HEALTHCARE FINANCING AND REIMBURSEMENT: A GLOBAL REVIEW OF MAJOR TOPICS AND TRENDS

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LAWS AND REGULATIONS ON HEALTHCARE FINANCING AND REIMBURSEMENT

1. Please provide a bird's eyes view on the healthcare economy, indicating, in general terms, the role of the government (public healthcare) and private actors (private healthcare).

Canada's healthcare system is primarily funded through tax revenue collected by the provincial, territorial, and federal governments. The federal government acts as the national funder for 'medically necessary' services, while provincial or territorial health insurance plans determine what qualifies as 'medically necessary' under their respective plans. These plans are responsible for fully covering the cost of these services for eligible patients. These 'medically necessary' services, also known as insured services, which are covered under the public system, are not permitted to be funded privately.

The federal government, in addition to providing healthcare funding to the provinces and territories, regulates pharmaceutical and medical devices, supports health research and disease prevention, and provides tax support for medical expenses and disabilities.

Generally, the delivery of direct healthcare is administered by the provinces and territories. This is except for direct care provided by the federal government, which includes care for first nations on reserve, eligible veterans, inmates in federal prisons, among a select few other specified groups.

For the public generally, most healthcare services including hospital care, physician visits and diagnostic testing are publicly funded with no direct cost to patients. In addition to the publicly funded healthcare system, Canadians in most provinces have access to healthcare services funded by workplace insurance boards and/or no-fault car insurance plans, depending on their province or territory's applicable legislation.

While 'medically necessary' services are covered under Canada's public healthcare system, many expanded services are not included. This list of service varies between the provinces and territories. Services such as psychological therapy, physiotherapy, dental care, prescription drugs, physiotherapy, and vision care are generally excluded from public healthcare funding unless provided to patients in a hospital. These services are often paid for out-of-pocket by Canadians or are covered through employer-sponsored benefit plans. Some provinces and territories provide supplemental coverage for these services for specific groups, such as seniors, children, or those in receipt of social assistance.

Private donations and funding from not-for-profit foundations, such as hospital foundations also help to support public hospitals. These foundations play a complementary role by enhancing healthcare services, infrastructure, and innovation beyond what public funding covers. This support ultimately improves the quality and sustainability of Canada's healthcare system. Hospital foundations typically operate under the not-for-profit legislation of their respective province or territory, supplementing other healthcare funding sources in the country.

Nationally, and at a provincial level, discussions on universal pharmacare are ongoing. While Canada has taken preliminary steps to improve access to drug coverage, the implementation of a comprehensive national pharmacare plan remains a distant goal; it currently is in place for those under 18 and over 65 who fall under a certain income bracket.

2. Please provide a high-level overview of the legal framework regarding healthcare financing and reimbursement.

Public health funding in Canada is delivered primarily pursuant to the Canada Health Act (the CHA). The CHA is federal legislation that codifies the national principles and requirements underpinning federal funding for hospital and physician services and the national prohibitions on patient charges, which may undermine universal access to care. The stated objective of the CHA is to protect, promote, and restore the physical and mental wellbeing of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.

The CHA establishes criteria and conditions related to insured health services and extended healthcare services that the provinces and territories must fulfil to receive the full federal cash contribution available to them under the Canada Health Transfer (CHT). The CHT is the funding mechanism whereby the federal government provides financial contributions to the provinces to help them deliver publicly funded healthcare.

Pursuant to the CHA, for a province or territory to qualify for their full allotted funding, broadly speaking they must respect the public administration, comprehensiveness, universality, portability, and accessibility of healthcare. When provinces comply with the CHA and its regulations, transfer payments are made by the federal government on an equal per capita basis to provide comparable treatment for all Canadians, regardless of where they live.

Moreover, the CHA does not define what constitutes 'medically necessary' services. Instead, the CHA is a broad statute and the decisions over which services to cover is made by the province or territory, in consultation with the medical profession. Once something is deemed 'medically necessary' it is an insured service and there is a ban on patient charges. Typically, the service and the constituent elements of the service are entirely covered. Transfer funds to the provinces pursuant to the CHT can and have been withheld for violations of the CHA and its accompanying regulations in relation to billing and extra user charges.

The CHA does not forbid the provision of health services by private companies so long as eligible residents are not charged for insured health services. In fact, many aspects of healthcare in Canada are delivered privately. For example, family physicians mostly bill the

provincial or territorial health insurance plans as private contractors. Hospitals are often independent non-profit corporations, and many aspects of hospital care (ie, lab services, housekeeping, and others) are carried out privately.

Medical services that are uninsured under their respective provincial insurance plans may be charged to patients or a third-party (ie, an employer). There is no federal legislation that bans charging for uninsured services on either a fee for service basis or as part of a block fee.

3. What are the key regulators and supervisory bodies regarding healthcare financing and reimbursement?

Health Canada oversees the implementation of the CHA to ensure the provinces and territories comply in order to receive federal funding. The regulations in force under the CHA ban extra-billing and user charges for patients receiving insured services. Further, these regulations require the provinces and territories to report annually to Health Canada on the amount of extra surcharged levied (if at all). Ultimately, the CHA requires the provinces to ensure there is no extra-billing and user charges for insured health services as the financial pressure encourages provinces and territories to maintain compliance with federal health standards.

Since 'medically necessary' services are not defined in the CHA, it is up to the provincial and territorial health insurance plans, in consultation with their respective physician colleges or other professional groups, to determine which services are 'medically necessary' for public health insurance purposes. If it is determined that a service is 'medically necessary', the full cost of the service must be covered by the public health insurance plan to comply with the CHA. If a service is not considered 'medically necessary', the province or territory need not cover it through its health insurance plan.

Pursuant to the CHA, provinces and territories that allow extra-billing and user charges (which is defined as an amount in addition to the amount paid under the insurance plan or other charges for the provision of services) are subject to mandatory dollar-for-dollar deductions from the federal transfer payments. For example, if it is determined that any amount of extra-billing by physicians has occurred in a province or territory, the federal cash contribution to that province or territory can be reduced by that same amount.

Apart from the federal oversight for funding, the provincial and territorial governments have primary jurisdiction in healthcare administration and delivery. This includes setting their own systemic priorities, administering their healthcare budgets, and managing their own resources. The applicable ministry in the province or territory is responsible for financing, administering, and delivering healthcare services.

Organisations such as the Canadian Medical Association and the Canadian Nurses Association, among others, often engage in advocacy related to healthcare funding, reimbursement, and other relevant policies. Medical regulatory colleges in the provinces regulate the practice of medicine, including ethical standards, billing practices, and broader compliance with financing rules. Finally, the Canadian Institute for Health Information is an independent, not-for-profit organisation that provides the public with essential information

about Canada's healthcare system. This information helps inform policy decisions and monitors broader system efficiency.

Moreover, healthcare providers' regulatory colleges, such as the College of Physicians and Surgeons of Ontario, provide guidance to their members on permitted patient fees.

4. Has there been a change with healthcare financing and reimbursement as a consequence of the Covid-19 pandemic?

The federal and provincial/territorial governments significantly increased healthcare funding to manage the Covid-19 pandemic. This included investments in personal protective equipment (PPE), Covid-19 testing, vaccines, and hospital capacity, among others.

During the pandemic most provinces provided additional temporary emergency funding to support the public health system and its hospitals. To support these initiatives, in addition to Canada Health Transfers, the federal government made targeted investments to areas such as vaccine procurement, increased testing, and access to care.

Throughout the pandemic, hospitals faced financial challenges not only from increased direct costs but also from lost revenue sources, such as co-payments for private rooms, visitor parking and reduced retail services, which typically help support patient care and clinical services.

While federal and provincial governments provided significant funding to manage the crisis, this support has since decreased, creating new and ongoing financial pressure for healthcare organisations.

In Ontario, wage restraints were imposed on both frontline staff and executives during the pandemic. The Ontario courts have since struck down this legislation, resulting in back pay obligations for frontline staff without additional funding to assist hospitals with these costs.

Further, the pandemic led to increased expenses for staffing, supplies, utilities, and medical equipment, exacerbating already existing hospital deficits. While some organisations with surplus funds can maintain operations in the short term, concerns persist about their long-term viability. Historically, Canadian hospitals have received financial support from the various levels of government during times of financial distress.

While private virtual care increased rapidly during the Covid-19 pandemic through fee-based models, public adoption lagged until provinces introduced temporary measures to allow virtual care billing under their health plans. Private and public virtual care services continue to coexist, with differences in coverage and billing rules across the country. In some cases, the temporary measures evolved into permanent virtual care billing structures, expanding access to remote healthcare services. Where virtual care became publicly funded as an insured service, all of the prohibitions on private pay and surcharges that apply to in-person care still apply.

5. Who has access to the healthcare system as a patient on the one side and as a medical service provider/supplier of medical goods on the other side? What are the conditions of admission?

To be eligible for insured healthcare services in Canada, an individual must be an eligible resident within a province or territory. The CHA defines an insured person as 'a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province'. For example, in Ontario under the Ontario Health Insurance Plan (OHIP), every Ontario resident is entitled to become an insured person. Residency typically includes citizens and permanent residents, in addition to eligible refugees and refugee claimants. However, each province or territory is responsible for determining its own minimum residence requirements with respect to an individual's eligibility for benefits under its health insurance plan.

Individuals visiting Canada, including students, foreign workers, and newcomers waiting for eligibility, are typically not covered by provincial health insurance plans.

Canadians travelling within Canada are typically covered for insured health services during temporary absences from their home province or territory; although prior approval may be required before coverage can be used for non-emergency services in another province or territory.

All nurses, physicians and most other allied healthcare providers are regulated by their applicable provincial and territorial professional colleges, which set out education requirements, as well as professional and ethical standards.

Finally, suppliers of medical products are required to meet safety, quality and efficacy standards, which are enforced federally by Health Canada.

HEALTH INSURANCE FINANCING AND COVERAGE

6. How are health insurance carriers financed? How are premiums determined?

Public health insurance, provided by the provinces and territories, is funded predominately through government revenue collected at the federal and provincial levels. Eligible residents automatically enrolled in their provinces health insurance plan do not pay a direct premium for basic public coverage. Some provinces do indirectly collect health premiums through their taxation systems. For example, in Ontario, a health premium based on total taxable income is automatically deducted from an Ontario resident's employment or pension income when they earn more than CAD20,000 a year (with some limited exceptions).

Private insurance for non-insured services (as outlined above) is funded by employee-sponsored benefit plans, workplace safety insurance plans, and privately out-of-pocket through individual premiums paid by policyholders. Premiums for private insurance are either paid as part of a group (often employment) or individual plan. Factors which affect the premium depend on the level of coverage, the recipients age, their health status, and whether the policyholder has any dependents, among other factors.

7. How is coverage of medical services by health insurance carriers regulated? Are there differences in coverage for in person medical appointments and telemedicine appointments?

Private insurance is available to supplement the coverage of services not covered under the CHA. Canadian residents often access these insurance plans through employer-sponsored benefit plans. These benefit plans tend to include insurance for services such as dental care, prescription drugs (outside of the hospital setting), vision care, physiotherapy, mental health support, alternative therapies and more. The underwriting and distribution of insurance in Canada is governed by both Canadian federal and provincial legislation. The federal regulation is principally concerned with prudential matters, including the creation, governance and financial viability of insurance companies. Provincial legislation, on the other hand, provides for the regulation of the distribution of insurance products and the contractual aspects of insurance coverages, including in connection with private health insurance. Stated in a general way, each provincial and territorial insurance regulator supervises market conduct within its province or territory for all insurers licensed to carry on business in such province or territory.

Across the country, coverage for virtual care and in-person medical appointments also varies by province or territory. For virtual care, the provinces publicly fund certain types of virtual care services through their health insurance plan. When patients seek virtual care independently, from private providers (ie, through a telehealth app or platform) and do not go through the public system, these services are sometimes uninsured under the public system and are privately funded either by employer-sponsored benefit plans, through private insurance plans, or out-of-pocket.

HOSPITAL SECTOR

8. How are services provided by hospitals in the stationary (inpatient) and ambulatory (outpatient) settings financed and reimbursed?

Canada's public hospitals are non-profit entities funded primarily through global budgets, which are allocated based on patient volumes, the scope of services offered, and funding designated for specific programmes. Insured hospital services typically include 'medically necessary' in-patient services such as accommodation and meals at the standard or public ward level and preferred accommodation if medically required, nursing service, laboratory, radiological, and other diagnostic procedures, together with the necessary interpretations, drugs, biologicals and related preparations when administered in the hospital, use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies, medical and surgical equipment and supplies, use of radiotherapy facilities, use of physiotherapy facilities, and other services provided by persons who receive remuneration from the hospital.

In an outpatient setting, 'medically necessary' tests and diagnostic services are for the most part publicly funded and are provided both within hospitals and privately in the community. To address a shortage of diagnostic services in public facilities, large provinces such as British Columbia and Ontario, have partnered with and funded private companies to conduct

'medically necessary' scans with services covered by public health insurance at no cost to patients.

In both inpatient and outpatient settings, physicians are reimbursed under a fee for service model based on negotiated rates with the provincial or territorial government. Physicians and specialists who are providing care bill the provincial or territorial health insurance plan based on the set fee schedule. Fee schedules are updated periodically.

9. How are the prices of such services determined? How is economic efficiency controlled?

Increases in healthcare spending mainly reflect fiscal government investment decisions or budgetary overruns. These controls include measures such as mandatory global budgets for hospitals and regional health authorities, negotiated fee schedules for providers, drug formularies for provincial drug plans, and resource restrictions for physicians and nurses (such as provincial quotas for students admitted annually to Canadian medical schools), and restrictions on new investment in capital and technology.

Hospital boards are accountable to the applicable provincial ministry and the government for the quality and efficacy of the care they provide. Further, global budgets are one means to control healthcare expenditure growth using spending 'caps', while also providing financial predictability for administrators and policymakers.

Prices for medical supplies, drugs, and equipment are now often managed through centralised procurement processes. Shared service organisations pool purchasing power to negotiate better prices with suppliers. Rising supply costs for hospitals and clinics has resulted in a growth of bulk purchasing agreements. New national shared service organisations have emerged, which support hundreds of hospitals and community healthcare facilities in maximising savings on high-quality medical supplies, life-saving drugs, and other services. By consolidating individual needs into larger volumes, they leverage significant purchasing power to secure better contracts, terms, and pricing from vendors.

For physician pay and other services under the fee for service model, each province and territory sets a fee schedule that outlines standardised rates for insured medical services (ie, physician visits, surgeries, diagnostic tests). These rates are negotiated between the provincial government and their respective medical associations. As provincial health budgets continue to be strained from increasing healthcare costs, provinces continue to delist certain medical services formerly covered by universal healthcare.

HEALTHCARE PROVIDERS IN PRIVATE PRACTICE

10. How are services provided by physicians, therapists, laboratories and other service providers financed and reimbursed?

Services provided by physicians, therapists, labs, and other healthcare providers are reimbursed through public means when they are an insured service. Non-medically necessary private physician services, such as cosmetic procedures, are paid out of pocket, or via private

insurance plans. The same mechanism of reimbursement applies for any other private therapies or private diagnostic testing.

Services that are typically private but are deemed to be 'medically necessary' (ie, physiotherapy following surgery or diagnostic tests) are covered by provincial health plans and reimbursed directly to the provider. Most services (ie, occupational therapy), when provided in hospital or designated public facilities, are publicly funded. Otherwise, many pharmaceuticals, dental, vision, other therapies, and rehabilitations (ie, beyond the covered physiotherapy), are privately delivered and privately funded or funded through employee benefits. Some community services are hybrid, for example, long-term care is made up of more than 43 per cent public or publicly funded non-profit homes, with the rest operated by for-profit businesses.

Some services provided by hospitals and physicians are not considered 'medically necessary', and, therefore, are not insured under provincial and territorial health insurance legislation. Uninsured hospital services for which patients may be charged include preferred hospital accommodation (ie, a private room unless prescribed by a physician or when standard ward level accommodation is unavailable), private duty nursing services, parking, and the provision of telephones and televisions. Uninsured physician services for which patients may be charged include: telephone advice (unless it is insured by the provincial or territorial health insurance plan); the provision of medical certificates (ie, for work, school, insurance purposes); the transfer of medical records; testimony in court; and cosmetic services. Amounts for these services are governed by provincial and territorial regulatory colleges, which generally require that charges be reasonable and reflect the cost of services provided.

In addition to private services, many aspects of healthcare in Canada are delivered privately and funded publicly. For example, family physicians mostly bill the provincial or territorial health insurance plan as private contractors. Walk-in clinics too would be an example of a service that is publicly funded but privately delivered. Tests and diagnostic services are also for the most part publicly funded, despite being privately delivered.

11. How are the prices of such services determined? How is economic efficiency controlled?

Private healthcare prices are determined by a range of factors, including, professional regulations, insurance coverage, and broader market dynamics.

Professional associations often publish recommended fee schedules to provide guidance on pricing for uninsured services. For example, the Ontario Dental Association (ODA) provides a suggested fee guide for dental procedures.

In Ontario, in calculating the fair market value of an uninsured service, Ontario physicians are required to give consideration to the College of Physician and Surgeons of Ontario' policies on fees and the Ontario Medical Association's Physician's Guide to Uninsured Services. This guide contains suggested rates and fees that apply to uninsured services of 'average' complexity.

For services covered by private insurance (ie, dental care, vision care, physiotherapy), insurers may negotiate rates or set maximum reimbursement amounts, indirectly controlling prices.

PHARMACEUTICALS AND MEDICAL DEVICES

12. How are pharmaceuticals and medical devices financed and reimbursed?

While Canada does not yet have a universal, single-payer, pharmacare programme, it has taken several preliminary steps to begin establishing one. On 10 October 2024, the federal Pharmacare Act became law and empowered the federal Minister of Health to enter into agreements with provincial/territorial governments to increase prescription drug coverage for certain contraception and diabetes drugs and related products. The provinces' support for this legislation has been mixed.

In the hospital setting, Canadians are generally not charged for 'medically necessary' pharmaceuticals that they receive during a hospital admission. This generally falls under the coverage of each province/territory's provincial health insurance plan – that a resident is automatically enrolled under. Outside of a hospital setting, Canadians are not generally entitled to government reimbursement for drugs or medical devices that they purchase. There are a few exceptions, examples of which are:

- There are federal drug benefit plans for Canadians who are members of certain eligible groups (eg, veterans, armed forces members, Royal Canadian Mounted Police).
- Some provinces have enacted benefit programmes that entitle qualifying individuals to receive assistance in paying for the cost of eligible prescription drugs (ie, the Ontario Drug Benefit) and medical devices (ie, Ontario's Assistive Devices Program).
- Some provinces have 'exceptional access programmes' to provide coverage in exceptional cases for drugs not otherwise covered by a provincial benefit programme.
- Manufacturers of brand name pharmaceuticals may offer 'patient support programmes' that assist individuals in affording the price of their products.
- Individuals may be able to receive coverage for certain drugs or devices through provincial social assistance or disability programmes.

Many private health insurance plans also provide for prescription drug coverage, though typically covering only a percentage of the cost.

13. How are the prices of pharmaceuticals and medical devices determined? How is economic efficiency controlled?

At the federal level, the Patented Medicine Prices Review Board (PMPRB) regulates the price that patentees can charge wholesalers, hospitals, or pharmacies for prescription and non-prescription patented drugs (referred to as the 'factory gate price'), to ensure the price is not excessive. Prices are reviewed with reference to the drug's prices in selected Organisation of Economic Co-operation and Development countries and with prices of other medicines in the same therapeutic class historically sold in Canada. The PRPRB does not have jurisdiction to regulate any mark-ups that wholesalers or retailers add to pharmaceuticals and does not regulate generic drug prices.

Provincial/territorial governments influence prices by establishing drug formularies, negotiating drug prices, and legislating price ceilings for generic drugs.

There is no price regulation for medical devices.

LITIGATION INVOLVING HEALTHCARE FINANCING AND REIMBURSEMENT

14. Please provide a high-level overview of major litigation topics and landmark cases regarding healthcare financing and reimbursement.

Conversations about expanding access to private healthcare in Canada are increasing as a result of strains on the public health system. The British Columbia Court of Appeal (Court of Appeal) provided a judicial answer to the constitutionality of private care in 2021 when it upheld provisions of the *Medicare Protection Act* (the BC health insurance plan) that banned extra-billing and private insurance for services covered under the public system, despite recognising these provisions can infringe on patients' rights to timely care.

The Court of Appeal held that while patients in the public system might wait for care beyond benchmarks at which point a patient presenting with a diagnosis may suffer negative consequences, this did not infringe their right to life, liberty, and security of the person pursuant to the Canadian Charter of Rights and Freedoms (the Charter). Moreover, if such a violation did occur, the breach would be justified. In 2023, the appellants were denied leave to appeal the decision to Canada's highest court.

This challenge to bans on private care was not the first challenge of its kind. In 2005, there was a similar challenge made against the provincial Québec Charter and the federal Charter. The Québec Court held that the Québec's health insurance plan, which bans private medical insurance, did violate the Québec Charter. However, considering Canada's constitutional structure, the decision does not have broader implications for Canadian healthcare outside of Québec.

Considering the state of the current public discord, Canada is likely to see continued challenges to private care prohibitions given the strains on the public system.

RECENT DEVELOPMENTS AND TRENDS

15. What are the recent developments and trends for the next few years? Please outline any unresolved issues, proposed changes, or trends for healthcare financing and reimbursement and briefly indicate how these may foreseeably affect the medical sector in the near future.

In Canada, healthcare is at the forefront of public and political debate. Entrenched in this debate is the ways in which access and delivery of public healthcare in Canada can be improved. Private versus public models of service have now become central to the debate.

The current national political climate is not favourable to private health models but foremost in the minds of Canadians is the reality that emergency rooms are overwhelmed, millions of Canadians lack access to primary care, surgical backlogs remain unresolved, and many healthcare workers face severe burnout. In response, Canada may continue to see challenges to private care prohibitions and broader public support for such measures.

For example, across Canada, it is estimated that approximately six million people lack access to a family physician, with the number expected to continue increasing. The Ontario Medical Association projects that, due to family physician shortages, one in four Ontarians will be without a family doctor by 2026. This is particularly concerning given that under the Canadian healthcare model, primary care physicians serve as key gatekeepers. Typically, Canadians must first consult a family doctor or a general practitioner at a walk-in clinic before being referred to and accessing specialised care. Recognising the critical role of primary care, governments are focused on reducing the burden on emergency departments and freeing up space for acute care by taking steps to stabilise the primary care system.

Beyond primary care shortages, widespread labour shortages are further straining the system. In some rural communities, hospitals are so understaffed that they have temporarily closed emergency departments and intensive care units.

Adding to these existing challenges, Canada's aging population is expected to place additional pressure on the healthcare system. This demographic shift is likely to increase healthcare costs and further strain the already limited long-term care facilities in many provinces.

While these challenges do not necessarily mean fundamental changes to how healthcare is funded or provided, they may prompt new measures to optimise funding and address gaps in the system.