SECTOR ANALYSIS

Canadian Private Health Services

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Strengths:

- Direct cost of dementia is projected to rise by 1051% to $92.8B by 2038
- Canadian populations affected by diabetes, high blood pressure, heart disease, respiratory disease, and cancer are projected to grow by double digits in the next few years
- Attractive alternative to patients looking to bypass long wait times
- Strong financial performance in several specializations
- 86%+ of Canada's population is concentrated in 4 provinces
- Dietary and lifestyle changes supported by new attitudes towards health and nutrition
- Public-Private Partnerships facilitating private healthcare investment
- Strong net wealth of seniors
- Growing population of seniors who need timely medical services

Weaknesses:

- Prices are partially controlled by regulatory bodies
- Minor inconsistencies in public insurance policy between provinces and territories

Opportunities:

- Supporting trends in obesity, population age, and high immigration from East and South Asia
- Low Canadian dollar along with a relative safe environment and high medical standards may attract medical tourism

Threats:

- Changes in Federal and regional policies
- Increase in supply of medical specialists in the public healthcare system

Travis Sun
Legacy Partners Wealth Strategies Inc.
647-205-7954
info@lpws.co

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LEGACY PARTNERS

Canadian Healthcare System

Healthcare in Canada follows a publically funded system known as Medicare, which is guided by the Canada Health Act (CHA). Medicare follows a single-payer system where the federal and regional governments finance all medically essential services. Each province and territory has its own public insurance plan. Eligibility for public insurance plans varies from region to region. However, prescription drugs and non-medically essential services such as dental and vision care are not publically insured, which forces Canadians to pay out-of-pocket (OOP) or rely on private insurance[1]. The estimated annual healthcare expenditure in Canada amounts to $212B, which is approximately 11.3% of the nation's gross domestic product (GDP) in 2013[2]. Out-of-pocket (OOP) expenses account for 14% of the national healthcare expenditure, and another 13% is attributed to payments made by private insurance[2].

Private Healthcare Landscape

While receiving free healthcare in Canada is often synonymous to being Canadian, private clinics do exist. These clinics typically offer medical services not publically insured to consumers looking to avoid wait times, and seeking proactive measures as opposed to reactive measures. Private clinics in Canada include services related to allergy, audiology, cardiology, chiropractic, corporate health, cosmetic, counselling and therapy, dermatology, diagnostic imaging, dietetics, fertility, gastroenterology, geriatrics, hearing aids, maternity, medical financing, medical insurance, medical management, natural medicine, neurology, nursing, obstetrics and gynaecology, occupational therapy, oncology, ophthalmology, orthopaedics, otolaryngology, pain, paediatrics, physiotherapy, podiatry, preventive screenings, psychiatry, psychology, rheumatology, sexual health, sleep, sports medicine, surgery, telemedicine, travel, urology, and weight loss[3]. There is also a cultural shift in Canada where people are taking their health and nutrition much more seriously[4]. Increasing demand for this lifestyle puts specializations related to dietetics, natural medicine, physiotherapy, sports medicine, and weight loss on the trajectory for potential growth. The judicial system has also paved way for private insurance to cover for insured medical services in private clinics[5].

Regulatory Environment

Federal and Regional Governments

Each province and territory has its own ministry of health that sets the policies in their respective regions. As a result, medical coverage by the public insurances varies to some degree. They also must comply with the terms set by the Canada Health Act (CHA) in order to receive the full Canada Health Transfer. While the federal government does not administer any policies at the regional level, it can exert influence in regional policies related healthcare through these transfer payments, as it amounted to $32B in 2014-2015[11].

Canada Health Act (CHA)

The federal government sets the health guideline through the Canada Health Act (CHA), which includes the following five principles:

- Public Administration: administration of public health insurance needs to be carried out by a non-profit and public authority. They also need to be accountable to the provinces and territories, and all records may be subjected to audits.
- Comprehensiveness: all medically essential services must be covered by public insurance.
- Universality: all Canadians are entitled to the same access of healthcare regardless of income, ethnicity, gender, etc.
- Portability: a publically insured Canadian should be medically covered when travelling to another province or territory, or to another country.
- Accessibility: all insured persons should have reasonable access to healthcare facilities.

Professional Colleges

As with any medical practice, the practitioner will be held against the operating standards set forth by the regulatory bodies in their fields, and must obtain the proper credentials and licensing from their respective colleges. Such colleges in the medical field include Royal College of Physicians and Surgeons of Canada, and College of Physicians and Surgeons.

Market Dynamics

The sentiments Canadians have toward private clinics are increasingly positive, and physicians are experiencing difficulties keeping up with the demand[12]. Those living in Canada have long been engaging in medical tourism where they travel to the US or overseas to seek medical treatment. This has resulted in increased out-of-pocket (OOP) expenses amounting to $43.2B in 2006, and is expected to increase significantly year over year[13].

Public-Private Partnerships (P3)

Public-Private Partnerships (P3) are arrangements between the public and private sector. It has fuelled significant private investments into the construction and maintenance of more than 50 hospitals with the most recent projects including Joseph Brant Hospital, ErinoakKids Centre for Treatment and Development, Calgary Cancer Center, and the Cambridge Memorial Hospital.

Wait Times

Wait times have been the main driving force behind the demand for private medical services in Canada. The Canadian Institute for Health Information (CIHI) has surveyed pan-Canadian wait time benchmarks, which communicate the appropriate amount time to wait for certain procedures. The benchmark wait time for hip fracture repair is 48 hours, radiation therapy is 28 days, cataract surgery is 112 days, and hip replacement, knee replacement, and bypass surgery are all 182 days. To date, it has been a realistic target for the provinces and territories to hit the wait time benchmark 90% of the time[14]. However, in 2015, cataract surgery met the benchmark wait time 76% of the time, 77% for knee replacement surgery, 81% for hip replacement surgery, 87% for hip fracture repair, and 98% for radiation therapy. While the benchmark times are close to being met, the actual wait time are still very lengthy for many of the procedures.

Population and Physicians Growth

Appendix I shows the annualized growth rate of physicians per 100,000 population from 2012 to 2015[15]. Appendix II illustrates the rate of population growth in each province and territory

from 2012 to 2015. Of the listed regions, there are three that are notable. Firstly, there is Ontario. The annualized 4-year growth rate of physicians per 100,000 persons in the province is 2.03% while the population growth is 1%. Secondly, the population of British Columbia also grew by roughly 1%, but interestingly, the growth rate of physicians per 100,000 persons is only 0.77%. Alberta, British Columbia, Ontario and Quebec are the largest markets in Canada as they represent 86.3% of the Canadian population. There were a total of 50826 permanent residents coming into Canada from the Philippines in 2015, 39525 from India, and 19532 from China.

Appendix I: Number of Physicians per 100,000 Population[15]

	2012	2013	2014	2015	4Year Compound Annual Growth Rate of Physicians	4Year Average Population Growth	Population Weight
Canada	**215**	**220**	**224**	**228**	**1.48%**	**1.10%**	**100%**
Newfoundland and Labrador	234	241	248	243	0.95%	0.20%	1.46%
Prince Edward Island	183	190	179	181	-0.27%	0.48%	0.41%
Nova Scotia	251	262	260	261	0.98%	0.00%	2.62%
New Brunswick	221	227	229	222	0.11%	-0.03%	2.09%
Quebec	234	237	239	242	0.84%	0.78%	22.95%
Ontario	203	203	214	220	2.03%	1.00%	38.54%
Manitoba	196	204	201	204	1.01%	1.23%	3.63%
Saskatchewan	179	184	189	196	2.29%	1.50%	3.17%
Alberta	216	221	229	237	2.35%	2.48%	11.72%
British Columbia	225	225	229	232	0.77%	1.03%	13.09%
Yukon	184	183	197	212	3.60%	1.38%	0.10%
Northwest Territories	84	99	101	84	0.60%	0.40%	0.12%
Nunavut	34	30	33	27	-5.60%	1.68%	0.10%

Appendix II: Percentage Change in Population Size across Canada				
	2012	2013	2014	2015
	% Change			
Canada	1.2	1.2	1.1	1
Newfoundland and Labrador	0.3	0.2	0.2	0
Prince Edward Island	0.7	0.1	0.5	1
Nova Scotia	0.1	-0.1	0	0
New Brunswick	0.2	-0.1	-0.1	0
Quebec	1	0.9	0.7	1
Ontario	1.1	1.1	1	1
Manitoba	1.3	1.2	1.2	1
Saskatchewan	1.8	1.7	1.5	1
Alberta	2.4	3	2.8	2
British Columbia	1	0.9	1.2	1
Yukon	1.9	0.7	1.5	1
Northwest Territories	0.2	0.4	0.2	1
Nunavut	1.5	2	1.8	1
Note: Population as of July 1. Source: Statistics Canada, CANSIM, table 051-0001. Last modified: 2016-09-28				

Net Worth

Private healthcare is a costly service, and requires the user to have the financial means to afford the services. Senior families have the highest median net worth of any economic group at a total of $650,000. Seniors between the ages of 55 to 65 have a median net worth of $533,600, and 65 and older have a median net worth of $460,700. To further this trend, median net worth of seniors of age 65 and over grew by 70.2% from 1999 to 2012. British Columbia's median net worth increased by 128.3%. The significant rise may be attributed to a net positive migration and as well a concentration of Chinese immigration into British Columbia from 2003 to 2011[17]. While British Columbia has highest median net worth of $344,000 in 2012, Ontario still is the largest market with a total regional net worth of $3.1 trillion[18].

Competition

The competitive environment for private clinics in Canada is a monopolistic competition with Ontario, British Columbia, Alberta and Quebec as the most saturated markets. Major competitors in the Canadian market include Medcan, RocklandMD, Surgical Centres, Preventous, Homewood Health, Canada Diagnostic Centres, Cleveland Clinic, Bayshore, Shouldice, and Centric Health.

Financial Performance

Of the surveyed categories in healthcare, those with the highest reported net profit percentage include offices of physicians at 18.60%, offices of dentists at 27.50%, and medical and diagnostic laboratories at 17.20%. Offices of physicians and dentists compete in a highly saturated market. Medical and diagnostic laboratories, on the other hand, only have 8,398 reported establishments in Canada. For offices of physicians and dentists, the key to be a top 25% financial performer seems to be better management of purchases, materials, sub-contracts, and professional and business fees. For medical and diagnostic laboratories, they seem to be dependent on better management of labour and commission costs, and professional and business fees.

Opportunities

Dementia

Dementia is the leading neurodegenerative disease in Canada. In 2010, Alzheimer Society of Canada published a study that showed direct cost of dementia on Canadians adding up to $8B in 2008. Direct costs are costs incurred while treating the disease within or outside the formal healthcare system. The direct cost is projected to rise by a staggering 1051% to $92.8B by 2038[23]. The majority of the direct cost is attributed to long-term care and community care. Appendix III below illustrates rising direct costs associated with dementia, and the incremental direct cost dementia with another co-occurring or co-morbid health concern. The growth in this area is supported by the growing seniors market in Canada.

Year	Appendix III: Direct Health Costs For Long-Term Care (LTC), Community Care (CC), No Care, and Excess Health Costs, Future Values							
	Direct Cost LTC Due to Dementia	Incremental Direct Cost LTC Due to Co-morbid Dementia	Direct Cost CC Due to Dementia	Incremental Direct Cost CC Due to Co-morbid Dementia	Direct Cost No Care Due to Dementia	Incremental Direct Cost No Care Due to Co-morbid Dementia	Excess Health Costs Associated with Caregivers	Total Direct Cost
2008	$3,488,976,859	$899,673,278	$899,663,518	$2,171,161,676	$148,158,636	$357,551,846	$98,548,155	**$8,063,733,967**
2018	$7,814,993,328	$2,015,186,959	$2,446,654,228	$5,904,520,732	$340,327,241	$821,313,134	$230,551,918	**$19,573,547,540**
2028	$16,589,338,377	$4,277,753,921	$5,863,632,470	$14,150,728,409	$724,283,584	$1,747,916,558	$489,10,815	**$43,842,755,134**
2038	$33,243,745,344	$8,572,286,535	$13,297,576,167	$32,091,095,371	$1,361,996,359	$3,286,911,426	$979,197,580	**$92,832,808,780**

Diabetes

Prevalence of diabetes in those between the ages of 12 to 19 increased by 24.08% and those of age 65 and over increased by 20.47% from 2010 to 2014[24]. Additionally, the number of individuals in Quebec diagnosed with diabetes increased by 26.48% from 2009 to 2014[34]. From 2010 to 2020, the total direct cost of diabetes in Canada is projected to grow by 47.62% from $2.1B to $3.1B. Direct cost of diabetes in Ontario is projected to grow by 62.04% from $1.075B to $1.742B by 2020. East Asians have a high likelihood of developing type-2 diabetes regardless of their body mass index (BMI). This group of individuals account for 4.5% of the Canadian population, with the highest density in Ontario at 5.6%, British Columbia at 10.7%, and Alberta at 4.4%.

Cancer

While the number of cancer cases has stayed consistent across genders from 2009 to 2013, the number of cancer cases in seniors of age 65 and older increased by 20.47%[25]. According to an analysis performed by Public Health Agency of Canada in 2008, the direct cost of cancer is $3.8B[26]. Persons in Canada over the age of 50 make up 88% of all cancer cases in the country, which amounts $3.34B in direct expenses by this group[27]. The population of seniors who are 65 and older is on track to grow 33% by 2025, and 50.2% by 2035[8]. On a related note, cancer is another major cause of mortality for persons of East Asian background[7].

High Blood Pressure and Heart Disease

Number of seniors of the age 65 and older with high blood pressure increased by 16.35% from 2010 to 2014, especially in the male population where it increased by 24.41%[28]. A group from the University of Calgary's Cumming School of Medicine surveyed that the estimated cost to treat high blood pressure and its consequences in Canada in 2010 was about $13.9B[29]. Of that amount, approximately $7.8B is the direct cost of heart disease, where hospitalizations account for 61% of the cost, drugs for 26%, and physician care for 12%. South Asian people from regions such as India, Pakistan, and Sri Lanka are highly susceptible to heart diseases. They represent 4.9% of the Canadian population as of 2011. Regions within Canada with the highest density of South Asians are Ontario at 7.9% of the population, and British Columbia at 7.2% of the population[6].

Respiratory Disease

The Conference Board of Canada estimates that in 2010 chronic lung diseases had total direct cost of $3.4B[30], and in 2008, the direct cost of asthma amounts to $2B[32]. The number of seniors diagnosed with asthma increased by 32.97% from 2010 to 2014[31]. Respectively, a conservative estimate by the Conference Board of Canada puts the direct cost of asthma at $4.2B by 2030, which is a 110% jump compared to the 2008 estimate[33].

Obesity

The health consequences of obesity include diabetes, high blood pressure, heart disease, stroke, and asthma. Coincidentally, the Canadian population has one of the highest rates of obesity in the world. The percentage of the persons in Canada increased steadily over the years reaching a measured rate of 25% in 2009, from only 14% in 1978. The prevalence of obesity also increases with age for both genders, peaks at the age range of 55-64, and decreases after the age of 65. Individuals of South Asian background are more susceptible to be overweight and have double the rate of diabetes compared to their European counterparts.

SWOT Analysis

Strengths:

- Direct cost of dementia is projected to rise by 1051% to $92.8B by 2038
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Five Forces Model

Bargaining Power of Suppliers

There are, in fact, many suppliers for most medical equipment. Regardless of the type of private clinic the practitioner is looking to start, equipment costs will likely be very high. For example, secondary market magnetic resonance imaging (MRI) machines sold by Providian Medical range from $150K to $1.4M United States dollars (USD). As the price tag increases, the sales cycle typically increases as well and each potential customer becomes more valuable. This results in taking away bargaining power from suppliers.

Bargaining Power of Buyers

There are buyers who will seek private clinics as a form of luxury, and there are also buyers who will seek private clinics as a necessity to bypass wait times in Canada. Both of these buyers will have the financial means to afford services provided by private clinics if they are considering it as an option at all. As a result, these buyers' financial resources give them options in choosing their healthcare provider since they are able to travel to seek medical help elsewhere. Buyers' bargaining power is high.

Intensity of Competitive Rivalry

Offices of physicians and dentists are heavily saturated with 106,708 establishments in Canada. Comparatively, there are only a handful of private clinics in operation such as Medcan. Even in competitive markets such as Ontario, very few clinics offer specialized services such as cardiology, diagnostic imaging, dietetics, fertility, and geriatrics. The intensity of competition is low.

Threat of New Entrants

The barriers of entry are significantly high, as it requires the operator to be medically trained. For example, each qualified physician must go through medical school, which includes 3-4 years of basic medical training, 2-7 years of residency, and a mandatory written exam. They must

then also be registered and licensed with the appropriate colleges to practice in their fields. In addition to high equipment cost and push back from taxpayers, it is incredibly difficult to enter this market[19].

Threat of Substitutes

Competing private clinics in the same field and region are substitutes to each other. Private clinics in Canada offer similar prices, the differences in the prices are often negligible when taken into account travel and hotel costs[20,21]. Public health providers only become substitutes of private clinics if the public insurance expands its service coverage. As such, the threat of substitutes is low.

Summary

The private healthcare landscape is constantly evolving to meet demand of consumers willing to pay for timely medical services. Projections of demand for healthcare services related to dementia, diabetes, high blood pressure, heart disease, respiratory disease, and cancer are all about to increase dramatically in the next 10 to 20 years. Population, immigration, and obesity trends in Canada act as support for the continuation of the aforementioned demanded services. In conclusion, private healthcare in Canada is a promising sector on-track to grow very aggressively.

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