including early travel restrictions and mandatory quarantine for incoming travelers, which helped prevent widespread transmission of the virus from overseas. The government also imposed nationwide lockdowns and stringent public health measures, such as social distancing and mask mandates, to curb community transmission. Clear and consistent communication from government officials, including Prime Minister Jacinda Ardern, played a crucial role in garnering public compliance and support for these measures. Natural factors like population size, density, distribution, and the availability of hospital beds per capita, as well as the presence of a land border, also contributed to the success of New Zealand during their COVID-19 response and were beyond the control of policymakers to implement. The aspects that policymakers can influence, such as the strictness of the COVID-19 restrictions they implement, only contribute marginally to the variation in the death toll, even when these measures are enacted promptly. For instance, According to Goldfinch, if Sweden's less stringent restrictions had been adopted in New Zealand, the additional COVID-19 deaths might have numbered around 300, significantly fewer than the

¹³⁰ Goldfinch, S., Taplin, R., & Gauld, R. (2021). Trust in government increased during the Covid-19 pandemic in Australia and New Zealand. *Australian Journal of Public Administration*, 80(1), 3-11.

¹³¹ Gibson, J. (2022). Hard, not early: putting the New Zealand Covid-19 response in context. *New Zealand Economic Papers*, 56(1), 1-8.

exaggerated claims circulating in the media about potentially thousands of deaths. Such claims often overlook the inherent differences in settings and fail to account for this diversity.

Exhibit 36. New Zealand Government Response to Coronavirus Was Not Notably Early.



Source: Gibson *et al.*

Section 11. 2024 Budget – Some significant measures

In Budget Implementation Act, 2024, No. 1, \$200 billion will be allocated over 10 years to enhance public health care.

This includes a guaranteed annual increase of 5% in Canada Health Transfer payments from 2023-24 to 2027-28 for provinces and territories improving health data management.

Provinces and territories are set to receive a record \$52.1 billion this year through the CHT. Doctors can receive up to \$60,000 and nurses up to \$30,000 in student loan forgiveness for working in rural areas.

Budget 2024 expands this benefit to include more health professionals like dentists, dental hygienists, pharmacists, psychologists, physiotherapists, midwives, and personal support workers.

Newcomers in health care and construction will have foreign credentials recognized.

Budget 2024 invests \$77.1 million over four years to support doctors and nurses in contributing to Canada's health care system.

Additionally, 120 new medical residency positions will be available for international graduates. The Canadian Dental Care Plan has been introduced to provide dental coverage to all in need.

Over 2 million Canadians have signed up, with coverage extending to seniors aged 65 and older, children under 18, and individuals with disabilities.

Uninsured Canadians aged 18-64 with a family income below \$90,000 will be eligible next year.

A \$500 million Youth Mental Health Fund has been launched to improve mental health care for young people by supporting community health organizations and enhancing referrals to mental health services.

This fund builds on the GST elimination on psychotherapy and counselling services announced in the 2023 Fall Economic Statement.

Health Canada will receive \$3.2 million over three years to address supply shortages of essential drugs and medical devices, improving supply management and mitigating effects of shortages.

Section 12. Summary and Analysts' Recommendations

12.1 Comparison of quality of health care in Canada with that in other high income countries, along all six dimensions in the Institute of Medicine Framework¹³².

Dimension: Safety

Definition: Avoiding injuries to patients from the care that is intended to help them.

Quality of health care in Canada compared with that in other high-income countries

- Although there is ample evidence that Canadians suffer preventable harm owing to unsafe care, useful international comparisons focusing on the safety of health care are rare.
- According to OECD, Canadians undergoing hip or knee replacement are nearly twice as likely to develop a postoperative pulmonary embolism than individuals in a range of comparator countries, and Canadians undergoing abdominal surgery are 37% more likely to develop postoperative sepsis.⁵⁴ However, it is not clear that these comparisons reflect genuine differences; OECD cautions in its report that “higher adverse event rates may signal more developed patient safety monitoring systems and a stronger patient safety culture rather than worse care.”

Dimension: Timeliness

Definition: Reducing waits and harmful delays for both those who receive and those who give care.

Quality of health care in Canada compared with that in other high-income countries

- Canadians wait longer for nonemergent care than people in many other high-income countries.
- A recent Commonwealth Fund survey found that 25% of Canadians reported waiting longer than 8 weeks to see a specialist, compared with just 3% in Switzerland and the United States, and between 10% and 20% in most other high-income countries.
- With respect to primary care, another Commonwealth Fund survey found that only 53% of Canadian family physicians reported that their patients were able to receive an appointment on the day they asked for one, or the next day, compared with 72% of counterparts across a range of similarly high-income countries

¹³² Dhalla, I. A., & Tepper, J. (2018). Improving the quality of health care in Canada. *Cmaj*, 190(39), E1162-E1167.

Dimension: Effectiveness

Definition: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).

Quality of health care in Canada compared with that in other high-income countries

- International comparisons suggest that Canadians have good health outcomes for many health conditions. For example, Canadians diagnosed with cancer can expect five-year survival rates that are as good as or better than those in most other countries. Similarly, on measures of “avoidable mortality” (i.e., mortality from conditions for which there is effective health care), Canada performs well in comparison with other countries.
- Nevertheless, there are still many examples of both underuse and overuse in Canada that highlight opportunities for improvement. For example, less than 1% of public drug plan beneficiaries in Ontario receive first-line, evidence-based medications for alcohol use disorder in the year following this diagnosis. With respect to overuse, unnecessary testing is a classic example, with preoperative electrocardiography before low-risk surgery ranging from 3.4% to 88.8% across different hospitals in one study.

Dimension: Efficiency

Definition: Avoiding waste, including waste of equipment, supplies, ideas and energy.

Quality of health care in Canada compared with that in other high-income countries

- The amount of money Canada spends on health care, on a per capita basis, is similar to that in other high-income countries.
- Looking beyond aggregate expenditure, Canada has fewer hospital beds and physicians⁶² for its population size than similar high-income countries, suggesting that physician and hospital care in Canada are reasonably efficient
- However, Canada may seem less efficient on other comparisons; for example, we pay more for prescription drugs than in most other high-income countries

Dimension: Equitability

Definition: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Quality of health care in Canada compared with that in other high-income countries

- The *Canada Health Act* was designed to ensure that Canadians are treated by physicians and in hospitals without charge. Despite the removal of this financial barrier, many studies have shown that poorer Canadians are less likely than richer Canadians to receive evidence-based preventive health care. Poorer Canadians also have worse health outcomes than more wealthy Canadians. Similarly, Canadians who live outside large urban centers appear to receive lower-quality care and often have worse health outcomes. This problem is particularly severe for Indigenous Canadians.
- In areas not covered by the *Canada Health Act*, such as home care and outpatient prescription drugs, financial barriers are common. For example, about 1 in 4 Canadians without prescription drug insurance do not take their medications as prescribed because of the cost, compared with about 1 in 15 Canadians who do have this insurance.
- The most recent Commonwealth Fund survey showed that 9% of older Canadians have problems getting care because of cost. This compares favorably to both the United States (23%) and Australia (13%), but unfavorably to Sweden (3%), Norway (4%) and the United Kingdom (4%).

Dimension: Patient Centric Approach

Definition: Providing care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions.

Quality of health care in Canada compared with that in other high-income countries

- Commonwealth Fund surveys show that Canadians tend to report good experiences with their physicians compared with individuals living in other high-income countries.
- However, there are areas in which patient-centeredness could be improved in Canada. For example, many hospitals allow visitors only at certain times, and many patients report that they do not receive care in a culturally sensitive way.

12.2 Recommendations for a More Robust Healthcare System in Canada

The Canadian healthcare system is renowned for its commitment to providing universal coverage. However, it faces significant challenges, particularly in the areas of specialist referral and surgical wait times, accessibility to prescription medications, access to primary care, and delivery of timely care for serious illness. These issues, exacerbated by outdated practices and inadequate infrastructure, necessitate innovative and efficient solutions.

Our recommendations draw inspiration from '10 Ways to Fix Canada's Health Care System Right Now' published in *The Globe and Mail*¹³³. Highlighting the urgent need for reform and innovative solutions, our report identifies practical strategies to address Canada's healthcare challenges without leaning on increased privatization. By prioritizing efficiency, accessibility, and quality of care, these solutions aim to reshape the healthcare landscape for the benefit of all Canadians.

Problem # 1: High-Cost vs Efficiency

Solution: Co-Pay,

Challenges: The Canada Health Act

In Canada, patients are fully covered for insured medical services, with no out-of-pocket expenses for physician or hospital care. This sets Canada apart from most developed countries, where universal healthcare systems require patients to share the cost of treatment through deductibles, co-insurance, and copayments. Countries like France, the Netherlands, and Switzerland have universal systems that outperform Canada on key metrics such as timely access to care. These countries expect patients to contribute financially towards their treatment, unlike the Canadian system that prohibits user fees or extra billing for medically necessary care.

Despite the potential backlash, the use of cost-sharing has been shown to reduce outpatient care usage without adverse health effects, with protections in place to ensure vulnerable groups can still access care. However, the current Canadian system faces restrictions under the Canada Health Act, limiting provinces' ability to experiment with cost-sharing and leading to an unsustainable status quo. It may be time for Canada to consider meaningful reform based on successful experiences from other countries to provide a more efficient and effective healthcare system for its citizens.

¹³³ Bell, R., Golden, A., Alofs, P., & Robins, L. (2022, August 4). 10 ways to fix Canada's health care system right now. *The Globe and Mail*. <https://www.theglobeandmail.com/opinion/article-canada-health-care-crisis/>

Case Study – France

Canadians keen on improving the state of our universal health-care system would do well to consider the case of France. Like Australia, Germany, the Netherlands, Sweden and Switzerland, the French health-care system is yet another example of a well-performing universal health-care system that delivers more timely, quality care, - for similar or lower costs than Canada. Unlike many Canadians, however, the French (and their counterparts in these other countries) do not appear to be frozen by a fear of profit-making in health care. Rather, they have embraced an expansive role for private for-profit hospitals as part of their approach to universality.

France spent 11.3 per cent of its GDP on health care in 2012, slightly less than Canada (11.8 per cent) on an age-adjusted basis. For that level of spending, France had only slightly fewer practising nurses and diagnostic technology units, but a higher number of physicians and hospital beds, and lower wait times.

France's universal-access healthcare system is based on a statutory health insurance [SHI] model where individuals are required to purchase a health insurance policy (based on their employment) from a regulated insurance company. Strong state regulations and subsidies ensure universal access to that insurance (although the general population is subject to cost-sharing). Private insurance is available but is generally of a complementary or supplementary nature. In 2007, 88 percent of the French population had some form of private voluntary health insurance.

Apart from the required copayments, the essentially non-competitive nature of the insurance system in France may seem quite familiar to Canadians. However, in stark contrast to Canada, both public and private insurers purchase care from a common pool of public, private not-for-profit, and private for-profit hospitals.

In 2012, there were 1,041 for-profit hospitals in France representing 39.2 percent of all hospitals in the country. These hospitals competed with 928 public and 688 private not-for-profit hospitals for patients under the universal scheme.

While acute medical, surgical, and obstetric care is provided by all three types of hospitals, their relative level of involvement varies.

For example, public hospitals are responsible for the majority (about three-fourths) of acute medical-care

capacity and full-time episodes and perform about a third of all surgical procedures (including more complex procedures). While private for-profit hospitals also deliver such services and perform more than half of all surgical procedures, they tend to focus on a smaller range of technical procedures (such as invasive diagnostic procedures) and specialize in routine procedures with short and predictable in-hospital stays. About 75 percent of all surgeries performed in a day-care setting are provided by for-profit hospitals. About one-third of obstetric procedures (related to pregnancy and childbirth) are also performed in private for-profit hospitals. In addition, private for-profit hospitals can also carry out public service duties paid for through contracts with a regional health agency. Meanwhile, private not-for-profit hospitals provide a range of services including follow-up and rehabilitation, and cancer treatment (including prevention, screening, treatment, surgery, and research).

Canadian health policy discussions are often hobbled by the misunderstanding that universal health care means government health care. The reality, however, is rather different. Private insurers and hospitals form the basis of many of the world's finest universal access healthcare systems. Even in France, whose core universal health insurance system is essentially non-competitive, private for-profit hospitals play an expansive role in the delivery of universally accessible services.

Canadians interested in enhancing our universal healthcare system should examine France as a successful example. The French healthcare system, along with those of Australia, Germany, the Netherlands, Sweden, and Switzerland, demonstrates efficient delivery of quality care at similar or lower costs compared to Canada. Unlike many Canadians, the French and citizens of these nations embrace the involvement of private for-profit hospitals in ensuring universal health care. This installment discusses the universal healthcare system in France, focusing on the role of for-profit hospitals. In 2012, France allocated 11.3% of its GDP to health care, slightly lower than Canada. Despite similar spending levels, France boasted more physicians, hospital beds, and shorter wait times. France's healthcare system operates on a statutory health insurance model, where individuals must acquire coverage from a regulated insurance provider. State regulations and subsidies guarantee universal access to health insurance, with private insurance serving a supplementary role for 88% of the population in 2007. While the insurance system may resemble Canada's, France distinguishes itself by allowing public and private insurers to purchase care from a mix of hospitals, including public, private not-for-profit, and private for-profit facilities. In 2012, for-profit hospitals in France accounted for 39.2% of all hospitals, competing with public and private not-for-profit counterparts under the universal scheme. Public hospitals in France handle the majority of acute medical care and surgical procedures, while private for-profit hospitals focus on technical procedures and routine surgeries with short in-hospital stays. These hospitals also contribute significantly to day-care surgeries

and a third of obstetric procedures. Private not-for-profit hospitals offer services like rehabilitation, cancer treatment, and research. Contrary to common misconceptions, universal health care does not equate to government-controlled health care. Private insurers and hospitals are integral to successful universal access to health-care systems worldwide. In France, private for-profit hospitals play a substantial role in providing universally accessible healthcare services.

Problem # 2: Lengthy Specialist Referral Wait Times.

Solution: Digital Referrals and E-Consultations.

For years, Canada has struggled with specialist referral wait times. According to the OECD in 2016, 61% of Canadians waited over a month for a specialist appointment, marking the country's poorest performance among its peers, with Norway closely trailing¹³⁴. In contrast, during the same period, France reported 36% and the United States reported 27% waiting over a month for specialist appointments¹³⁵. In 2022, a report by the Fraser Institute revealed that the median wait time for referrals to specialist physicians in Canada was approximately 27 weeks, marking a 195% increase from 1993, when the average wait time was less than ten weeks¹³⁶.

Moreover, medical referrals still rely on fax machines, causing delays in the referral and booking process and ultimately affecting patient care timelines. Due to the absence of a centralized national organization overseeing provincial initiatives, disseminating effective strategies, or evaluating the outcomes of investments aimed at reducing wait times, the lack of coordination leads to fragmented progress and a proliferation of 'ongoing pilot projects' in various health regions.

To address the issue of lengthy wait times, Canada must adopt digital referral systems:

E-Referrals: Securely and directly send patient information to specialists via digital applications, eliminating the need for handwritten notes or faxes.

¹³⁴ *Waiting Times for Health Services: Next in Line*. (n.d.). OECD. Retrieved June 5, 2024, from https://www.oecd-ilibrary.org/sites/242e3c8c-en/index.html?itemId=/content/publication/242e3c8c-en&csp_#e90031be7ce6b03025f09a0c506286b0&itemGO=oecd&itemContentType=book

¹³⁵ *Waiting Times for Health Services: Next in Line*. (n.d.). OECD. Retrieved June 5, 2024, from https://www.oecd-ilibrary.org/sites/242e3c8c-en/index.html?itemId=/content/publication/242e3c8c-en&csp_#e90031be7ce6b03025f09a0c506286b0&itemGO=oecd&itemContentType=book

¹³⁶ *Health Care Wait Times*. (n.d.). Fraser Institute. Retrieved June 5, 2024, from <https://www.fraserinstitute.org/categories/health-care-wait-times#:~:text=Dec%208%2C%202022-.Waiting%20%20Your%20Turn%3A%20Wait%20Times%20for%20Health%20Care%20in%20Canada.began%20track%20ng%20medical%20wait%20times>

E-Consultations: Enable family doctors to send patient information and specific queries to specialists who can provide timely advice or determine the need for an in-person consultation.

Benefits of Digital Referrals:

Reduced Wait Times: Centralized systems can identify the specialist with the shortest wait time, streamlining the referral process.

Increased Efficiency: E-referrals and e-consultations are faster and more reliable than fax-based systems.

Enhanced Data Collection: Digital records improve understanding of wait times and system performance, aiding in better resource allocation.

Kim et al. (2009) conducted a study in the United States utilizing an 18-item questionnaire to evaluate the effects of eReferral on the workflow and clinical care of 298 primary care providers. The findings revealed that 72% of these providers perceived improvements in tracking referrals, facilitating pre-visit work-up, and reducing wait times for new appointments¹³⁷. In a separate study conducted in the United States, Scheibe et al. (2015) examined 2,105 referrals to rheumatologists by primary care providers between 2008 and 2012. The study highlighted that the primary advantage of the eReferral system was the enhanced ability of specialists to engage in iterative pre-consultation communication, including requests for additional information. Their analysis indicated that the frequency of pre-consultation exchanges increased from 55% in 2008 to 74% in 2011. However, during the same period, only 63% of these pre-consultations resulted in scheduled face-to-face appointments¹³⁸.

Implementation Strategy:

Mandate Integration: Provincial governments should mandate that electronic medical records (EMRs) integrate seamlessly with e-referral and e-consultation systems.

¹³⁷ Yeuen K, Chen A, Keith E, et al. Not perfect, but better: primary care providers' experiences with electronic referrals in a safety net health system. *J Gen Intern Med.* 2009;24(5):614–619. doi: 10.1007/s11606-009-1087-5.

¹³⁸ Scheibe M, Imboden J, Schmajuk G. Efficiency gains for rheumatology consultation using a novel electronic referral system in a safety net health setting. *Arthritis Care Res (Hoboken).* 2015;67(8):1158–1163. doi: 10.1002/acr.22559.

Incentivize Adoption: Implement deadlines for mandatory e-referrals, with potential pay discounts for non-compliance.

Case Study: The Creation of a Modernize Access to Specialized Treatment (MAST) Institute

To address Canada's ongoing healthcare challenges, including lengthy wait times for specialized treatment, Dr. Jennifer Zwicker, the Director of Health Policy at the School of Public Policy, posits that the creation of a Modernize Access to Specialized Treatment (MAST) institute is recommended¹³⁹. This independent body would play a pivotal role in modernizing, measuring, and monitoring healthcare access across the country.

According to Zwicker, the MAST institute would act as an equalizer and capacity builder, focusing on implementing evidence-based practices to reduce wait times. It would function as a regulator, offering legislative, policy, and financial support to ensure accountability within Canadian health systems.

Central to its mandate would be streamlining the referral process to promptly connect patients with appropriate specialists. Collaboration with provincial and territorial governments would be integral to achieving this goal, ultimately leading to reduced wait times, enhanced transparency, improved administrative efficiency, and increased overall patient satisfaction.

Zwicker underscores that the proposed institute aligns with successful international models, citing Healthcare Improvement Scotland as an example. Established to improve healthcare efficiency and effectiveness in Scotland, HIS serves as a comprehensive body integrating various health-related functions under one umbrella, including performance assessment and delivery improvement programs¹⁴⁰.

In Canada, Zwicker envisions the MAST institute empowering provinces to modernize their healthcare data infrastructure. This would involve promoting transparent reporting of wait time data that accurately reflects patient journeys across provinces, specialties, and healthcare providers.

Furthermore, the institute would advocate for the establishment of a standardized digital infrastructure

¹³⁹ Russ, G. (2024, April 25). *Modernizing patient referrals could be one way to eliminate Canada's wait-time woes.*

<https://thehub.ca/2023/12/04/modernizing-patient-referrals-could-be-one-way-to-eliminate-canadas-wait-time-woes/>

¹⁴⁰ *Healthcare Improvement Scotland.* (n.d.).

<https://www.healthcareimprovementscotland.scot/>

encompassing scheduling systems, referral processes, patient interfaces, electronic health records, and wait-time reporting. Such a cohesive approach, Zwicker argues, is essential for addressing Canada's healthcare challenges comprehensively and efficiently.

Overall, Zwicker asserts that adopting a centralized approach with robust system-level leadership is crucial for the MAST institute to gain broad stakeholder support and achieve widespread adoption across all provinces and specialties.

Problem #3: Accessibility to Affordable Prescription Medications

Access to affordable prescription medications is a cornerstone of effective healthcare delivery, yet millions of Canadians continue to grapple with significant barriers to obtaining essential drugs. Fragmented coverage, soaring drug prices, and inequitable access pose formidable challenges to the realization of universal pharmacare in Canada. In response to these pressing concerns, policymakers and healthcare advocates have called for the establishment of a national pharmacare program to ensure equitable access to medications for all citizens.

Solutions

Establishment of a National Pharmacare Program

Solution: Introduce a comprehensive, federally funded pharmacare program to provide universal coverage for essential medications to all Canadians.

Data indicates that a significant proportion of the population faces financial barriers to accessing prescription drugs, compromising health outcomes and escalating healthcare costs. A national pharmacare program would optimize drug affordability, improve medication adherence, and enhance overall health equity.

Standardization of Drug Formularies

Solution: Harmonize provincial drug formularies under the auspices of the national pharmacare program to ensure consistency and comprehensiveness of medication coverage.

Disparate formularies across provinces contribute to inconsistencies in access to medications and administrative inefficiencies. Standardizing drug lists under a national pharmacare framework would streamline procurement processes and enhance medication accessibility nationwide.

Negotiating Lower Drug Prices

Solution: Empower the federal government to negotiate lower drug prices with pharmaceutical manufacturers on behalf of all Canadians enrolled in the pharmacare program.

International comparisons reveal that Canadians pay disproportionately high prices for prescription drugs compared to their counterparts in other developed countries¹⁴¹. By leveraging its purchasing power, the federal government can secure more favorable pricing arrangements and generate substantial cost savings for the healthcare system.

Public Awareness and Education Campaigns

Solution: Launch public awareness campaigns to educate Canadians about the benefits and implications of universal pharmacare, fostering public support and engagement.

Public perception and awareness play a crucial role in shaping policy discourse and garnering political momentum for healthcare reforms. By disseminating accurate information and dispelling misconceptions, advocacy efforts can mobilize grassroots support for the implementation of a national pharmacare program

Problem # 4: Canada's Surgery Backlog

Canada's healthcare system is currently grappling with prolonged wait times for surgeries, exacerbated by significant disruptions caused by the COVID-19 pandemic. Patients like Yan, who require essential knee replacements, are experiencing debilitating delays that not only impact their health but also their quality of life¹⁴². To effectively reduce these wait times and improve healthcare delivery, innovative

¹⁴¹ How Canada Compares. (n.d.). In *Canadian Institute for Health Information*. Retrieved June 6, 2024, from <https://www.cihi.ca/sites/default/files/document/text-alternative-version-2016-cmwf-en-web.pdf>

¹⁴² Bell, R., Golden, A., Alofs, P., & Robins, L. (2022a, May 14). Months-long surgery wait times are the norm in Canada. Dedicated community surgery centres will reduce the backlog. *The Globe and Mail*. <https://www.theglobeandmail.com/opinion/article-surgery-wait-times-backlog/>

solutions are urgently needed.

Wait times for surgeries in Canada have reached critical levels, with patients enduring months, and in some cases, years of waiting. This delay not only results in deteriorating health conditions but also contributes to psychological distress and loss of independence among patients like Yan. The current system's capacity constraints, exacerbated by the pandemic, have underscored the need for immediate action to clear the surgery backlog.

Solution: Dedicated Community Surgery Centers

To expedite the reduction of surgery, wait times in Canada, the establishment of dedicated community surgery centers emerges as a viable solution. Unlike traditional hospital settings, these centers are designed to streamline surgical processes, focusing solely on efficient and high-volume procedures such as joint replacements, cataract surgeries, and certain laparoscopic procedures¹⁴³.

Why Community Surgery Centres?

Community surgery centers offer several advantages over traditional hospital settings:

- **Increased Efficiency:** By concentrating on a limited range of procedures, community centers can achieve higher throughput rates compared to hospitals. This efficiency is crucial for clearing backlogs swiftly.
- **Cost-effectiveness:** Studies from the United States have shown that ambulatory service centers (ASCs), similar to community surgery centers, can reduce the cost of care significantly while maintaining quality standards.
- **Patient-centered Design:** Community centers are purpose-built to enhance patient experience and safety. They feature streamlined processes from admission to discharge, minimizing the need for patient movement and optimizing recovery times.
- **Utilization of Underutilized Spaces:** Vacant commercial real estate, such as office towers or malls, presents an opportunity to establish community surgery centers without substantial capital

¹⁴³ Bell, R., Golden, A., Alofs, P., & Robins, L. (2022a, May 14). Months-long surgery wait times are the norm in Canada. Dedicated community surgery centres will reduce the backlog. *The Globe and Mail*.

<https://www.theglobeandmail.com/opinion/article-surgery-wait-times-backlog/>

expenditure on new infrastructure.

Successful Models and Implementation

The Jim Pattison Outpatient Care and Surgery Centre (JPOCSC) in British Columbia serves as a successful Canadian model¹⁴⁴. Operated under the provincial health authority, JPOCSC has demonstrated the effectiveness of shifting surgeries to community settings, ensuring high-quality care while enhancing operational efficiency.

The adoption of dedicated community surgery centers represents a strategic approach to addressing Canada's surgery backlog promptly and effectively. By leveraging existing infrastructure and focusing on specialized care delivery, these centers can alleviate the burden on hospitals, improve patient outcomes, and restore public confidence in the healthcare system.

Next Steps

It is recommended that provincial health authorities collaborate with stakeholders to identify suitable locations for community surgery centers and develop implementation plans tailored to regional needs. Furthermore, ongoing evaluation and adjustment of these centers' operations will be essential to optimize their impact on reducing wait times and enhancing healthcare delivery across Canada.

Challenges – Private clinics have limited abilities to deal with complicated cases, for example Shouldice, a world-renowned institute but unable to administer blood etc.

Problem # 5: Barriers to Accessing Primary Care

Accessing timely appointments with family doctors remains a significant challenge for many Canadians, leading to unnecessary emergency room visits and delays in essential medical care. Larysa's experience with her daughter Elena highlights the critical need for improved access to primary care services, especially during times of urgent medical need. To address this issue effectively, innovative solutions are required to enhance the availability and accessibility of primary healthcare providers across Canada.

¹⁴⁴ Bell, R., Golden, A., Alofs, P., & Robins, L. (2022b, May 14). Months-long surgery wait times are the norm in Canada. Dedicated community surgery centres will reduce the backlog. *The Globe and Mail*.

<https://www.theglobeandmail.com/opinion/article-surgery-wait-times-backlog/>

The difficulty in securing timely appointments with family doctors in Canada has resulted in patients like Larysa facing prolonged waits for essential medical attention¹⁴⁵. Despite efforts to increase the number of family doctors, particularly in underserved regions, significant gaps in primary care persist, impacting patient health outcomes and satisfaction.

Solution: Fast track of foreign doctors and Emphasizing Primary-Care Nurse Practitioners

Fast-tracking foreign-trained physicians through new programs for exams and lab training should be a priority. National physician's certification body aims to fast-track certification of more foreign-trained doctors in 2023 and this is an excellent start.

Nurses

To alleviate the strain on family doctor availability and improve access to primary care, Canada should focus on expanding the role of primary-care nurse practitioners (NPs). Nurse practitioners possess the necessary skills and qualifications to provide a wide range of primary healthcare services traditionally offered by family doctors. With shorter training periods compared to physicians, nurse practitioners can be deployed more swiftly to address immediate gaps in healthcare delivery.

Why Nurse Practitioners?

1. **Equivalent Quality of Care:** Numerous studies, including those reviewed by the Cochrane Library, have demonstrated that nurse practitioners provide care that is equal to or even better than that provided by primary care doctors. This includes patient outcomes and satisfaction rates, making nurse practitioners a reliable alternative in delivering high-quality healthcare.
2. **Cost-Effectiveness:** Nurse practitioner-led care models have shown potential cost savings compared to traditional physician-led care. This is particularly relevant in optimizing healthcare resources and managing healthcare expenditures effectively.
3. **Accessibility in Underserved Areas:** Nurse practitioners are more likely to work in rural and remote

¹⁴⁵ Bell, R., Golden, A., Alofs, P., & Robins, L. (2022c, May 16). Nearly 15 per cent of Canadians don't have a family doctor, but the solution isn't hiring more. *The Globe and Mail*. <https://www.theglobeandmail.com/opinion/article-family-doctor-shortage-nurse-practitioners/>

communities compared to family doctors. By investing in nurse practitioner training and deployment in these areas, provincial health ministries can bridge gaps in primary care access more efficiently than relying solely on physician recruitment efforts.

Successful Models and Implementation

Ontario's experience with nurse practitioner-led clinics serves as a successful example. Currently, 25 nurse practitioner-led clinics operate in the province, demonstrating the feasibility and effectiveness of integrating nurse practitioners into primary care settings. Similar models can be replicated and expanded across Canada to improve access to timely primary care services¹⁴⁶.

Problem # 6: Delivery of Timely and Coordinated Care for Serious Illnesses

The case of Mylène, who experienced delays in receiving a breast cancer diagnosis, underscores the urgent need for improved diagnostic pathways¹⁴⁷. Statistics indicate that while some patients benefit from rapid diagnosis in specialized clinics, many others face lengthy waits for essential diagnostic tests and consultations. For instance, delays in accessing mammograms and subsequent biopsy consultations can lead to unnecessary anxiety and progression of the disease¹⁴⁸.

Solutions

Investing in Expert-Designed Systems

Provinces must prioritize investment in expert-designed systems that facilitate seamless coordination among radiologists, pathologists, surgeons, and oncologists. These systems have proven effective in countries like the United States, where rapid-diagnosis clinics for breast cancer have significantly reduced the time from detection to treatment initiation, thereby improving patient outcomes.

¹⁴⁶ Bell, R., Golden, A., Alofs, P., & Robins, L. (2022d, May 16). Nearly 15 per cent of Canadians don't have a family doctor, but the solution isn't hiring more. *The Globe and Mail*.

<https://www.theglobeandmail.com/opinion/article-family-doctor-shortage-nurse-practitioners/>

¹⁴⁷ Bell, R., Golden, A., Alofs, P., & Robins, L. (2022c, May 15). Taking the pain out of one of the biggest challenges for patients – getting a diagnosis. *The Globe and Mail*.

<https://www.theglobeandmail.com/opinion/article-diagnosis-wait-times-canada/>

¹⁴⁸ Habeeb, Syed Yaser, et al. "Time to follow-up of an abnormal mammogram in women with diabetes: a population-based study." *Cancer Medicine* 5.11 (2016): 3292-3299.

Expanding Rapid-Diagnosis Clinics

Building on successful models in provinces like Ontario and Saskatchewan, which have implemented rapid-access clinics for musculoskeletal conditions, similar clinics should be expanded to other critical illnesses such as cancer. These clinics not only expedite diagnosis but also reduce unnecessary healthcare costs by minimizing redundant tests and consultations.

Enhancing Interdisciplinary Collaboration

Effective treatment of serious illnesses like cancer requires collaborative efforts among various healthcare professionals. Statistics reveal that interdisciplinary teams comprising radiologists, pathologists, surgeons, oncologists, and support staff are essential for developing comprehensive care plans and ensuring timely interventions¹⁴⁹.

Supporting Provincial Health Agencies

To maintain and strengthen specialized care delivery, provincial health agencies such as Cancer Care Ontario or strategic clinical networks should be empowered rather than centralized under broader "super agencies." These specialized agencies possess the expertise necessary to develop and implement evidence-based treatment protocols tailored to local healthcare needs.

Adopting Alberta's Strategic Clinical Networks Model

Alberta's strategic clinical networks have demonstrated success in integrating new clinical discoveries into province-wide treatment strategies. Provinces across Canada should consider adopting similar models to enhance responsiveness to evolving clinical challenges and improve patient outcomes.

Allocating Administrative Resources

Adequate administrative resources are critical for coordinating primary-care providers with diagnostic and therapeutic services effectively. Investing in administrative infrastructure will ensure efficient care pathways and improve patient access to timely interventions, thereby optimizing healthcare delivery.

Prioritizing Patient-Centered Care

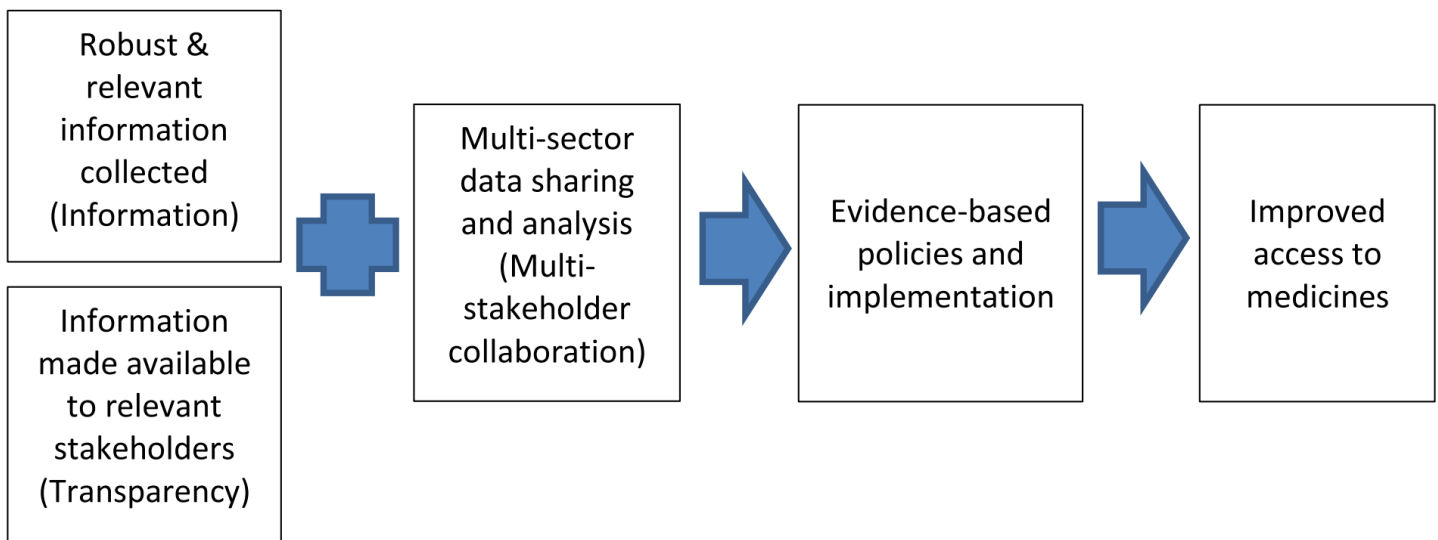
Central to all recommendations is a commitment to patient-centered care. By prioritizing patient needs and experiences, healthcare systems can ensure that individuals receive timely, compassionate, and efficient care throughout their diagnostic and treatment journey. For instance, a study by Cooper et al. (2018) found that patient-centered assessment and treatment of chronic pain includes identifying appropriate tests and outcome measures to monitor treatment effectiveness aligned with patient goals,

¹⁴⁹ Scott, Brigitte. "Multidisciplinary team approach in cancer care: a review of the latest advancements." *Oncology* (2021): 2-13.

adapting treatments to individual differences, and evaluating their impact on treatment outcomes¹⁵⁰. Additionally, there was consensus on the need to identify effective elements of self-management programs for chronic pain and to explore nonmedicinal approaches such as exercise, mindfulness, and alternative therapies for pain management.

Problem #7: Improve transparency for patients and the public including plain language summaries

Exhibit 37. The Medicines Transparency Alliance (MeTA) Model



Source: Vian *et al.* Promoting transparency, accountability, and access through a multi-stakeholder initiative: lessons from the medicines transparency alliance¹⁵¹.

MeTA was originally modeled after the Extractive Industries Transparency Initiative (EITI). Established in 2003, EITI aims to enhance governance and encourage transparent and responsible management of natural resources like oil, gas, metals, and minerals. The EITI principles emphasize the importance of governments being answerable to their citizens for handling revenues and public spending effectively. This necessitates clear disclosure of company payments and improved public financial management and accountability. EITI mandates timely reporting of key metrics to facilitate public discourse and a multi-stakeholder group process

¹⁵⁰ Poulin, Patricia, et al. "Researching what matters to improve chronic pain care in Canada: a priority-setting partnership process to support patient-oriented research." *Canadian Journal of Pain* 2.1 (2018): 191-204.

¹⁵¹ Vian, T., Kohler, J. C., Forte, G., & Dimancesco, D. (2017). Promoting transparency, accountability, and access through a multi-stakeholder initiative: lessons from the medicines transparency alliance. *Journal of Pharmaceutical Policy and Practice*, 10, 1-11.

to ensure that reports are publicly available, and their findings are acted upon. MeTA adopted a similar strategy to gather and evaluate indicators from the pharmaceutical sector, data that would inform discussions among stakeholders and support the formulation of evidence-based policies to enhance access to medicines. MeTA aimed to establish national-level multi-stakeholder platforms for sharing information and enabling dialogue. Supported by the United Kingdom Department for International Development (DFID), Phase II has been overseen and backed by the World Health Organization (WHO) and Health Action International. Operating in seven pilot countries—Ghana, Jordan, Peru, the Philippines, Kyrgyzstan, Zambia, and Uganda—the initiative undertook various activities through the MeTA: Pathways to Transparency, Accountability, and Access program, involving the collation and dissemination of data and convening a diverse group of stakeholders to analyze evidence and propose policy changes.

Table 2. MeTA Strategic and Tactical Approaches to Accountability¹⁵²

Country	Strategies
Ghana	Open meetings model with MeTA forum events. Proactive dissemination through web site, television, and newspapers. Contributed to progress toward a national policy on transparency and accountability in pharmaceutical sector. Created model policies/procedures at facility level where previously absent or ad hoc. Developed educational activities to increase demand for and use of data.
Jordan	Proactive dissemination model with some elements of open public meetings. National Medicines Policy now has section on transparency. Disseminated hard copy and electronic versions of documents to government offices and civil society organizations; published workplans, analytical reports, and approved policies on government web site. Educational activities included advocacy training.
Kyrgyzstan	Proactive dissemination model included publishing state medicine policy in a trade journal. Held numerous public roundtables for policy discussions. Took actions to overcome legal barriers to disclosure, and to develop technical tools to enable transparency (medicine codifier software). Promoted public information campaign to increase awareness of rights, and to inform the public of dangers of unsafe medicines. Civic education on advocacy and monitoring of policy implementation. Started web site, but no longer available.
Peru	Mainly proactive dissemination through the Medicines Price Observatory. Open meetings; for example, medicines policy meetings held in different cities, attended by civil society groups, academics, and local officials.

¹⁵² Vian, T., Kohler, J. C., Forte, G., & Dimancesco, D. (2017). Promoting transparency, accountability, and access through a multi-stakeholder initiative: lessons from the medicines transparency alliance. *Journal of Pharmaceutical Policy and Practice*, 10, 1-11.

Table 2. Cont.

Country	Strategies
Philippines	Open meetings model and proactive dissemination with strong social media component. Increased process transparency with information about rules, laws, and procedures, and access to performance data. Disseminated documents at meetings, through e-mail, and on password-protected web sites intended for multi-stakeholder initiative members only.
Uganda	Open meetings model with some proactive dissemination. Findings from survey of access & pricing shared at a national meeting. Study on quality of medicines was not published due to sensitive data, but was presented at a public meeting. Stories in print media and television. Started a blog and web site, though the blog has not been updated.
Zambia	Proactive dissemination through radio programs, television, website, social media, brochures, pamphlets, fact sheets. Used a strategy of in-person communication through creation of MeTA groups at district levels. Created Facebook pages for advocacy. Disseminated some information through MeTA Forum and Roundtable events.

In recent decades, there has been a surge in transparency across various aspects of life.

This shift has been fueled by advancements in computing power, increased Internet accessibility, and evolving societal standards. While the evidence on transparency's impact on health outcomes is limited, it serves as a crucial tool for fostering trust. Additionally, transparency can pinpoint areas in need of enhancement, such as identifying hospitals with higher-than-anticipated mortality rates post specific procedures through basic statistical methods. It is imperative that these analyses are primarily used to offer assistance and drive progress, reserving punitive measures for cases of deliberate misconduct.

Solutions

- It would be beneficial to have a system to know who you have been referred to and the wait time and have the means to change the course as deemed appropriate following a discussion involving your primary health care professional
- Successful commercialization relies on establishing strong scientific evidence showcasing your product's safety, effectiveness, and worth, as well as effectively conveying this proof to various parties. Medical jargon can be challenging for non-experts to grasp, hence the rising importance of Plain Language Summaries (PLS) as a crucial tool to broaden the reach of your research and enhance collective healthcare decision-making. Various audiences, including patients, caregivers, healthcare

professionals, and payers, benefit from easily understandable and accurate research information. This webinar will explore the increasing utilization of plain language summaries and their unique contribution to your communication strategy. The presenters will share insights on best practices and key considerations for crafting PLS. Attendees will gain knowledge on the significance of PLS in providing reliable disease and treatment information to patients and stakeholders, facilitating patient involvement in drug or device development, and enhancing physician-patient decision-making. Additionally, the webinar will cover aspects to ponder when simplifying your research and the types of PLS available and where to publish them.

Problem #8. Lower wait times in different provinces and how to access independent surgeries? More networks like the Surgical Solutions Network

Solution: A means whereby there are mechanisms for Co-pay or paid through existing Provincial plans in conjunction with new Acts to enable this.

Case Study – Surgical Solutions Network

Inter-Provincial Travel Surgical Solutions Network is a leading private healthcare provider with 9 multidisciplinary centers located throughout Canada. Due to regulatory restrictions at the provincial level, it may be necessary for you to travel outside your home province to access independent surgical procedures or other necessary medical services.

Traveling out-of-province allows you to access the care you need in a timely manner while remaining within Canada.

Travel for Independent Surgery in Canada For individuals in Canada who prefer not to wait for publicly funded surgery in their home province or are unable to do so, Surgical Solutions Network offers support in accessing prompt surgical treatment at one of our specialized centers located outside their province. They also assist those who opt to undergo surgery within Canada rather than traveling abroad, as their services provide comprehensive and consistent care that may not be available in other countries.

Traveling for private surgery can be a practical choice. Instead of waiting long periods for a procedure in Canada, consider having surgery at an accredited Surgical Solutions Network surgical center in another province.

By opting for one of our surgical facilities within Canada, you can:

- Schedule surgery promptly to address any quality-of-life issues.
- Access a variety of surgical services using advanced medical technology and minimally invasive techniques.
- Benefit from care provided by experienced specialists and registered nurses.
- Ensure continuity of care with follow-up services and physiotherapy available closer to home.

Medical Travel FAQ for Out-Province Care

Do I need to be a citizen of Canada?

You do not need to be a citizen of Canada to receive our high-quality surgical services. They cater to Canadian citizens, non-citizens, permanent residents, non-residents, temporary visitors to Canada on a visa, and international patients from outside Canada. If you are traveling from outside Canada, they recommend obtaining travel insurance to cover emergency medical issues.

How long is the wait?

With independent surgery, you can benefit from short wait times. Your procedure will be scheduled promptly, typically within a few weeks of your initial surgical consultation.

Where should you stay during my procedure?

Their intake team can recommend preferred hotels near their facilities. The length of your stay at their surgical centers will depend on the type of procedure. You may be discharged the same day or stay 1 to 2 nights for post-operative care.

When will you be able to return home after your procedure?

Most patients can safely return home within a day to a few days after their procedure. Upon returning home, their clinical team will maintain communication with you and your primary medical team for continued care.

Do I need a referral?

A referral is not mandatory, but they may need confirmation of a diagnosed condition or specific medical history details from a doctor or specialist.

Will your benefit plan cover the procedure?

Typically, private benefit plans do not cover procedures. However, some plans may allow partial claims for medically necessary procedures. It is advisable to check with your benefit plan for confirmation. Some

provinces may reimburse a portion of the costs for out-of-province services. Their team can provide guidance on this process. The patient is responsible for payment before treatment and for pursuing any available reimbursements.

Are there any tax considerations?

Most medical expenses are tax-deductible. Consult your accountant for confirmation.

Is financing available?

Yes, financing options are available through various providers. Their team can assist you in exploring these options if you are interested.

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