

Social Models for Health Care: Canada in International Perspective

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A Changing Social Model?

Conference Theme – But **description or
prescription?**

**What does foreign evidence tell us about
description?**

**perspective on Canada system and
performance**

**What can foreign evidence tell us about
prescription?**

**mostly that some common ideas
would not help**

But What Is a “Social Model?”

Must distinguish from rest of health policy

What aspects of peoples’ lives are of public concern?

could ask this about education, pensions, poverty...

So: Whose business is it?

Who is responsible? Who pays?

What does it include?

How should it be governed? – e.g. by market processes, public administration, or professional discretion

Social Model for Health

Questions include...

How much of a person’s care should be paid out of pocket or from social sharing?

How should that social sharing be organized and governed?

Which medical goods and services should be subject to social sharing?

Investment: should (or how should) the physical capacity to provide services be determined?

Who should be compelled by the government to contribute how much?

Which Does Not Include...

Internal Organization of Health Care

Primary care vs. specialty, role of the hospital, “integration,” end of life, prevention vs. cure... etc., etc., etc.

Payment and “Incentives”

Concerns about fee-for-service, “P4P”, DRGs vs. budgets, etc., etc., etc.

The Aspirational Agenda

Promoted around the world – e.g. medical care largely governed by written guidelines, fantasies/falsehoods about Britain’s NICE...

Canada’s Social Model for Health Care

Canada Health Act Framework – What is in it and what is not in it

Government insures all legal residents for medical/hospital care (so public administration)

No cost-sharing for that care (well....)

But less universal and more private arrangements for other medical goods and services

Who owns hospitals? It’s arguable...

Strong government limits on supply of hospitals, equipment, physicians

Types of Health Shared Finance

“Public” – Mandatory Participation

Use of government bureau (e.g. NHS)

Government insurance (Canada, Korea)

“Sickness funds” (e.g. Germany)

Mandatory private insurance (Switzerland)

“Private” – Voluntary Participation

Primary – i.e. United States

Complementary: Cost-sharing for public benefits

Supplementary: What public does not cover

Duplicative: Alternative for public benefits

Compared to Other Countries (1)

Canada’s “Public” is directly government

Single, not multiple, insurance pools for provinces for the main public benefits

Out of pocket spending share pretty typical – because low cost-sharing but big gaps

Structure of voluntary private insurance is unusual:

Lots of “supplementary” (68% of people)

NO “primary,” “duplicative,” or “complementary”

Compared to Other Countries (2)

Publicly financed share of health care spending is relatively low: **71% in 2009**

19th of 25 richer democracies

Private voluntary insurance share of spending is relatively high - **almost 15% in 2009**

France about the same

Germany, Swiss, Oz around 10%

U.S. much higher of course - 40%

Other comparable countries about 5% or less
(OECD definitions)

Performance? Not so Distinctive

Costs: In a group of 8 countries at about 11-12% of GDP in 2009 **See next slide for trends**

Health Outcomes: Middling on premature mortality, life expectancy.

Volume of Services

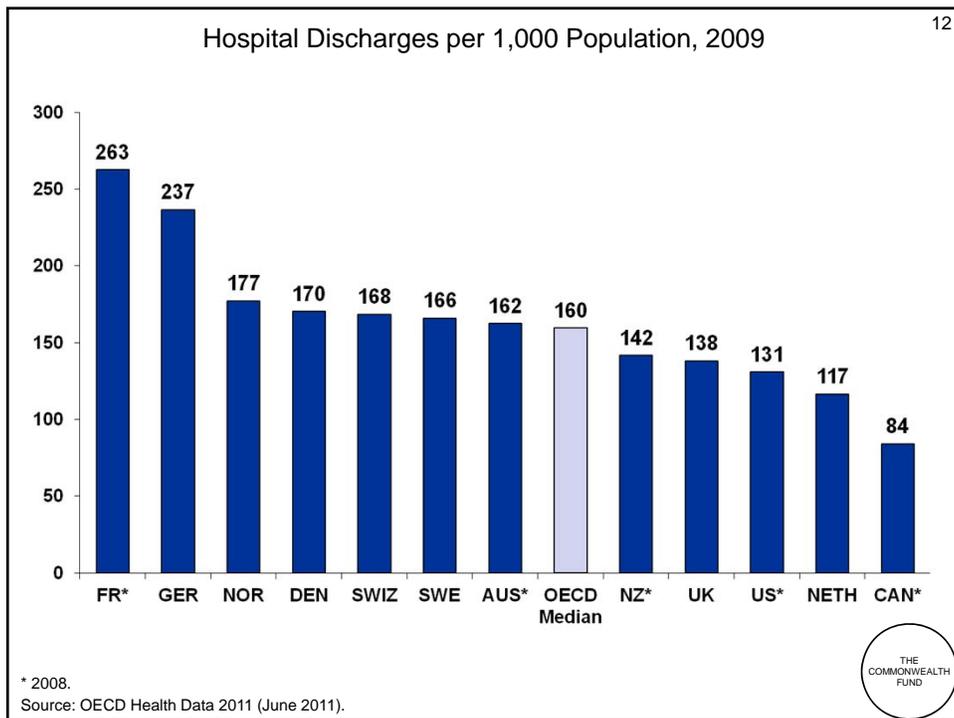
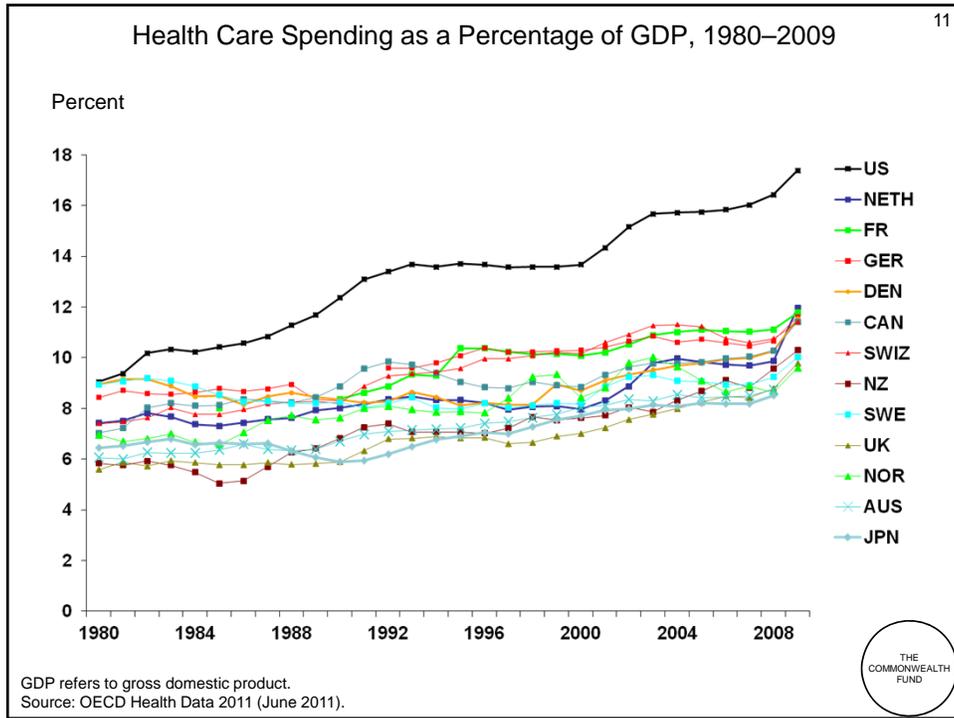
low average MD visits (but busy docs)

similar on scans (but busy machines)

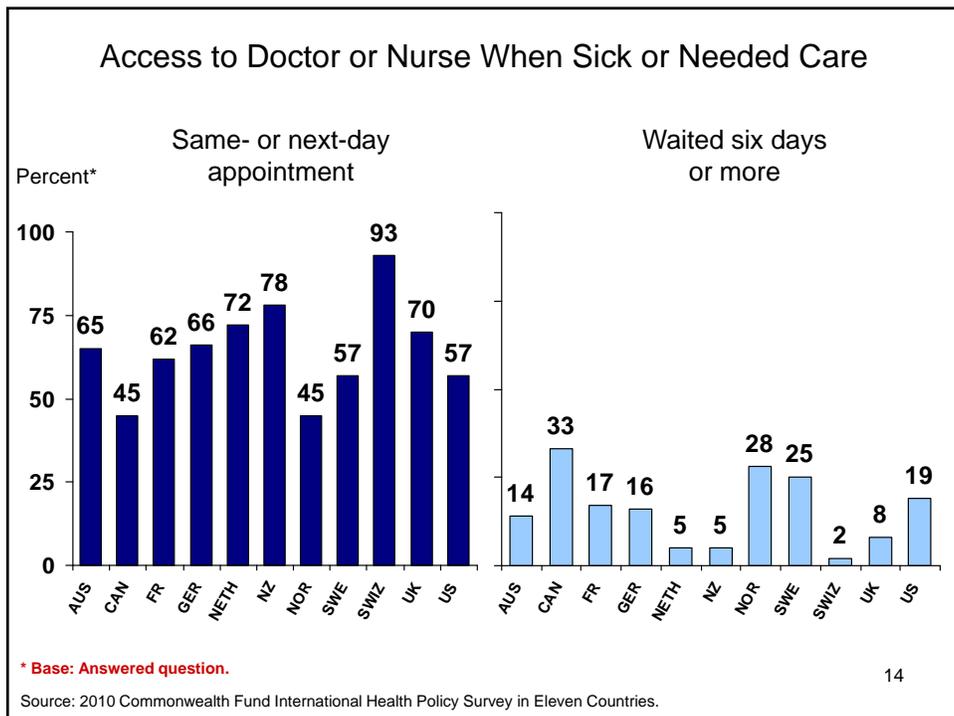
low on hospital discharges (but beds are filled)

comparisons vary by condition/treatment - hips, knees, kidneys, bypass vs. angioplasty...

High Level of Waiting for Some Services



13											
Wait Times for Elective Surgery and Specialist Appointments											
Percent	AUS	CAN	FR	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
Specialist appointment*											
Less than 4 weeks	54	41	53	83	70	61	50	45	82	72	80
2 months or more	28	41	28	7	16	22	34	31	5	19	9
Elective surgery**											
Less than 1 month	53	35	46	78	59	54	44	34	55	59	68
4 months or more	18	25	7	0	5	8	21	22	7	21	7
* Base: Needed to see specialist in past 2 years. ** Base: Needed elective surgery in past 2 years.											13
Source: 2010 Commonwealth Fund International Health Policy Survey in Eleven Countries.											



Why The Waiting?

Unusually Constrained Supply:

Less than 2.4 caregiving MDs per 1000
among rich democracies, only Japan has
fewer – and they do 5-minute visits

And less than 1.2 specialists
again only Japan lower

Low-end supply of machines, beds

Unlike U.S., everyone's insured

**Result: resources used intensely and
efficiently but also some delays**

Are International Trends Making Canada More of an Outlier? (1)

Public administration of insurance? Mixed

**Germans, Dutch, Swiss: more room for insurer
entrepreneurship and competition talk. But
bigger pools, more mandatory.**

**Canada no longer sole government as single-
insurer system. Taiwan, Korea, virtually France**

Government replacing “social partners”

**Cost-sharing: Modest increases, but adding
extra protections too (e.g. France)**

**Extent of benefits: Mild paring, but some
additions too (long-term care in '90s)**

Are International Trends Making Canada More of an Outlier? (2)

**Some move to less government ownership
of supply in “Beveridge” systems**

**A way to expand capacity but pay over time
(maybe extra) for the investments – e.g. England.**

More acceptance of waiting lists as problem

**Funding moves both directions from
sickness fund (“Bismarck”) model**

**Greater use of taxes but also some flat
premiums that then are subsidized**

Voluntary insurance: Not much new

Relevance to Canadian Debate

**Should Canada expand benefits made
universal in its social model?**

Up to you. It’s more a values question

**Should Canada have higher cost-sharing
within its social model?**

**Small savings if any; voluntary coverage reduces
savings but increases health inequality unless
there are offsetting policies.**

**Move to funding by dedicated contributions
instead of general revenues?**

Efficiency effects unclear; can raise more money

Chaoulli and Aftermath

Should there be private coverage for the benefits guaranteed by Canada Health Act?

Careful Skepticism from OECD...

“Duplicative health insurance has the potential to increase the responsiveness of the health system, at least for the part of the population with this coverage. On the other hand, it increases inequity in access and is suspected to divert human resources from the public sector in those countries where dual practice is authorized for physicians. According to the evidence collected by the OECD, the existence of duplicative health insurance has often added to health expenditures and increased service utilization, thus entailing additional costs for the public primary source of coverage in some circumstances. Its contribution to overall efficiency has been assessed to be small.”

OECD Health Working Paper No. 50, “Health Systems Institutional Characteristics: A Survey of 29 OECD Countries” April 2010, p.

Contrary to claims it can reduce need for public funding

Problems with Duplicate Coverage

Duplicate cover exists to “jump the queue” in statutory sector. MDs get paid more for those patients - higher fees, or fees instead of salary.

So strong incentive for doctors to slow down, steer patients to their “private practice.”

Clearly favors those who can afford it.

Can duplicate coverage fund extra capacity that leaves more room in public facilities for people without private insurance?

Not clearly enough to make up for extra costs, cream-skimming, negative incentives for MDs

Policies to encourage duplicate cover are expensive

Likely cheaper to just expand supply directly

So, to Conclude...

Canada's social model for health care:
Somewhat unusual, but other countries
moving towards it as much as away from it.

Canada's results: Not particularly wonderful
(except compared to U.S.) but OK.

Being next to U.S.: Might have subtle effects
on policies - e.g. prices, incomes.

Worried about Waiting? Expand capacity
And Beware!
Of ideological agendas, and policy experts'
unicorns, and zombies...

Some Sources

The primary source for data comparing health care systems in advanced industrial countries is the Organization for Economic Cooperation and Development (OECD), which has been building a data base for three decades. The full dataset is available by subscription, but large portions of it can be downloaded from <http://www.oecd.org/health/healthpoliciesanddata/oecdhealthdata2012.htm>

The Health Committee of OECD's Directorate for Employment, Labour and Social Affairs also does a wide range of analyses. In preparing this presentation I especially used data from:

OECD Health Working Paper No. 50, "Health Systems Institutional Characteristics: A Survey of 29 OECD Countries," which can be downloaded from <http://www.oecd-ilibrary.org/docserver/download/fulltext/5kmfxfg9qbnr.pdf?expires=1344705276&id=id&accname=quest&checksum=E68B529CB9D5EE75E76EC9C563FC4933> as well as

Health at a Glance 2011, which is at <http://www.oecd.org/els/healthpoliciesanddata/healthataglance2011.htm>

I also used data from the Commonwealth Fund's International Health Policy Center, which sponsors analyses, conducts surveys, and compiles OECD data. Its various publications and chart packs can be found at <http://www.commonwealthfund.org/Topics/International-Health-Policy.aspx>

Another good source is the Health Systems and Policy Monitor, which was created by the World Health Organization's European Observatory on Health Systems and Policies and the Bertelsman Foundation. It includes the archives of the previous Health Policy Monitor project <http://www.hpm.org>, which includes reports about policy developments over the first decade of the 20th century from twenty countries, including Canada. The European Observatory also produces a wide range of analyses, also including Canada, which can be found through <http://www.euro.who.int/en/who-we-are/partners/observatory>

There are also many articles in journals such as *Health Affairs*, *Health Policy*, *Health Economics*, *Health Economics, Policy and Law*, and the *Journal of Health Politics, Policy and Law*. I provide an overview of the roles of private insurance, with numerous citations to other sources, in an article with too long a title in the latter journal's August, 2009 issue, Vol. 34, no. 4