

March 1999 (Volume 40, Number 2)

Cost Containment Mechanisms in Canada

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Aim. Describe the mechanisms currently being used by federal and provincial/territorial governments, medical associations, and private insurers to control the cost of health care in our country.

Methods. Descriptive method used. Statistics on percentage GDP spent on health, and health status of the population, were compared with other OECD countries. Questions discussed: importance of cost control, why difficult to control, and what is needed to control costs.

Results. System-wide mechanisms used to control health care costs include: single payer financing, universal coverage for hospital/physician services, global budgets, preventive health services, evidence-based information systems, and regionalization. Sector specific mechanisms used to control costs of physicians, hospitals, drugs, and technology. Cost control within the health care sector allows spending on other sectors (e.g., employment) that have a proven impact on one's health. Future health care cost containment policies must focus on restraining private sector costs and encouraging movement towards the determinants of health approach.

Conclusions. Canada's relative success in containing costs is the result of public financing of the health insurance system. Our single payer, publicly financed health care system, allows for cost containment and universal access based on need for services rather than ability to pay. The shift of costs from the public to private sector must be curtailed. The determinants of health approach is instrumental in containing and channeling future spending on health.

Key words: Canada; health care; health expenditures; health insurance; health plan implementation; hospital costs; insurance, health; planning, health and welfare; resource allocation reform

The purpose of the paper is to present, within a general descriptive framework, the mechanisms of health care cost containment which Canadian jurisdictions are pursuing, albeit at different levels of comprehensiveness and intensity. It is not, nor does it propose to be, a detailed analysis of all the individual mechanisms within the health care sector, which combined have an effect on the rate of change in the costs of health care in Canada.

Introduction

Canada's health care system ranks amongst the best in the world. According to the results of the Canadian polling firm, Angus Reid, "... 90% of Canadians consider our health care system to be the best in the world" (1). Also, the United Nation's Human Development Reports have ranked Canada as number one for several years in terms of life expectancy, educational attainment, and adjusted real income (2). One of the key characteristics of our success has been the ability to ensure universal access to medically necessary hospital and physician services while at the same time exercising a fair degree of control over public sector health care costs.

In order to control health care costs, both the price and quantity of services must be managed.

Canada has adopted some measures that address these two dimensions; some are at the system-wide level and others at the sector level. All combined produce the results observed in the aggregate health expenditure data.

The purpose of this paper is to provide some examples of cost control mechanisms in operation in Canada at both the system and sector specific levels.

General Observations

Three key questions that need to be reviewed when examining the issue of cost containment in the health care sector are: Why is cost control an important issue, for governments and for society generally? Why are health care costs difficult to control? What instruments can be evoked to control health care sector costs?

Cost control in the health care system is paramount from a public policy perspective, given the large opportunity costs associated with resource allocation in this area. We know that beyond a certain point, expenditures on health care, especially on chronic care, do not continue to produce positive population health status gains. This is especially the case when measured against the health status improvement that would result from similar sized investments in other areas such as in the reduction

of poverty, improved education, and reduced unemployment. The health status of Canada's population, as measured by such macro indicators as infant mortality and life expectancy, is lower than that of other countries, like Japan, which spend less of their total wealth on health care. In 1995, the life expectancy for Canadians at birth was 81.3 years for females and 75.3 for males. Based on information from the Organization for Economic Co-operation and Development (OECD), internationally, Japan had the highest life expectancy at birth – 82.8 years for females and 76.4 for males. Our 1995 infant mortality rate was 6.1 per 1,000 live births (4.3 in Japan) (3).

Consequently, cost control within the health care sector is important to ensure that societal resources for other sectors that are known to have a greater positive impact on population health status are available. Controlling the growth of both public and private health care expenditures is also important from the perspective of maintaining the competitive advantage of Canadian companies in the world marketplace.

The nature of health care and the "market" for health care services make cost control difficult. Health care is not a typical commodity that can be bought and sold in an unregulated market. One notable reason is that the demand for health care, based on illness is unpredictable. Moreover, the demand for health services is largely supply driven, by physicians and other providers.

Another difficulty in containing health care costs has to do with the "income/expenditure identity". Total health care "costs" in any society are equal to total expenditures on health care, which in turn are equal to total incomes earned in the health care sector. Therefore, any attempt at containing costs has a direct impact on the incomes of providers. Consequently, changes that affect the incomes of those who derive their economic well-being from the health sector invariably elicit strong opposition. It is not the health outcome of the expenditures that is being protected but rather the wages, salaries, profits, and dividends of the vested interests.

Whether or not Canada's cost containment experience is viewed as a success depends on how it is measured. The OECD reports that internationally, Canada (9.3%) ranks fourth among the Group of Seven industrialized nations, after Germany (10.4%), the United States (14.0%) and France (9.9%) in the ratio of total health expenditure to the Gross Domestic Product (GDP) in 1997. It should be noted that the "... OECD standardizes GDP figures for consistency with all member countries". Thus, Canada's health to GDP ratio differs from that reported elsewhere in this document (4).

Since the advent of public health insurance, Canada has been better able to control aggregate costs than the United States of America. Starting from a situation of equality of total health care spending as a percentage of GDP in both Canada and the U.S. prior to the introduction of health insurance (7.4% in both countries in 1971) (5), the gap between the countries has steadily and consistently widened. In 1996, the United States was devoting 14.2% of its GDP to health care spending, Canada's share was 9.2% (5). Canada's health care spending as a percentage of GDP is projected at 9.0% for 1997. By contrast, United States health spending is projected for 14.0% of its GDP (5).

There is little doubt that the involvement of governments – the ten provinces and two territories – as single payers and active regulators, especially of the hospital and physician services components, has also resulted in a scenario where public sector health care expenditures have actually declined in recent years. At the same time, private sector health care expenditures have continued to rise. Public sector health care expenditures in Canada is forecast to be 69.7% of total expenditures in 1998. Private expenditures for drugs, dental services and some components of institutional care, make up the remaining 30.3%. In 1975, the shares of public and private expenditures were 76.4% and 23.6% respectively (4).

In 1997, total public sector health care expenditures are estimated to have decreased by 1.5% while private sector health care expenditures increased by 0.6%. The proportion of total expenditures spent on hospital and physician services, which are predominately publicly financed, declined over the period 1975 to 1997. Expenditures on hospital services declined from 45.0% in 1975 to 33.7% in 1997. Expenditures on physician services declined from 15.0% in 1975 to 14.4% in 1997. The portion of total expenditures spent on drugs, which are largely privately financed, rose from 8.8% in 1975 to 13.7% in 1997 (4).

Canada has been relatively successful in containing costs. A key contributor to this success is the fact that Canada's universal health insurance system for necessary hospital and medical services is publicly financed. The extent of public sector involvement, as the payer for services, is important. "In general, the OECD countries that have contained costs better have greater government control of health spending and a larger public share of total expenditures" (6).

Given that the demand for health care services is infinite, costs must therefore be controlled by "top down" measures on overall spending, or what we call system-wide mechanisms. These measures must be complimented by "bottom up" policies to improve efficiency and effectiveness, or, in other words, mechanisms that impact on the cost of delivering particular services (7). A combination of

approaches is used in Canada; some examples of mechanisms at each level are briefly described below.

System-Wide Mechanisms

System-wide mechanisms or attributes that help to control health care costs include: a single payer approach to financing, universal health insurance coverage for hospital and physician services, global budgets, preventive health services, professional management, evidence-based information systems, and regionalization.

The Single Payer System

The single payer system in Canada refers to an approach where health services/providers are mainly compensated by one public authority, rather than by a large number of private sources, as for example, is the case in the United States. In Canada, 90% of hospital budgets and 99% of physician services are publicly financed.

One of the advantages of the single payer system is its ability to control administrative costs. This is largely due the ability of provincial Ministries of Health, as sole financiers, to apply a number of restraints and control measures on these two sectors (i.e., global budgets, fee schedule negotiation). Administrative costs in Canada are roughly 8% to 11% of total expenditures. In the United States, administrative costs represent roughly 19%-24% of total expenditures (8).

In Canada, private insurers are not allowed to offer coverage for services that are covered by the public insurance system. While this "no-competition" policy strengthens and ensures that Canadians can benefit from the full advantages of the single payer system, it does allow private insurers to offer coverage that is "supplemental" (i.e., private accommodation in hospitals, dental care, out-of-hospital drugs) to the public system.

The Canadian single payer approach results in an exclusion of point of service user charges or extra-billing by hospitals and physicians. These charges create financial barriers from the point of view of equitable access to necessary services and do not lower system-wide demand for health services. They are not an effective means of controlling costs.

Universal Coverage

Universal access to hospital and physician services contributes to lower health care costs by facilitating early detection and treatment of disease (i.e., tuberculosis) that would otherwise require expensive treatment. Also, by eliminating the costs associated with mechanisms necessary to administer adverse risk exclusion practices (i.e., only selecting to insure patients with good health status) that are generally associated with private insurance markets, universal coverage ensures lower per capita health care costs and access to higher quality of care for all.

With access and quality of care maintained in the public sector, pressures to introduce second, private tier medicine, are minimized. Universal coverage also, and very importantly, provides governments with the necessary support to take on the vested interests (e.g., physicians) and introduce cost containment measures on a system-wide basis.

Global Budgets for Public Health Care Services

Each provincial government allocates the resources that it will spend for publicly funded health care services through its annual budget exercise. These global health (care) budgets are set with regard to the needs of the population and the fiscal means of the government. It is a finite pool of resources which will then be subdivided into budgets for physicians, hospitals, other institutions, etc. The exercise of this blunt instrument, which is subjected to the approval or rejection of the voting public at regular intervals, (i.e., provincial/territorial elections), is the most significant aggregate cost control measure.

Prevention/Promotion

One of the most important ways of addressing cost pressures in the long term is to deal with the demand side pressures on the health care system by moving to a health determinants approach; that is, an approach that focuses the health sector on illness prevention and wellness promotion within a population health framework. This approach helps to contain costs by preventing the onset of illness. Over the years, federal and provincial governments have developed a number of programs aimed at improving the health of the population. Childhood immunization occurs through local public health units. Programs that promote early screening for certain diseases (e.g., breast cancer) as well as tobacco and drug strategies primarily aimed at youth are part of the population health strategy that is being put into place. The health care system is an important element in illness prevention and wellness promotion but more needs to be done in this area, particularly with regard to promoting efficient and effective clinical preventive care.

More recently, the federal government announced the enhancement of two programs that target high risk children. The Community Action Program enables communities to develop programs and services which promote the health and social development of at-risk children and their families. The Canadian

Prenatal Nutrition program focuses on pregnant women who are at risk of having unhealthy babies due to poor health and nutrition. Food supplementation along with nutrition counseling support, education, and lifestyle counseling are key components.

Another important aspect of controlling costs is disease surveillance and risk management. In Canada, the federal government exercises a great deal of responsibility in these areas. For example, the Laboratory Center for Disease Control at Health Canada carries out disease surveillance, risk assessment, and control of diseases of national and international significance (e.g., AIDS, chronic diseases such as asthma, reproductive health, and child health).

Professional Management

The public health care system is primarily managed by professional administrators rather than providers of care. From a system-wide cost containment perspective, the main advantage of utilizing professionally trained administrators is their ability to apply financial expertise and objectivity to resource allocation and planning. In Canada, the Canadian College of Health Service Executives has established a certification program for basic knowledge and competency of hospital administrators.

Information Systems

It is estimated that up to 30% of all health services provided to the Canadian population are either unnecessary or not cost-effective (9). In order to acquire the necessary evidence to support the delivery of appropriate care from both a cost and quality perspective, the Canadian Institute for Health Information (CIHI) was formed in December 1993 as an independent, non-profit national organization responsible for coordinating an integrated health information system. CIHI assembles and provides information on: Health Human Resources (who provides health services); Health Service events (what treatments Canadians receive), and Health Expenditures (how much we spend).

In its 1998 budget the federal government announced new funding to support the planning, development, and implementation of a network to ensure that medical and health evidence and research is nationally accessible to health practitioners and service providers. The Health Infrastructure Support Program will support projects that stimulate the use of advanced information technologies and applications in the health field.

Regionalization

Governance of provincial health care systems is rapidly changing as all but one province have adopted some form of decentralized or regionalized organizational structure for their health systems and most health services. The goal of regionalization is to serve local population health needs more effectively and efficiently by allocating funds directly to specific regions. Regionalization can result in reduced administrative expenditures as existing boards and management structures are consolidated, contain costs by shifting the program emphasis away from expensive institutional care and into the community, and achieve savings through the downsizing and restructuring of provincial health departments.

Sector Specific-Mechanisms

In addition to system-wide mechanisms and attributes that help to contain health care costs such as the ones noted above, there are also cost control mechanism being applied at a macro and micro level in such sectors as physicians, hospitals, drugs and technology.

Physician Services

In Canada physicians, essentially general practitioners, are the gatekeepers of the system. They determine the services a patient needs including tests and referrals to specialists, admit to hospital, and prescribe drugs. As a result of their role, physicians are the group that has the greatest impact on health care expenditures. Mechanisms introduced to contain physician costs at the macro level include:

1. Setting global budgets: global budgets for physician services are established by the provincial governments. Since governments pay for virtually all of the services provided by all physicians, they are in a position to achieve their expenditure targets.
2. Negotiating fee schedules and increases: provincial governments negotiate aggregate fee schedule increases/decreases with medical associations who represent the interests of physicians as their bargaining agent and who work out the relativities of fees to be paid between the different groups of specialist and non-specialist doctors. Because governments are able to take a proactive bargaining position with physicians, as a group, they are better able to contain aggregate physician expenditures.
3. Alternative payment schemes: fee-for-service remains the dominant method of remuneration in Canada; in 1998, 64.1% of physicians received 90% or more of their earnings from this method (10). Given both cost and appropriate care concerns associated with this system of remuneration, several Canadian provinces (i.e., Alberta, Manitoba, Ontario and Nova Scotia) are currently in the process of considering some form of a capitated and/or blended (i.e., capitated and fee-for-service) payment model for their primary care physicians. Positive outcomes commonly associated with capitation

include the ability to achieve predictability in physician expenditures for a defined population, and a reduction in hospital utilization through substitution of ambulatory care and improved preventive practices. Other forms of alternative payment schemes which are being considered for particular circumstances include sessional fees and salary.

4. Licensure: physicians wishing to practice in Canada must, after their formal training, obtain licenses from provincial/territorial licensing authorities.

5. Physician supply policies: "For much of the 1970's and 80's the rate of growth of physician supply was in excess of population growth" (11). Canada had an oversupply of physicians, leading to an increased, supply driven, demand for health services. In order to reduce the number of practicing physicians and to ensure an appropriate physician/population ratio, a national strategy was announced in 1992 which focussed on reducing medical school entry class size (by 10%); reducing national postgraduate medical training positions by 10%; and reducing recruitment of visa trainee graduates of foreign medical schools into Canada for postgraduate medical training (12). From 1993 to 1996 the number of physicians decreased relative to the population (11).

6. Controlling the general practitioner/specialist split: in Canada the split between the number of general and family physicians (GP/FPs) (51% or 28,108) and specialists (49% or 27,135) is almost equal (13). This proportion has remained essentially constant for the last 20 years. This balance which is a matter of policy and not happenstance, is deemed to be essential in order to minimize costs arising from an inappropriate number and/or mix of physicians (14) and helps to avoid overspecialization.

7. Alternative providers: most provinces are looking to expand the role of providers other than physicians to ensure the availability of less costly, more appropriate care. The emphasis to date has been on the licensing of midwives and nurse practitioners. In addition to the desire to substitute lower cost providers for certain services, the movement towards the use of alternative providers is also consistent with the objective of strengthening Canada's primary care system by providing more integrated service delivery. This is not an easy sell as it means a loss of market and prestige for certain groups of providers, particularly physicians.

8. Malpractice insurance: almost all physicians in Canada belong to the Canadian Medical Protective Association, a non-profit organization funded by premiums paid by physicians which provides malpractice insurance to its members. Cost savings result from administrative efficiencies gained by pooling the risk associated with individual physicians into one insurance scheme that covers the entire membership. From a malpractice standpoint, the public nature of health care in Canada has also created an environment wherein the public is less litigious and the courts are less generous with awards as regards health matters.

Micro Level Instruments

1. Clinical Practice Guidelines (CPGs): several provinces as well as physician organizations at the national level are developing and utilizing clinical practice guidelines. These guidelines are viewed as a means of reducing cost by seeking to eliminate practice variations and promoting the most appropriate service. Provinces such as British Columbia and Saskatchewan have focussed guideline development around certain diagnostic procedures, such as thyroid testing and prostate screening. In 1993, Saskatchewan doctors saved \$1 million by reducing thyroid testing by 55% through elimination of unnecessary series of tests and by using the most reliable and current tests when thyroid disorders were suspected. It now has a similar program in effect for cardiograms which has reduced their use by 10% (15).

2. Individual physician caps – in an effort to gain predictability and control over medical expenditures, all provinces have imposed medical expenditure caps at the level of individual practitioners. For example in Ontario, only 67% of the negotiated fees are reimbursed after a doctor reaches \$404,000 in billings to the province's health insurance plan, and 33% of fees are reimbursed after \$454,000. Separate thresholds can also apply to general practitioners and specialists, as is the case in Prince Edward Island and Newfoundland.

3. Differential fees/restricted billing numbers: as a means of altering the financial incentive structure and addressing physician maldistribution situations, particularly shortages of physicians in rural and remote areas, some provinces are restricting the allocation of billing numbers (e.g., Manitoba) and/or providing differentiated fee reimbursements on the basis of location of practice.

Hospital Services

Beginning in the late 1970's the line by line hospital budget process was replaced with global budgets in an effort to support better management practices. Separate funding for capital requirements was also introduced.

1. Global hospital budgets: hospitals in Canada negotiate annual global budgets for their operating expenses with provincial governments. Once a global budget is struck, the hospital is expected to

work within it. The hospital has the freedom to move money around inside its global budget and to benefit from efficiencies. Some funds are also available from external sources such as parking revenues.

2. Capital funding: funding of capital expenditures is not included in the operating budget of institutions. For example, a hospital that wishes to acquire an expensive piece of high technology equipment must demonstrate a need and seek provincial approval on a project-by-project basis. As an additional means of controlling the diffusion and number of "big ticket" technology items, hospitals must raise a significant proportion of the costs of the asset.

Other mechanisms to contain macro hospital costs include:

1. Not-for-profit hospitals: approximately 96% of the hospitals in Canada are operated as private, non-profit entities run by community boards of trustees, voluntary organizations, or municipalities.

2. Reconfiguration: the period between fiscal years 1986/87 and 1994/95 has seen a reduction in the number of hospitals in Canada and fundamental changes in the way they deliver their services. During this time, the number of public hospitals fell by 14%, and the number of approved beds in these hospitals declined by 11%. As a result, the number of staffed beds per 1,000 population dropped from 6.6 to 4.1 (16). The average length of stay in hospitals has also declined from 13.85 days in 1987/88 to 10.7 days in 1995/96 (17). Declines in hospital discharge rates are due to multiple factors. The trend toward more frequent use of ambulatory care and day surgery, improved medical technologies and treatments, as well as new pharmaceuticals, may have reduced the need for hospitalization or surgical intervention (17). Consequently, a greater proportion of patients can be treated on an out-patient basis, such as for cataract surgery. In 1993/94 there were 1.34 visits by outpatients for every one day an inpatient spent in an acute-care public general hospital (with no long term beds) – an increase of 42% over the ratio of 0.95 recorded in 1986/87 (18).

3. Accreditation: The Canadian Council on Health Services Accreditation (previously health facilities accreditation) sets accreditation standards and evaluates compliance with them. Compliance with these standards improves the quality, effectiveness, and efficiency of care. The standards for accreditation address all services provided in acute care facilities, long term care centers, mental health and rehabilitation centers.

At the micro level, individual hospitals are increasingly contracting out many of their non "core" business functions such as food preparation, laundry, and grounds keeping (19). They are also introducing treatment protocols, like reducing the length of stay for certain services such as childbirth and promoting day surgery as an option to more expensive inpatient care.

Drugs

Publicly funded drug coverage in Canada varies by province and territory and tends to target specific population groups such as seniors and social assistance recipients. The private sector pays most drugs in Canada. In 1996, employees, insurance companies, unions, and individuals paying out-of-pocket accounted for 64.4% of drug expenditures (almost \$7 billion) (20). The public sector accounts for 35.6%. Within the public sector, the two largest payers are provincial governments (25.4%) and hospitals and other institutions (7.3%) (20). It is followed by the federal government and Workers' Compensation (1.8%) and public health and other (1.0%) (20).

Although drugs represent the fastest growing segment of total health care expenditures, the existence of a highly regulated market ensures that some cost containment is achieved. At the macro level, drug costs are controlled in the following ways:

1. Drug evaluation/approval: Health Canada is responsible for ensuring that drugs which are sold in Canada are safe and effective.

2. Control of patented drug prices: since 1987 the Patented Medicines Prices Review Board has regulated the prices of patented drugs. For example, a) price increases for existing medicines are limited to changes in inflation; b) prices for most new drugs are limited to the range of prices for other drugs used to treat the same disease; c) prices of breakthrough drugs are limited to the median of the prices charged for those drugs in other industrialized countries.

3. Formularies: provincial formularies list drugs that will be paid for under the provincial plans. In order to contain the cost of public drug programs, provinces limit their reimbursement to certain classes of drugs and to certain population groups (e.g., seniors). With respect to the former, all provincial drug programs apply limits on the selection of products covered and the price at which they will be reimbursed. The two most common policies that are being pursued to contribute to controlling costs of public drug plans are generic substitution and reference-based pricing.

4. Generic drugs: in an effort to contain costs, provincial drug formularies substitute brand name products for less expensive, generic versions with the same chemical composition. Patients whose drugs are reimbursed by provincial plans but who nonetheless wish to receive brand name drugs usually have to pay the difference between the brand name and the generic version.

5. Reference-based pricing: reference-based pricing goes one step beyond the use of generics in drug formularies in that it results in the reimbursement of the lowest cost alternative in a therapeutic category which may not be of the same chemical composition as is the case with generic substitution.

Technology

As indicated earlier, a hospital that wishes to acquire an expensive piece of high technology equipment must seek provincial approval on a project-by-project basis. In most instances hospitals must raise a significant proportion of the costs of the required asset.

New technology can also represent a major cost driver. Efforts to contain costs in this area have focussed on encouraging more appropriate use and undertaking evaluation of outcomes.

In December 1989 the federal, provincial and territorial ministers of health announced the creation of the Canadian Coordinating Office for Health Technology Assessment (CCOHTA). It is a non-profit corporation funded by the thirteen governments in Canada. CCOHTA was established "to provide information on emerging and existing health care technologies to decision makers, and to facilitate the exchange and coordination of information on health technologies". Examples of CCOHTA priorities/projects include:

(a) The Pharmaceutical Advisory Committee (PAC) has been established to provide advice to the CCOHTA Board of Directors on pharmaceutical-related issues. At present, the membership of the PAC comprises provincial drug program managers, and representatives of Health Canada and the Patented Medicine Prices Review Board.

(b) CCOHTA also publishes "Selected Health Technologies in Canada" to provide researchers and health policy makers with an accurate description of the status and distribution of key medical technologies in Canada (e.g., Magnetic Resonance Imaging [MRI], open heart surgery centers). There are also health technology assessment organizations at the provincial level (i.e., British Columbia Office of Health Technology Assessment, the Health Services Utilization and Research Commission in Saskatchewan, and the Conseil d'évaluation des technologies de la santé du Québec).

At a micro level, cost control occurs by regulating technology use. For example in Alberta, guidelines are used to manage MRI technology. Ontario has guidelines governing the use of ultrasound imaging during pregnancy.

Conclusion

Canada has been relatively successful in containing health care expenditures. Much of this success is owed to the single payer approach. What has been learned in Canada, through much experimentation, is that a single payer, publicly financed health care system promotes cost control and universal access based on need and not on the ability to pay. Highly valued by Canadians, it is an important element of the Canadian health care system infrastructure. Consequently, the single payer system is not being called into question or being reviewed within the context of further cost containment.

The introduction of system-wide cost control mechanisms like the single payer approach as well as sector specific measures have also over time assisted in ensuring that cost containment policies are comprehensive across the entire health care system. Improved partnership and collaboration between governments, providers and patients will be necessary to ensure the success of these instruments in the years to come.

Future health care cost containment policies will need to focus on restraining ever-increasing private sector costs and encouraging a movement towards a determinants of health approach. With respect to the former there is a growing concern that costs are simply being shifted to the private sector as restraints are placed on public sector health care services. The end result could well be that while costs are contained in the public sector, private sector as well as total health care expenditures would be driven up.

A good example is the public hospital sector. As a result of restraint as well as technology, which allows for a transfer of activity out of institutions, many hospital services are being replaced by drug therapy and home care. These services are largely financed by the private sector. Measures and incentives must be put in place to avoid shifting costs from public to private purses.

Moving towards a determinants of health approach will also be instrumental in containing health care sector costs. From a societal point of view the objective is to spend the last marginal dollar where it will achieve the greatest increase in the health status of the population. It is increasingly recognized in Canada that future investments, particularly public, should not go solely to health care but rather to other determinants of health that are likely to have a greater positive impact on health status, such as employment, healthy lifestyles, and the reduction of poverty and health promotion projects.

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Received: January 25, 1999

Accepted: February 19, 1999

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