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Better Value for Money in Healthcare: European Lessons for Canada

Canada would benefit from a serious look at European countries' efforts to align incentives within their health systems to encourage better performance.

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The Study In Brief

Modern health systems, like Canada's, face similar pressures. Populations are aging, government revenues are dwindling, and the scope for new services is increasing as new technologies develop. However, each country is responding to these pressures in unique ways.

Arguably, Canadians pay too much attention to the United States health model – which is expensive and has a large uninsured population – making it a distraction for provincial policymakers. This *Commentary* instead focuses on the United Kingdom's and the Netherlands' healthcare systems. Those systems have undergone a period of reform to attain greater value for money and they adhere to equity principles similar to those underlying the Canadian system.

Like Canada, the United Kingdom pays for the bulk of its health services out of general tax revenue, but emphasizes the delivery of health services through a single, primary care provider who acts as a screen and entranceway to the health system. It also makes a clear distinction between purchasers and providers of health services. The basic principle of the Dutch health system, in contrast to Canada's approach, is to allow regulated competition among alternative insurance plans.

Both the United Kingdom and the Netherlands have developed tools to promote cost-effective use of health resources. Their experience shows that funding delivery – how spending decisions are made – can improve system performance. Lessons for provincial policymakers include looking to realign the incentives physicians face by making greater use of alternative compensation schemes and also encouraging greater competition at the point of service, paid for by public insurance.

A serious look at how these European countries align incentives within their systems to encourage better performance would be beneficial to health policy development in Canada.

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Advanced countries around the world face similar health-system challenges. Aging populations and new technologies have created, and will continue to create, rising demand for healthcare services, challenging governments' abilities to finance high-quality care.

In response to these concerns, some countries have changed the way healthcare is financed, encouraging greater reliance on consumer choice and competition among private insurers. Other nations have maintained a large single public-payer umbrella to finance care and instead reorganized the roles and incentives of decisionmakers within their health systems. Canadian provinces have, thus far, avoided major changes to the status quo. But budgetary pressures make now an ideal time for provinces to consider the merits of alternative responses to health-system challenges.

In looking for ways to reform the health sector in Canada, we believe that policymakers have a great deal to learn from other countries' experience. We share the view of those who think that the Canadian healthcare system is much better than the US one in certain critical respects. But some European nations and others have developed health systems based on equity principles similar to those underlying our system, with comparable outcomes but at lower costs. In this *Commentary*, we argue that Canada's provinces would do well to give serious consideration to organizational reforms modelled on the UK health system, which encourages alternative payment models for physicians and permits a greater role for competition in the purchasing of health services. Further, with respect to financing, recent reforms in the Netherlands suggest that competition in the insurance market can encourage better value for money in health services delivery, and do so in an equitable manner.[1]

Reforms in both the UK and Dutch systems aim to attain greater value for money. In the UK, the health system's design emphasizes the role of the family physician and his or her influence on the allocation of funds and purchase of services. The United Kingdom, like Canada, pays for the bulk of its health services out of general tax revenue, but emphasizes the purchase of health services through a single primary-care provider screen, as the entranceway to the health system, and makes a clear distinction between purchasers and providers of health services.

The Dutch model takes a different tack to drive efficiency. It promotes competition among potential insurers and encourages patient choice, allowing individuals to periodically shift among competing insurance plans. Substitute health plans are allowed to compete with one another on the basis of price and quality of service.

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1 The Senate Standing Senate Committee report on healthcare (Kirby 2002) looked at its design in Canada and abroad and discussed the role of incentives on healthcare delivery (see, in particular, Section 2.2 of the report). Many chapters in Flood, Stabile and Tuohy (2008) explore European health financing systems and the particular role played by social insurance funding of healthcare costs.

Both the United Kingdom and the Netherlands have a well-articulated view of where they want their healthcare system to be in the future. The United Kingdom has been able to achieve greater value for money by encouraging competition under the public-payer umbrella. Canadian provinces can learn from the UK model because, like the United Kingdom, they each run a large publicly funded health system that has wide popular support.

Meanwhile, the Dutch system, while encouraging a larger role for private insurance – an approach very different from that in Canada – challenges the notion that neither equity nor value for money can be attained via competition among insurers. The UK and Dutch experiences show that the funding of health services delivery – to influence how spending decisions are made – is a critical area with multiple policy levers that can be used to improve system performance. Provincial policymakers should take a serious look at those countries' efforts to align incentives within the system to achieve greater performance.

Value For Money in Healthcare: Canada and its Peers

How efficiently are resources used in our healthcare system today? Different people give different answers. One reason why it is so difficult to give a precise answer is that health services, by and large, are non-tradable. Therefore, our system is not subject to competition from foreign providers. In industries that do produce tradable goods or services, foreign competition has sometimes shown that what we thought was an efficient domestic industry was less efficient than those in other countries. A good example is the auto industry. If health insurance and healthcare could be imported, would our system be able to compete with those in other countries?

The country whose experience figures most prominently in Canadian discussions of health policy is, of course, the United States. This is unfortunate. For one thing, the US healthcare system is much more expensive than the Canadian one (Figure 1). Crude indicators also show that, on average, health outcomes are better in Canada than they are in the United States.[2] The focus on comparisons with the US system therefore tends toward the conclusion that ours is doing well, weakening the case for change.

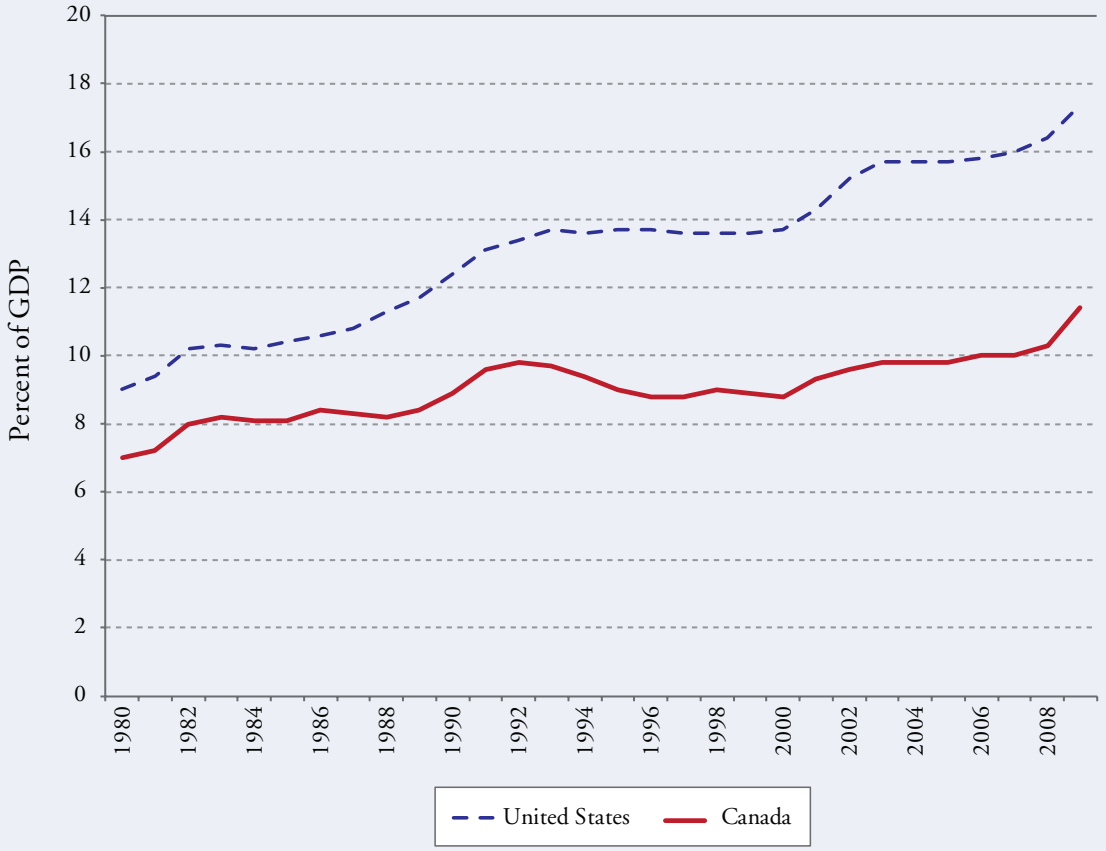
But the United States, it turns out, does not just have a healthcare system that is more expensive than Canada's. In fact, it is much more expensive, in per capita terms, than that of any other country. However, if Canada's system is compared with those of other developed nations, it appears to be a little less costly than some – for example, those of the advanced welfare states in continental Europe, such as France, Germany and the Netherlands – but considerably more expensive than those in the United Kingdom, Australia or Japan (Figure 2).

Taking the observations for per capita health spending and per capita GDP for some economically advanced OECD countries, we can predict the expected level of health spending given a country's per capita income. This is represented by the solid straight line that cuts through Figure 2. This line shows that Canada is near the level of health expenditures that one would predict.[3] But its position is heavily influenced by the data from the United States, which is an outlier. When the United States is removed from the peer group – see the dashed line in the figure – Canada is found to spend noticeably more on healthcare services than might be expected.

2 See Appendix Table A1 on page 26 for a list of relative health outcome measures in Canada and other advanced countries.

3 The regression lines on the figure are the simple ordinary least squares (OLS) results for predicted per capita health spending as a function of GDP per capita using data from a sample of OECD countries.

Figure 1: Total Health Expenditures as a percent of GDP, Canada vs. United States, 1980-2009



Source: OECD health data.

Further, Canada's relative position has been deteriorating in recent years. Because the countries below the predicted level of health spending in Figure 2 have outcome measures that are the same or better than those in Canada, they may be using their health resources more efficiently.[4] Could we draw on their experience to do better?

European Alternatives: The United Kingdom and the Netherlands

For obvious geographical reasons, the foreign healthcare system most familiar to Canadians is the US one, and most of us feel strongly that, taken as a whole, our system is much better. Not only is our system much less costly, it is also more equitable

4 Another reason to suspect that healthcare resources in Canada could be used more efficiently is simply that many industry insiders – doctors, hospital managers, health policy analysts – are saying so. It is not difficult to find doctors or other health professionals who are willing to say that, given the opportunity, they could provide the same standard of care that their patients currently receive at considerably lower cost. While such individual opinions should be treated with caution, they tend to reinforce the macro evidence from international comparisons.

Figure 2: Health Expenditures and National Income, per capita, Canada vs. Selected OECD Countries, 2000-2009 Average.

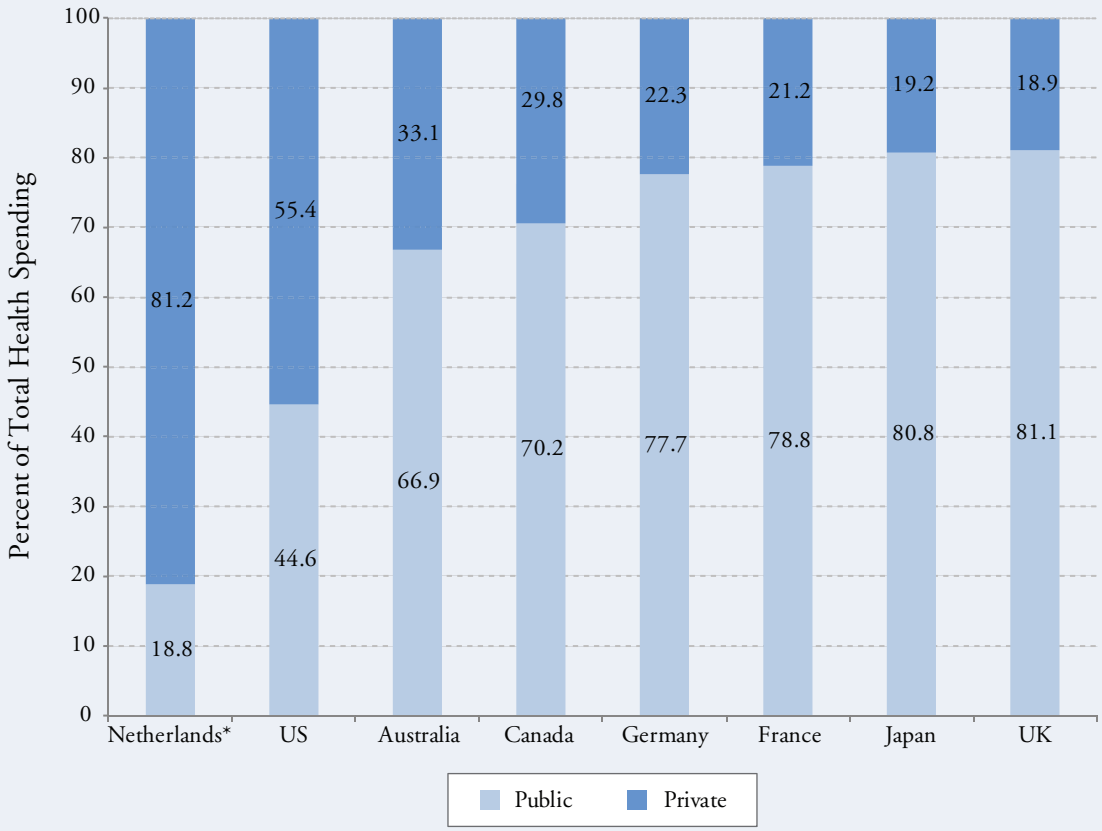
Sources: OECD health data; authors' calculations.

because in Canada access to necessary care is available to every citizen regardless of ability to pay. While many readers may be familiar with the basic features of the Canadian and US healthcare systems, we provide a brief comparative description in Appendix A.

But while the Canadian system compares favourably with the US one, both in terms of equity and cost-effectiveness, there are other countries – Japan and Australia – that offer health insurance coverage on more equitable terms than is available in the United States and also score better in terms of cost and health outcomes. While provincial governments finance a much larger share of healthcare costs than governments in the United States, the share of private financing in Canada is relatively high in comparison with most European countries, or Japan – both via insurance payments and out-of-pocket costs (Figure 3A and 3B).

Some countries have healthcare sectors that offer value for money comparable or even superior to Canada's. In the remaining sections, we focus on two systems, the UK and the Netherlands, which offer potentially useful ideas that may be helpful in a Canadian debate about health-system reform. We chose the United Kingdom because it has a healthcare system that has produced outcomes comparable to Canada's, but at a much lower cost (the data in Figure 2 suggest that UK healthcare spending per capita is more than 20 percent lower than in Canada, even though the United Kingdom has an older population). We chose the Netherlands because, like the United Kingdom, it has been engaged in a process of health-system reform that

Figure 3A: Public and Private Financing of Total Healthcare Costs, Canada and Selected OECD Countries, 2000-2009 Average



Note: The data for the Netherlands must be carefully interpreted: While most payments to providers is through private insurance plans, most of the (risk-adjusted) premiums collected by insures come from a government fund to which all taxpayers must contribute. Hence the Netherlands could be seen as a largely publicly financed system, although with an extensive role for private insurance.
Source: OECD health data.

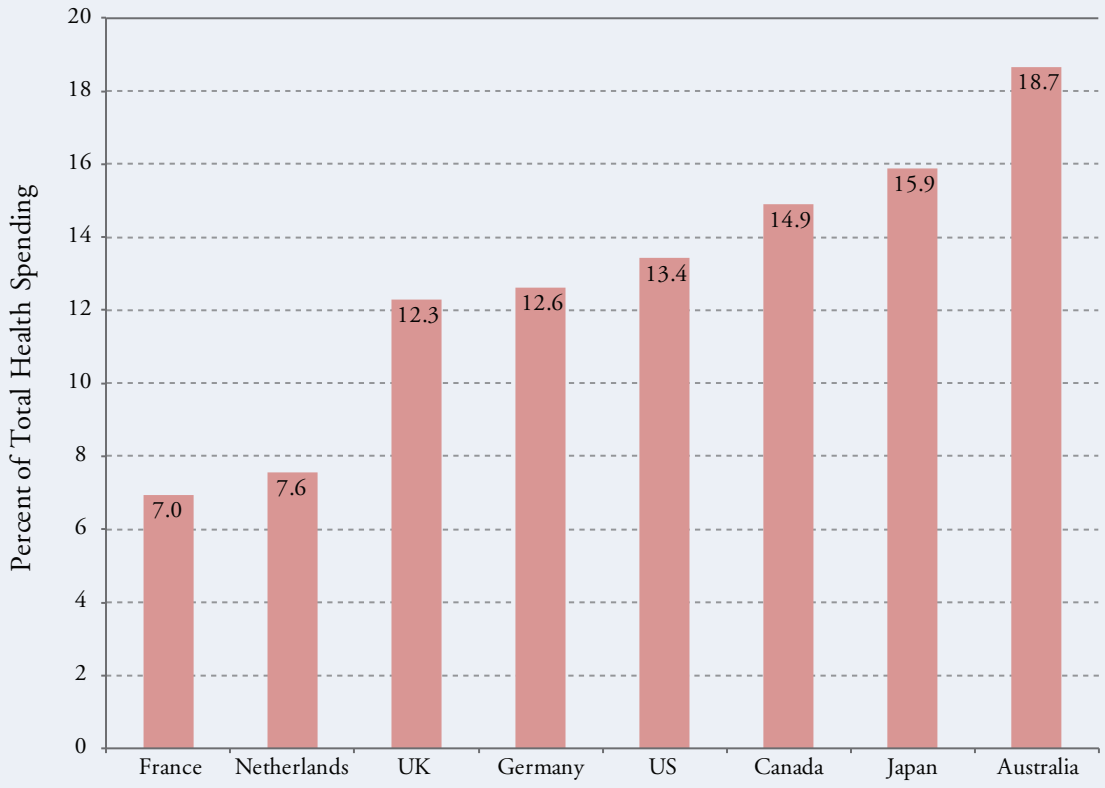
is based on a well articulated view of how they want their systems to function in the future. We think the models underlying this process are ones that Canadians should consider.

The UK Healthcare Model

Under the UK National Health Service (NHS), all citizens are entitled to a broad range of health services when they need them, including those of physicians and acute-care hospitals. As in Canada, patients pay no user charges and there are no premiums—the NHS is financed almost entirely out of general tax revenues. In contrast to the Canadian system, the NHS also covers all or part of outpatient drug costs, some dental care and most of the cost of long-term care in nursing homes. With this broad range of benefits, it is perhaps not surprising that the UK government's share of total healthcare costs was approximately 85 percent in 2009, substantially higher than the some 70 percent in Canada in the same year.

However, public sector health spending as a percentage of GDP is about the same (around seven percent) in both countries. Put differently, for the same percentage of GDP, the United Kingdom covers 85 percent of all healthcare costs, while in Canada the same amount of government

Figure 3B: Out-of-Pocket Payments Made By Households, 2000-2009 Average



Source: OECD health data.

spending covers only some 70 percent of the total. What accounts for the apparent cost-effectiveness advantage of the UK system? Could reform along UK lines enable Canada to reach a comparable level of cost-effectiveness?

Part of the answer may be found in the different systems for producing health services, with respect to primary care as well as to hospital and specialist care.

Hospital and Specialist Services

In Canada, hospital services and specialist care are supplied mostly in privately owned, non-profit hospitals and mostly by specialist doctors who are paid on the basis of fee-for-service (FFS), even when they treat patients in hospitals. While most patients who receive hospital and specialist care do so after referral from a primary-care physician, patients nevertheless do have the right to seek such care without a referral, and many do. In the United Kingdom, in contrast, most hospitals are owned and managed directly by the NHS and most specialist care is supplied by doctors who are employed by the NHS and are paid a salary.

Non-emergency hospital and specialist care under the NHS is available only after a formal referral from a primary-care provider; that is, the general practitioners (GP) who supply primary care manage the path of care – secondary and tertiary – for patients. However, UK patients can also obtain specialist care privately, including care from specialists employed by the NHS who also practice privately on a part-time basis. If they do, they have to pay the entire cost out of their own pocket, or through private insurance.

Primary Care: Capitation

Perhaps the most important feature of the NHS is the way primary care is supplied. GPs work under contract with the NHS and are paid through a mixed system of salary, capitation and pay for performance, but with capitation as the most important element. Under the capitation system, a GP receives a monthly amount for each patient who has registered with his or her practice – who is on the practice's "roster" – in return for undertaking to supply primary-care services as necessary at no additional charges to the patient or the NHS. As a result, the revenue that doctors receive for each patient in a given month is independent of the amount of services they supply during that month, even if that amount is zero.

A patient must be registered with a GP practice to receive any of the services or drugs covered under the NHS, and he or she is not supposed to go to any other GP unless the patient decides to switch registration. The GPs are also responsible for deciding when their patients will be referred to a specialist and hospital treatment and to what providers they will go on referral, in addition to supplying their own services and prescribing drugs.[5]

Capitation and Incentives

Paying primary-care doctors via capitation implies that they are subject to a different set of incentives than if they are paid via FFS. Under capitation, a doctor's incentive is to have a large roster – to take responsibility for the care of as many patients as possible – but not to provide a high volume of services for each one. Indeed, under capitation a doctor has an incentive to supply as small a volume of services per patient as possible. A conservative treatment strategy allows doctors to take on more patients and earn a large income from the capitation system without having to work excessive hours.

While the incentives inherent in a capitation system clearly work in the direction of reducing the aggregate cost of primary-care services, they also have some obvious potential disadvantages. First, if the incentive to reduce the volume of services is too strong, the quality of care may suffer. Second, primary-care doctors paid by capitation may have little incentive to reduce costs elsewhere in the health system. They might, for instance, refer patients to hospitals and specialists even when they might have been able to deal with the patients' health problems themselves. Similarly, they may have an incentive to prescribe more advanced drugs for their patients, rather than experimenting with similar, cheaper ones first.

In practice, capitation systems in the United Kingdom and elsewhere have tools to counteract these potential disadvantages. With respect to the quality of care, the first and most important factor is, simply, professional ethics. While doctors respond to financial incentives like everyone else, there is a strong tradition in the medical profession, passed on first in medical school, which emphasizes doctors' responsibility to place the safety and well-being of their patients ahead of other considerations. The doctors' legal responsibility to provide appropriate care works in the same direction.

5 A medical reform that has been recently discussed in the North American context is the concept of a patient's "medical home" (see, for example CFPC 2011). Loosely speaking, this refers to the idea that, in order to make effective use of the wide range of services that are available in modern healthcare systems, patients need to have a provider or clinic with responsibility not just to provide their own services, but also for guiding and monitoring them when they receive care elsewhere. The UK system under which each patient is attached to a GP practice with "gatekeeping" responsibility is a good example of how such a model can work.

Patients in the United Kingdom are also encouraged to exercise choice. They are free to choose which GP in their catchment area to register with and can switch to another practice if they are unhappy with their current ones. GP practices therefore compete with each other to some extent and, as in other markets with competing sellers, each one has an incentive to safeguard his or her reputation for providing good service to avoid losing patients to a competitor.

In addition to these factors, real-world capitation systems generally are also designed in ways that reduce somewhat the strength of the capitation incentives. For example, typically the systems have upper limits on the number of patients that a practice can register. Secondly, mixed-payment systems under which part of a doctor's compensation is in the form of salary or FFS are more common than pure capitation. It is possible, therefore, to design compensation mechanisms that strike an appropriate balance between the incentives for cost reduction and for the provision of high-quality care.

Front-Door Managers and Fundholding

Capitation primary-care systems in the United Kingdom, as well as US managed-care plans, have tried also to address the potential problems of excessive referrals to secondary care and the prescription of expensive drugs when cheaper alternatives suffice. In the United Kingdom, the government introduced an approach in the 1990s – a version of which is now being re-instated in recent reforms – known as GP fundholding.[6] Essentially, it is a form of extended capitation under which the GP practice receives a larger amount for each patient on its roster, but in return has to pay a share of the cost of drugs that the patients are prescribed, as well as of certain hospital and specialist services its patients receive on referral. The logic of this approach is that, under a system where episodes of care are managed by GPs, doctors have an indirect influence on a large share of healthcare expenditures such as prescriptions, hospital referrals and specialist care, among other items. In this way, GP fundholding makes GPs more accountable financially for their medical choices.

Controversy enveloped the original UK fundholding experiment: it was voluntary and hence implied that there were two versions of NHS coverage, depending on whether the patient was on the roster of a fundholding practice. The term "fundholding" was abolished under the Blair Labour government in 1997, partly for this reason.[7] However, the principle of giving GP practices a financial incentive to reduce the cost of drugs and secondary care has survived, and a system of budget holding by consortia of GP practices is an integral part of the reforms being implemented under the Conservative-Liberal coalition government elected in 2010.

The Purchaser-Provider Split, Primary Care Trusts and Practice-Based Commissioning

The model of budget-holding consortia of GP practices can also be interpreted as the most recent version of a policy approach begun by the Thatcher government in the 1980s when it was known as the purchaser-provider split. Essentially, this approach aims at increased devolution of resource management from the NHS bureaucracy to individual hospitals, including more authority for them to do their own hiring and firing. It

6 After the 2010 British election, the new government published a White Paper, "Equity and Excellence: Liberating the NHS," which discusses how the GP practice consortia model would give a greater role for GPs in running the NHS while bolstering patient choice.

7 The 1997 White Paper, "The New NHS: Modern, Dependable," contained policy initiatives to unwind previous reforms, but as further discussed below, while the terminology changed, many of the substantive ideas in earlier reforms were retained and developed further.

also includes an associated change in the hospital funding system.

Under the Thatcher system, instead of receiving resources in the form of a negotiated annual global budget, each hospital was expected to earn its revenue from contracts to provide specific types of care on terms negotiated with a local funding authority – the purchaser. A key provision of this scheme was that the purchasing agency, which technically remained a part of the NHS bureaucracy, was not bound by the pattern of care that had been provided in the past, but was mandated to contract for different kinds of care with whichever hospital offered the best terms. The purchasers were also allowed to contract with hospitals outside their district for particular kinds of care if they were able to get a better deal than from a local hospital. Thus the task of the purchaser was to negotiate the best possible package of healthcare for its district population, given its budget, thereby providing incentives for the hospitals to compete with one another for funding contracts and hence bring about a more efficient and less costly pattern of care.

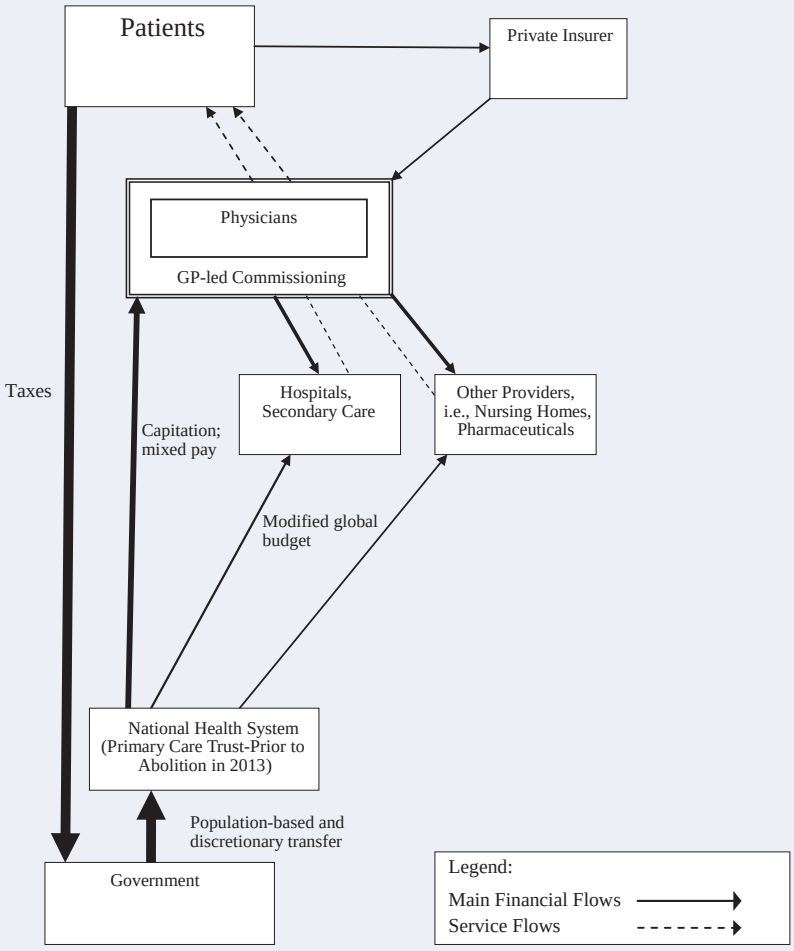
While the Blair government in 1997 abolished the original version of this internal market model, the principle of funding hospitals through some form of competitive bidding continued, although under different names. For a number of years, a substantial part of hospital funding was channelled through the so-called Primary Care Trusts, locally based organizations that arranged hospital care for patients enrolled in groups of GP practices.[8] Under the new model, the Primary Care Trusts will be replaced by the consortia of GP practices referred to above. Through this model, GPs will have a financial incentive to be conservative in their use of hospital services. They will also no doubt put pressure on hospitals to strengthen the value for money of services they produce for the GPs' patients under the terms of contracts negotiated with the consortia. In other words, the model combines the incentives on GPs inherent in the fundholding model and those on hospitals as they compete to supply services to GP consortia in ways similar to the earlier purchaser-provider split. For a basic illustration of the UK health system and the unique financing role of GP fundholding, see Figure 4 where the solid lines demonstrate the main financial flows and dashed lines represent service flows.

While the design and terminology details of the current reform efforts are not important in themselves, certain longstanding principles underlying the various versions of the model are fundamental. First, the provision of primary care has always been based on the requirement that every person covered by the NHS plan has had to appear on the roster of one GP practice that is funded mainly through capitation and has both prescription and gate-keeping responsibilities as part of its primary-care function. Second, financial incentives for GP practices have been used in an attempt to improve the value for money in hospital care, specialist care and pharmaceuticals. Third, attempts have been made to improve the cost-effectiveness of the hospitals and specialist sector by funding hospitals through competitive bidding for contracts with a purchasing or funding agency responsible for a given population.[9] We will return

8 Some 150 different local Primary Care Trusts controlled approximately 80 percent of the 2000 NHS budget (HIT 2011).

9 Since GPs will only refer their patients to hospitals that have service contracts of this kind, and since the purchasing agencies can choose only to award contracts to selected hospitals, the UK government plan is similar in these respects to the US managed-care plans in which patients are covered only for services rendered by the "preferred providers" with whom the plans have contracts. In the United States, these methods are often referred to as involving "selective contracting" and "patient steering."

Figure 4: UK Healthcare System



Source: Authors' compilation.

later to a discussion of how these principles could form the basis for healthcare reform in Canada.

The Dutch Healthcare Model

In comparison to the Canadian system, the Dutch one has recently not looked particularly cost-effective. The latest available data suggest that the Netherlands spends a somewhat larger share of its GDP on healthcare than Canada (12.0 percent compared to 11.4 percent, respectively, in 2009). However, the Dutch system is currently undergoing a major restructuring as it transforms into a model of universal health insurance with major elements of choice and competition. Supporters of the model believe that if it is fully implemented, it could provide a flexible and pluralistic alternative to the single-payer approach as a method to attain the objective of better cost-effectiveness in an equitable healthcare system. While we recognize that it is not yet established with a track record, we nevertheless believe that the Dutch approach may supply useful ideas for future healthcare reform in Canada.

The most fundamental difference between the UK and the Dutch healthcare systems is with respect to financing. The UK system is the

most-cited example of a (single-payer) national health insurance model under which universality is attained by giving all citizens access to health services that are produced by government itself. There are, of course, some qualifications to this principle. First, while every citizen has access to GP services paid for by the NHS, these services are "contracted out." Technically, GPs are managers of private firms, not government employees. Nevertheless, it is true that government is responsible for the production of most health services in the UK—most hospitals are owned by the NHS and staffed by doctors who are salaried NHS employees.

Second, although most UK health services are paid for under the NHS, some physician services are provided by doctors in private practice and paid for by patients out of their pockets, or by their private insurance plans. In this sense, the United Kingdom has a less pure single-payer system than Canada with respect to physician services.

In contrast to the UK case, the Dutch system is often described as an example of both a mixed social and private insurance model with multiple payers on the financing side. It is also a prime example of the public-contract model with primary care and most hospital and specialist care supplied in privately operated facilities.

The Dutch introduced the current version of the multiple-payer model in 2006.[10] Since then, every Dutch citizen has to belong to an insurance plan with a specified minimum level of coverage, while all citizens are covered for catastrophic injury or chronic illness under a government plan. Insurance plans are free to offer more or less extensive coverage beyond a minimum accepted standard, and individuals can choose their plans. Hence, the system is universal only in the sense that all individuals must be members of a plan with a minimum level of coverage.

While these rules reflect an attempt to induce health insurance competition, the Dutch government still intervenes in the market in three important ways. First, as noted, each plan must offer coverage that meets minimum criteria. Second, government pays a substantial subsidy toward the cost of every individual's insurance. A fundamental property of this subsidy is that it is risk-adjusted. That is, it is higher for individuals with high risk of serious illness, and hence higher costs, because of factors such as age, previous illness history and so on. Third, although plans are allowed to set their own premiums, the government stipulates that any premium over and above the risk-adjusted subsidy – the individual premium – must be the same for every enrolled client.

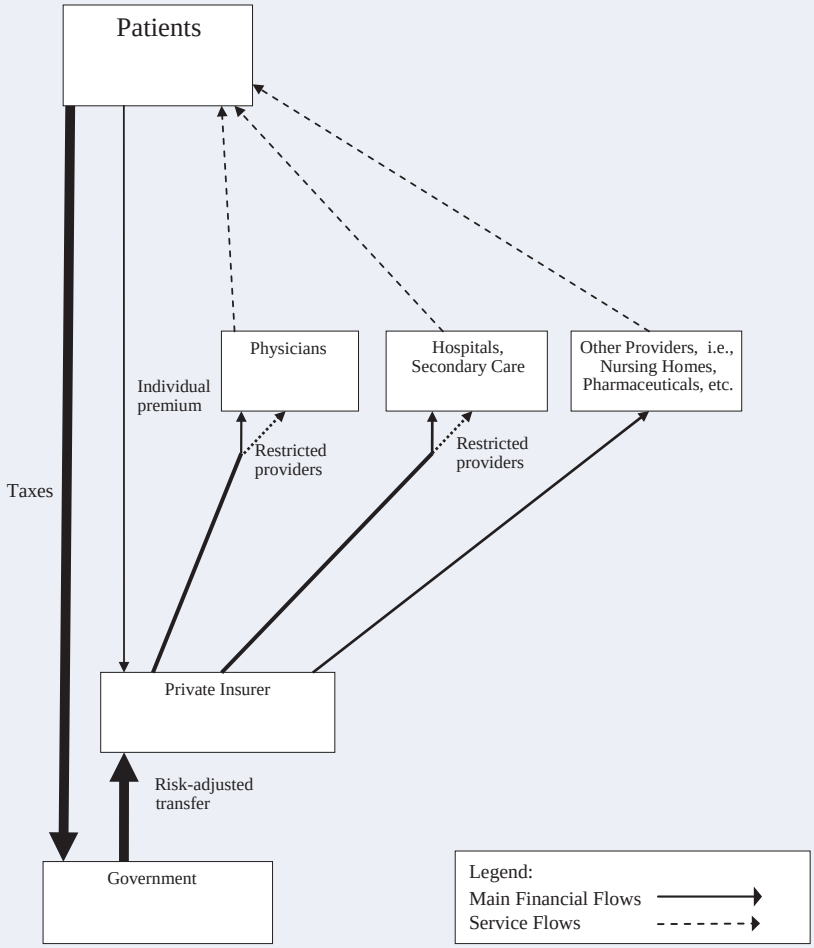
Furthermore, a plan cannot deny coverage to anyone who wants it and is willing to pay the individual premium. The latter features are, of course, related in the sense that the risk-adjusted subsidy reduces the incentive for insurers to charge higher premiums, or deny coverage, to individuals with higher risk of serious illness and hence higher expected healthcare costs.

The Rationale for Competition on the Insurance Side

Upon full implementation of these 2006 reforms, each Dutch insurance plan will be responsible for the full cost of the healthcare used by its members. Moreover, while the fees charged by hospitals and physicians continue to be collectively negotiated between provider organizations and insurers, the intention is to allow insurers to engage in selective contracting, as in US managed-care plans or in the United Kingdom system of contracting between

10 *The Dutch Health Insurance Act*, *Zorgverzekeringswet*, is more commonly known as ZVW. In 2007, 1.5 percent of the Dutch population was uninsured. Mechanisms are in place to cover some of the healthcare costs of illegal immigrants (Commonwealth Fund 2010).

Figure 5: Dutch Healthcare System



Source: Authors' compilation.

hospitals and GP consortia. Insurers will be able to negotiate with providers regarding fee levels, compensation methods and other terms according to which their services will be provided to the plans' members.

Similarly, plans will be allowed to steer their clients to providers with whom the plans have contracts, again as done by US managed-care plans and UK GPs. As a result, the system for providing primary care as well as hospital and specialist care, and for regulating the use of pharmaceuticals, will evolve and be shaped by the contracts that will emerge between insurers and providers. The solid lines on Figure 5 show the unique financing design of the Dutch health system.

If the system works as envisaged, the nature of the coverage offered by insurers and the structure of incentives in the plans' co-payment provisions and provider-payment arrangements will tend to be cost-effective because consumers are free to choose plans with the best combination of costs and expected outcomes. An interesting question is whether the result will be a trend toward a system that resembles that in the United Kingdom, with primary care mostly supplied on the basis of rostering and capitation and with a managed entranceway function for primary-care providers.

Multiple versus Single-Payer Financing System

Perhaps the most important difference between the Dutch model and the single-payer systems in the United Kingdom and Canada, or the social insurance systems in France or Japan, for example, is that in all these other countries, government intervention in the healthcare system takes the form of offering the same insurance plan to everyone. In other words, all citizens are entitled to the same set of benefits. The Dutch model, in contrast, is more like a voucher system, where the government offers a risk-adjusted subsidy that the citizen can use to buy any insurance plan of his or her choice, subject to the rules that stipulate a minimum set of benefits and the restriction that the out-of-pocket premiums for a given plan must be the same for every enrolee.[11] But this, of course, means that different individuals may end up with somewhat different types of coverage and may not receive the same treatment when they are ill. For example, low-premium plans may have more restrictions on expensive drugs or diagnostic tests than more expensive plans, leading to different patterns of care depending on which plan a person belongs to.

To some, a healthcare system in which patients are treated differently, depending on what insurance plans they choose, is inconsistent with their view of equity. Clearly, if one defines equity in healthcare by the principle that every person should receive the same treatment when ill, regardless of ability to pay, a voucher system is inequitable. In a voucher system, it is reasonable to expect that many of those who buy low-cost plans will be individuals with low incomes.

However, a more conventional view of equity would be that it is not a concept that can be defined with respect to the consumption of any specific kinds of goods and services. Instead equity must be defined on the basis of different groups' access to all valuable goods and services. Under this view, the degree of equity in a society can be defined only by reference to the degree of inequality in the distribution of real income.

Whether equity in this broader sense is promoted by a healthcare system in which everyone receives the same services when they are ill is not clear. What is clear, however, is that giving consumers more leeway to choose a plan that corresponds to their individual preferences – and his or her informed understanding of individual health risks – potentially makes them better off, in comparison with a situation where everyone would have to belong to a common plan. For example, highly risk-averse consumers may opt for plans that are more expensive but in which their doctors are willing to recommend advanced diagnostic tests or specialist treatment even in situations where the risk of adverse outcomes is small. Less risk-averse consumers (or those with lower income) can opt for less expensive plans in which doctors have incentives to limit the use of such services to cases where the risks of serious consequences are relatively high.

Supporters of the Dutch model would emphasize the potential advantages of allowing individuals freedom of choice with respect to how they allocate their resources between health insurance and other items. As well, it offers more scope for individuals to exercise their freedom to

11 Private insurers must be registered with the Supervisory Board for Health Insurance to enable supervision of services provided and to qualify for payments from risk-adjusted government transfers. Under the French and Japanese social insurance systems, each citizen belongs to a predetermined insurance fund (depending on place of residence or work), and the (compulsory) contribution to the fund is equivalent to a tax. In France and Japan, each citizen can receive care from any provider, and providers are paid the same amount for their services regardless of which fund the patient belongs to (i.e., the funds don't engage in selective contracting, as they are allowed to do under the Dutch plan).

enter into voluntary contracts than a universal system in which every citizen must belong to the same public plan.[12] Supporters would also stress that a system of risk-adjusted vouchers and uniform individual premiums promotes equity in the sense that it eliminates the discriminatory treatment of those at high risk of illness that would occur in an unregulated private insurance system.

The UK and Dutch Models' Implications for Health Reform in Canada

The UK model has shown its ability to control healthcare costs more effectively than those in most other countries, without major negative effects on standard measures of population health or widespread public dissatisfaction. Could elements of this model be used as a guidepost for health reform in Canada's provinces?

The UK System as a Model

A number of features of the UK system contribute to the relatively low cost of healthcare in that country. The first, and necessary element is rostering – having a list of patients for whose care individual GPs are responsible. The second is capitation in primary care. The combination of these two elements yields a managed entranceway role for primary-care doctors with incentives for them to perform that role in a cost-effective manner. A third, distinctive UK feature is the effective control over secondary – specialist and hospital – care, which earlier was accomplished primarily through a strategy of tight central budget control, but which now also includes various forms of decentralization of hospital decisionmaking and competitive "purchasing" by district health authorities, GP practices and Primary Care Trusts.

Rostering/Capitation

Capitation as a method of paying for primary care is already being used in Canada to a considerable extent, notably in Ontario and some Atlantic provinces (CIHI 2008, Ontario 2010). However, there is as yet no formal rostering and managed entranceway system under which each person is restricted to seeking primary care only from the doctor with whom he or she is registered, and whose referral is required before a patient can consult a specialist or be admitted to a hospital for elective treatment.

Introducing a mandatory rostering and managed entranceway system would obviously be a controversial measure, but is a necessary first step toward a reform along the lines of the UK model. Part of the reason it would be controversial is that it would restrict the right that patients currently have to go directly to any primary-care doctor, or specialist, without referral from the primary-care provider with whom they are currently registered.

Moreover, a formal rostering system would also require provincial governments to ensure that enough primary-care providers are available so that every resident could find a practice to register with. In order for this to be possible, it might become necessary for governments to contract with some doctors who currently practice as specialists to supply primary care and to set relatively high upper limits on a practice's allowable roster size.

In principle, an important element in the UK system is the competition among GP practices that

12 The concept of freedom of contract is fundamental in countries that organize their economic activity through a system of private competitive markets. It has played a large role in the debate about a move toward universal insurance protection in the United States and was prominent in the Canadian debate surrounding the 2005 Chaoulli Supreme Court of Canada decision allowing insurers in some circumstances to offer plans to pay for access to certain kinds of healthcare outside the ambit of the provincial insurance plan in Quebec.

results because patients can register with any doctor in their catchment area.[13] Introducing a formal rostering system in Canada would therefore require criteria for enrolment and rules, including possible fees, for switching to a different practice.

A system of rostering and capitation might not, by itself, produce very substantial aggregate cost savings. The models that are used to pay Canadian primary-care physicians already contain features designed to keep costs down, such as limits on the number of specific services per patient per year in some cases, rewards for certain preventive procedures and so on. Moreover, as noted, some provinces already use capitation to some extent.[14]

However, following the establishment of a rostering system, it would be possible to use some of the mechanisms that have been used in the United Kingdom and elsewhere to give primary-care providers an incentive to perform their manager and coordinator functions in such a way as to promote cost-effective care. For example, they could be made responsible for a share of their patients' diagnostic services costs and specialist and hospital care as well as a share of the cost of the drugs they prescribe for patients covered by a provincial drug plan. Although the providers would receive a higher capitation amount for each patient in return for taking on these responsibilities, it seems likely that stronger incentives on doctors to be more cost-conscious in their prescription decisions, or in their recommendations for diagnostic services and visits to specialists, could produce substantial savings.

More Cost-Effective Secondary Care

A system of entranceway management combined with financial incentives for primary care providers to be conservative in referrals of patients for diagnostic testing and for specialist and hospital care would go some distance in lowering the costs of secondary care. However, an important component of the UK approach to health-system reform in the last several decades has been an attempt to promote better service value in the secondary care sector. This has involved increased decentralization of hospital management and introduction of incentives for hospitals to become more efficient by channelling a larger share of their funding through service contracts negotiated in competition with others. Similar methods could be used in reform of Canada's provincial plans.

In Canada today, hospital funding in most jurisdictions still retains elements of the traditional global budget negotiation. When the United Kingdom began the transition from global budgeting to a purchasing approach many years ago, the basic idea was that hospital funding should be more closely linked to services, rather than to different components of hospital costs such as salaries, building management, etc. While purchasers translated this idea into concrete funding contracts differently, the natural basis of payment in purchaser-provider negotiations tends to be the number of treated patients with specific illnesses.[15]

Funding hospitals on the basis of service output measures would, over time, tend to make the hospital system more efficient because high-

13 Some critics of the UK system are skeptical about the effectiveness of this type of competition in improving the allocation of healthcare resources and suggest that only more educated populations are likely to be deliberate in their choice of a GP (Fotaki et al. 2008; Jones and Mays 2009). For Canadians who are used to a free choice of provider under the current system, it may be a more important consideration, however.

14 One astute reviewer on this paper noted that there is a high probability that many doctors already would prefer a salaried employment instead of FFS, which would allow them to focus more on patient care and the delivery of medical services.

15 This is reminiscent of the concept of Diagnosis-Related Groups (DRGs) originally developed in the United States but now used in countries all over the world. In Canada, a version of DRGs has been developed (under the name of Case-Mix Groups) by a federal agency, laying the groundwork for some form of service-based funding.

cost hospitals would have to cut back the range of patients they treat as they focused on those conditions they could handle at relatively low costs. There is ample evidence to suggest that for many kinds of illnesses, the cost per case treated is lower, and the expected outcome is better, in hospitals that treat a large number of patients with similar conditions. A funding mechanism based on the number of cases treated in different categories will, indirectly, tend to produce an efficient pattern in which many smaller general hospitals treat only patients with comparatively uncomplicated common problems, while relatively rare and complex problems are treated in a small number of more specialized institutions. Importantly, here, the incentives chosen to be included in this type of reform must be strong enough such that the hospitals could face financial difficulty if they failed to respond to the new measures.

Also, the ability of the UK funding strategies to drive greater efficiencies among hospitals or care providers increases with greater clustering and small geographic distances among alternative providers in densely populated areas. Rural hospitals in Canada would require special funding rules because the conditions for a competitive environment are limited.

An institutional difference between the UK and Canadian systems that potentially complicates a decentralized funding process in Canada is that hospital-based physicians here are paid independently by provincial plans – typically on the basis of FFS – whereas in the United Kingdom they are salaried hospital employees. In the United Kingdom, therefore, treatment of hospital patients in particular diagnostic categories can be paid for as a package that includes the services of the hospital itself as well as its doctors who treat the patients. Under this arrangement, the hospitals' administrators have an incentive to hold down not just costs of services, but also to manage the time of their physicians to treat as many patients as possible.[16]

When physicians are paid independently via FFS, as in Canada, the incentives to keep costs down are less strong, since the doctors are paid more if they supply more services to each patient. Also doctors have no direct incentive to try to reduce the cost of the hospital's services that their patients utilize, since those costs are paid for by the hospital, not by the doctor. In a reformed Canadian system, paying hospital-based physicians on a basis other than FFS – to a greater extent than the 20 percent of non-FFS payments currently made nationwide (CIHI 2008) – is worth exploring.

Incentive-based payment mechanisms could be used in a reformed Canadian system even if hospitals' funding continued to come directly from provincial governments. However, an element in the UK reforms has been a funding mechanism for hospitals via agents that act as "prudent purchasers" of care for specified patient populations, such as district health authorities, GP practices and Primary Care Trusts. Part of the rationale for this arrangement has been to introduce an element of competition to the funding process, allowing purchasing agents to contract selectively with hospitals for supplying various kinds of services. For example, when the district health authorities acted as purchasers, they could restrict certain services to some local hospitals, but not to others, and they could also contract for some specialized services with hospitals outside their home districts. In many Canadian provinces, regional health authorities have already been assigned a role in the allocation

16 A greater role for nurses and nurse practitioners should also be considered since it could help improve access and efficiency in healthcare delivery (Drummond 2011).

of provincial funds to local hospitals and could be given enhanced responsibilities as purchasers, along the lines of the UK model.[17]

Hospital and specialist care are large components of aggregate healthcare costs in Canada (roughly 50 percent of total costs), and it seems likely that stronger incentives for consolidation and efficient operation of that sector could lead to significant cost reductions.

At the same time, it is clear that implementing reforms of this type is not easy. Under Canada's political system, local politicians have a strong incentive to be seen as defenders of hospitals in their ridings. As well, doctors, as prominent members of their community, and hospital employees, through their numbers and unions, can exert considerable political influence.

Reform Along Dutch Lines

The basic principle of Dutch health-system reform is regulated competition among alternative insurance plans. Although this approach may appear as a radical departure from the current model underlying Canada's current system, it could be introduced in a gradual and incremental fashion. In this way, most people would continue initially to be covered by their existing provincial plans, with only a minority electing coverage through a competing private plan. Over time, the market share of the alternative plans might change, depending on whether they were profitable and able to retain their enrollees in competition with the basic provincial plan.

Under this competitive approach, continued coverage through the (tax-financed) provincial plan would be the default option that would apply to people who took no action. However, private insurers would be allowed to offer alternative plans covering the same services as existing plans, and every citizen would have the option of leaving the provincial plan and enrol instead in an approved private substitute plan. While private plans would charge each enrollee a premium, those who left the provincial plan would be eligible for a subsidy that could be used to pay all or part of this premium. As in the Dutch system, the subsidies would be risk-adjusted, and substitute plans would be required to accept all applicants and charge each member an identical premium.[18]

Rules of the Game: How to Encourage Competition

With sufficiently generous subsidy levels and reasonable coverage requirements, private insurers could be expected to offer substitute plans. A key issue would be how physicians and hospitals that currently provide services under existing provincial plans would be allowed to supply, and be paid for,

17 In considering the possibility of reforming Canada's healthcare system along lines that have been tried in the United Kingdom, it may be worth noting that one of the UK system strengths is its comprehensiveness, which gives it an ability to integrate the provision of different inputs and services. As an example, because the NHS plan covers outpatient pharmaceuticals, it has been possible to include incentives for GPs to make cost-effective prescription decisions in their capitation contracts. Similarly, because nursing home care is covered as well as treatment in acute-care hospitals, it is potentially easier in the United Kingdom than in Canada to ensure that elderly patients are being treated at the most appropriate level. In Canada, the management of provincial insurance plans is separate from the management of the programs that subsidize nursing home care. Reform of Canada's provincial health insurance plans inspired by the UK example might therefore also include an expansion of the scope of the provincial plans beyond physician and hospital services to include outpatient drugs and nursing home care.

18 Producing an appropriate risk-adjustment schedule would obviously be a major task, as would be the formulation of exactly what coverage would be required in order for an alternative plan to be approved as a substitute for the regular provincial plan. For example, would substitute plans be allowed to levy limited user fees for utilization of physician and hospital services, even though provincial plans are not allowed to do so?

services covered by substitute plans. For example, if a province were to stipulate that providers paid under the public plan would not be allowed to also be paid for services supplied to members of substitute plans, private insurers would find it difficult to compete. They would be able to offer coverage only in places where enough patients opt for private coverage. The demand for services would have to be large enough to induce at least one doctor to switch out of the provincial plan. But if providers were allowed to supply services to members of both the public and substitute plans, rules would have to be established to ensure that they would not give preferential treatment to patients in substitute plans.[19]

If rules were formulated that enabled insurers to compete effectively with existing provincial plans, it is reasonable to expect, on the basis of the US experience, that plans would have restrictions on the patients' choice of provider. The preferred providers – doctors and hospitals – on the plans' lists would be those with whom the plans had contracts regarding fees and other terms.[20]

The ability of substitute plans to compete with the basic provincial plan would depend on what advantages they could offer. If substitute plans were sufficiently successful in using incentives and restrictions on providers so that they could cover their members at a lower average cost than in the provincial plan, they might compete by offering premium rebates. Part of the subsidies they received from a provincial plan might be returned to the enrollees. Alternatively, the substitute plans could compete by offering a broader range of benefits than the basic provincial plans; for example, they could cover outpatient drugs and dental care in addition to physician and hospital services.

A final observation is that a reform of this type – under which the provincial plan was the default option but citizens had the right to enrol instead in an approved subsidized alternative plan – could serve as a complement to the UK reform approach. That is, the tax-financed default option could be a provincial plan that already incorporated the principles of rostering, capitation and entranceway management in primary care, and competition among hospitals for contracts with purchasing agencies. In this case, private insurers might compete by offering plans that did not have managed entranceway requirements and paid doctors via fee-for-service.

Alternatively, if the default option were to be provincial plans of the current type, with no formal managed entranceway restrictions and most doctors paid on the basis of fee-for-service, substitute private plans could incorporate the features of the UK model. In either case, allowing some degree of competition among alternative insurance models could test whether the UK model does, indeed, offer a combination of cost and quality of care that many people, though not necessarily everyone, would find superior to the current one.

Conclusion

Many Canadians recognize the need to drive greater efficiencies within our health system. Few, with good reason, would support a reform approach modelled on the current US system. But the way in which we pay for health services, and the alignment of incentives for suppliers of care, affects

19 Issues of this type have given rise to controversy in the United Kingdom and also in Australia, where patients can opt for coverage of hospital services through either the public plan or through alternative private plans. Researchers have noted that this type of parallel private-sector coverage may draw resources out of the public sector (Tuohy et al. 2004).

20 A pattern of this type has emerged under the US Medicare Advantage plan that, in 2003, gave enrollees (i.e., Americans over age 65) the option of either being covered by the regular plan that pays providers on the basis of FFS or using a government subsidy to arrange coverage through an approved alternative plan (HAP 2011).

a health system's ability to deliver high-value care. Casting the net of international comparisons wider, one finds the alternative models of the United Kingdom, and possibly the Netherlands, which, if they can be made to function as intended, look appealing both in terms of equity and value for money.

The United Kingdom appears to have controlled healthcare costs much more effectively than Canada, without significantly reducing the quality of care. It has done so by emphasizing competition in the delivery of health services, paid for under the public umbrella, and by aligning the incentives of actors within the system – particularly physicians via alternative compensation methods and managed entranceway functions – to make cost-effective choices. In contrast, the Dutch model, whose reforms have yet to take full effect, emphasizes the power of competition among insurers to drive down costs and pass along to consumers the benefits of selective contracting with healthcare providers. The Dutch are free to choose from a variety of plans and receive a government subsidy to purchase health insurance, enabling competition among plans with different characteristics.

Both the United Kingdom and the Netherlands have developed tools to promote cost-effective use of health resources in a way that is both equitable and, in the Dutch case, responsive to individual preferences. In Canada, policymakers should look to realign the incentives facing physicians with a greater use of alternative compensation schemes and encourage greater competition at the point of service delivery, paid for by public insurance. More daring reforms would explore the role of competition among insurers, such as in the Dutch system, but this would make a reasonably large departure from the current system of healthcare funding to which many Canadians are attached.

Construction of a healthcare system is a complex undertaking and no model is perfect. But some countries that face similar economic and demographic challenges to Canada have been more able to improve the cost-effectiveness of their healthcare systems. While many Canadians recognize that we also need to address these issues, thus far there has been little discussion in the political arena about concrete policies to improve healthcare's value for money. We hope that a critical review of the options presented will help form a basis for the serious debate about healthcare reform that many Canadians want, and that all of us need.

Appendix A: The Canadian and US Health-System Designs

An Overview of Canada's Healthcare System

The basic principles underlying Canada's healthcare system are familiar to most readers. With respect to financing, each province since the early 1970s has had a government insurance plan, funded from general tax revenues covering all approved physician and acute-care hospital services. In some cases, these plans – which were put in place by the provinces but with federal cost-sharing – required limited user fees (patient co-payments). However, following a debate in the early 1980s, the *Canada Health Act* (CHA), which sets out the principles that the provincial plans must satisfy in order to be eligible for the agreed-upon federal contribution, was modified to essentially rule out user fees.

Private insurance plays almost no role in financing physician and acute-care hospital services. But while provinces are bound by the *Canada Health Act* with respect to these service categories, the CHA does not cover pharmaceutical costs outside of hospitals or long-term care, items that in the 1970s were of limited overall importance in total healthcare costs. As a result, there is no uniformity in the way these components of healthcare costs are financed in different provinces: they are funded through a diverse mixture of private and government sources, where the former include both patient out-of-pocket payments and private insurance.

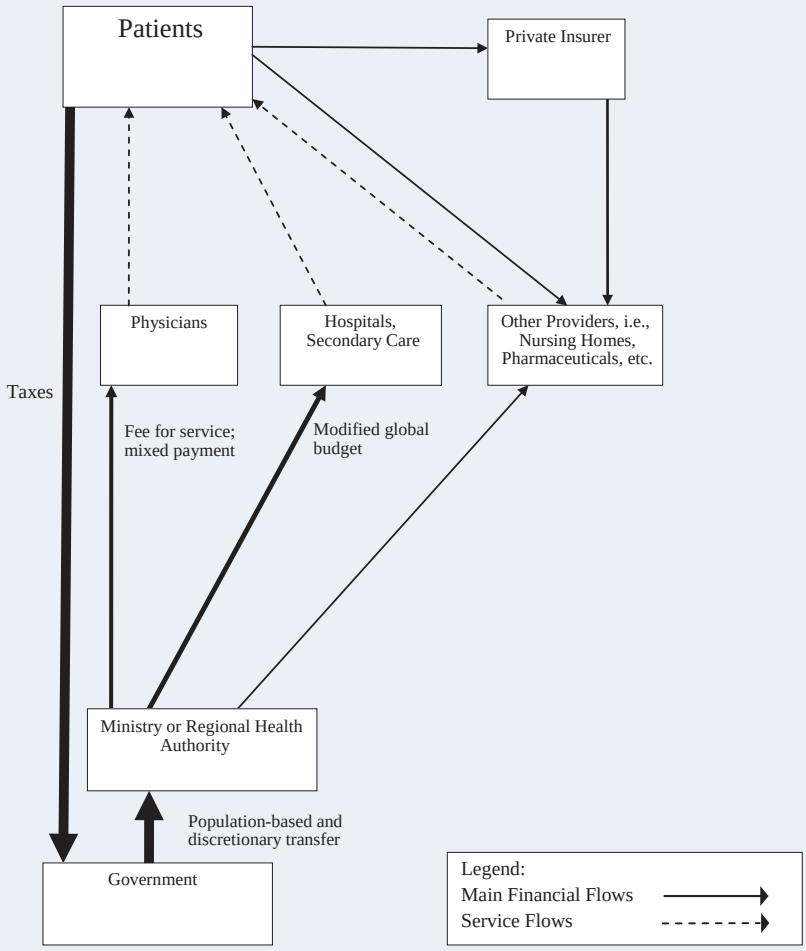
While the public sector predominates on the financing side, most health services in Canada are privately produced. Most primary-care services are supplied by private physicians in solo or group practice. Payment is mostly through fee-for-service (FFS); that is, after seeing patients, the doctor submits a bill detailing the particular services he or she has provided and is paid in accordance with a fee schedule that has been negotiated between the provincial plan and the medical profession. In recent years, mixed-payment systems involving capitation – periodic payments based upon the number and characteristics of patients registered in a physician's practice, regardless of the volume of services that has actually been provided – and some type of pay for performance have become more common, but FFS remains the predominant method.

Secondary care is provided by specialist physicians in private clinics or in hospitals. Most specialists are also paid by the provincial plans on the basis of FFS, though some, such as interns or doctors in teaching hospitals, may be paid partly through salaries from the hospitals. While most patients who see a specialist do so following a referral from a primary-care provider, the provincial plans allow patients to go to other primary care providers, specialists or hospitals on their own – there is no official, managed entranceway, also known as gatekeeping. While doctors prescribe the medications that patients use, the cost of pharmaceuticals used outside hospitals is paid by the patients themselves or their public or private insurance plans.[21]

Most hospitals in Canada are operated as non-profit entities. The bulk of their revenue comes from the provincial governments in the form of negotiated annual budgets. Decisions about how the hospitals will be managed are made by hospital administrators who operate under the supervision of hospital boards and the government officials who

21 Quebec has an elaborate public insurance scheme for individuals not covered by employer-provided private insurance for pharmaceutical costs. It covers roughly half of the population, and slightly more than one-third of all costs are covered by individual premiums and contributions.

Figure A1: Canadian Healthcare System



Sources: Authors' compilation, modified from Forget and Forget (1998).

fund them. While hospitals compete for patients, they do so principally through the specialist doctors who bring their patients to the hospitals. Most of those doctors are not hospital employees, but instead are paid independently for their services from the provincial insurance plans.

In the long-term care sector – which does not fall under the CHA – most patients are cared for in privately owned nursing homes, most of which are operated on a for-profit basis but under government regulation. Long-term care patients pay most of their costs out of their own pockets. Figure A1 is a simplified illustration of the Canadian healthcare system where solid lines demonstrate the main financial flows and dashed lines represent service flows.

Finally, pharmaceuticals in Canada that are administered to hospitalized patients are paid for by the hospitals, with no charges to the patients. For outpatients, drugs are prescribed by physicians but bought in pharmacies and paid for by the patients, or their insurance plans if they have one. These plans may be private (recall that insurance for outpatient drug costs is not required under the CHA), or one of the provincial government schemes that cover seniors or certain population groups. The prices of many drugs are partly regulated by governments. What patients pay may

also depend on the provisions of their insurance plans, which may include cost-containing features such as formularies and reference-based pricing and which may also require pharmacists to substitute cheaper versions of drugs that the patients' doctors have prescribed.

Why the US System Is Not a Good Model

Even though few Canadians seriously think that we should copy the US healthcare system, most are aware that the quality of medical care there can be very high for those who can afford it. From time to time, there are well-publicized cases of seriously ill Canadian politicians and others who travel to the United States for treatment. What, then, are the reasons why the US system is so widely regarded as a bad model for Canada?

One reason, of course, is its high cost. The most striking difference between the US healthcare system and those in Canada and other countries is that the US one is much more expensive, whether measured as a percentage of GDP or by average spending per capita. But the US system is different from ours in many other important respects. Most significantly, the US system does not ensure universal coverage, so that many millions of people have no insurance and hence are restricted to using care they can pay for out of their own resources, even when seriously ill.[22]

However, the *Patient Protection and Affordable Care Act*, signed into law by President Obama in 2010, uses a combination of regulation and subsidies to address this problem. If its provisions are implemented as planned, the United States will move toward universal coverage by 2019.[23] One key element of this reform is that citizens by 2014 will be required to purchase insurance or otherwise pay a tax penalty.[24] All residents will be required to own a minimum level of health coverage, with subsidies available for low – to middle-income citizens, and health plans will no longer be able to refuse people coverage because of pre-existing conditions.

While the government share of total US healthcare costs is lower than in all other advanced countries, the United States does have two major government insurance plans, Medicare – a federal plan – and Medicaid – a set of state-administered plans – for specific population groups. Medicare covers citizens 65 years or older, while Medicaid covers social assistance recipients and other population groups with incomes below, or close to, the poverty line.[25] Most of those who are not eligible for either of the government plans have some sort of private insurance coverage, largely in the form of group plans offered through employers. However, many of those who are not working, are self-employed or work for employers who don't offer group plans, remain uninsured.

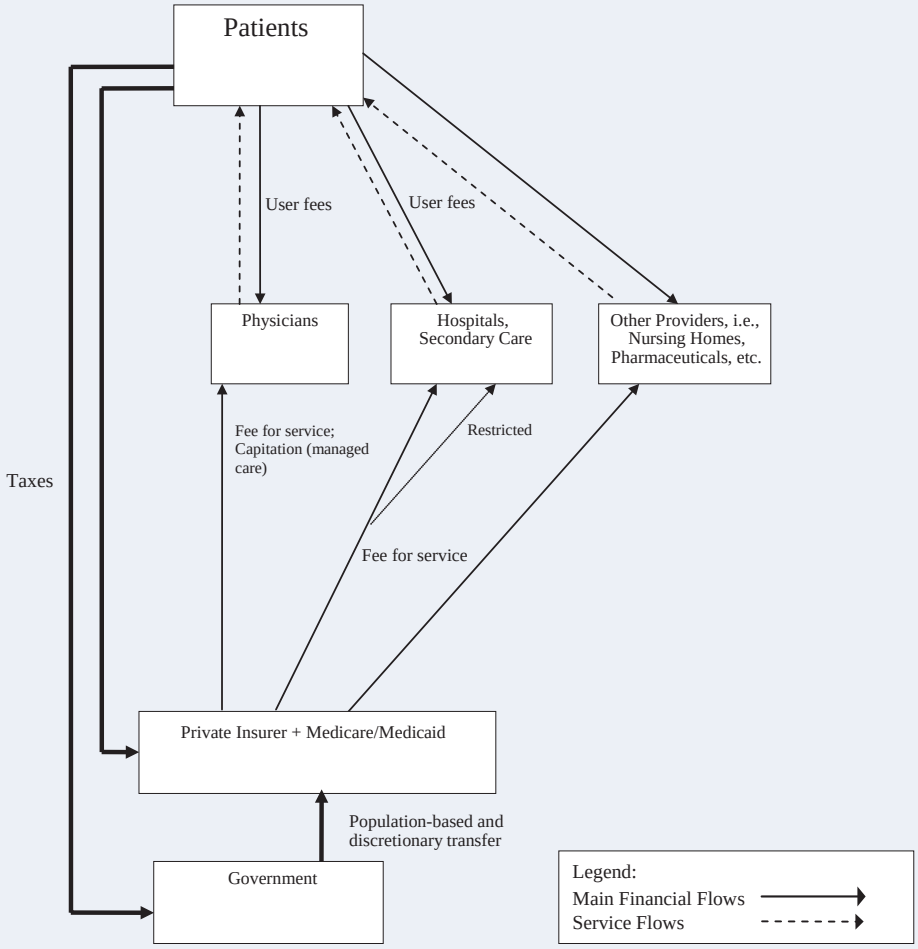
22 The 1986 US *Emergency Medical Treatment and Active Labor Act* compels hospital emergency rooms to care for patients, regardless of ability to pay. There is no government compensation for hospitals who do not receive payment, leading to substantial amounts of "uncompensated care," the cost of which has to be covered from other sources.

23 Congressional Budget Office estimates for the effect of the *Patient Protection and Affordable Care Act* suggest that the number of uninsured people should drop by 60 percent, or 32 million, by 2019. Still, 23 million residents, one-third of whom are illegal immigrants, are predicted to remain without insurance in 2019 (CBO 2010). For a good description of the Act and its timeline for implementation, see the Commonwealth Fund's online analysis at http://www.commonwealthfund.org/Health-Reform/Health-Reform-Resource.aspx.

24 The requirement to purchase a basic level of health insurance has been challenged in the court system, with some success, as an unconstitutional expansion of Congressional power.

25 In 2008, 24 percent of the population was covered under federal programs: 13 percent by Medicare; 10 percent by Medicaid; and one percent under military healthcare programs. Meanwhile, 60 percent of residents were covered by private insurers – 55 percent through employers and five percent directly.

Figure A2: US Healthcare System



Source: Authors' compilation.

With respect to the system for producing health services, most US primary care is supplied by privately practising doctors. While different forms of blended payment models – partly capitation, partly FFS – may be used in some private insurance plans, straight FFS remains the most common method, partly because it is the one used in the basic Medicare plan for those over 65.

For secondary care, a major difference between the Canadian and US systems is that in the United States, hospitals are predominantly funded through itemized billing, a form of fee-for-service; that is, from the revenue they earn by billing patients or their insurers. In general, the amounts that hospitals charge for different kinds of services are not regulated, but are supposed to be determined by competition.

While itemized billing remains common, the fees charged by hospitals to patients in particular insurance plans are often determined through advance agreements with the plans. For example, hospitals that treat patients covered by the basic Medicare plan are paid according to a schedule of Diagnosis-Related Groups (DRGs). Under this schedule, the amount that a hospital is paid is, in principle, determined in advance by the kind of illness for which the patient is being treated, not by the actual type and volume of the services actually

provided to the patient. As in Canada, most of the specialists who treat patients in hospitals are not paid by the hospitals, but are independent practitioners who bill patients or their insurers separately. However, in some insurance plans both hospital and specialist care is provided directly by the plan and the doctors are salaried plan employees (see Figure A2 for an illustration of the US healthcare system).

Why is the US system so expensive? One reason is the high cost of administration. In comparison with countries where most health financing is through a single government plan, the US system of mixed public and private insurance is much more costly to administer. In part this reflects the marketing and administrative costs in the private insurance industry, but it also is due to the fact that for providers – physician practices and hospitals – it is costly to manage a business when revenues must be collected from individual patients or from a wide range of insurance plans.[26]

International comparisons have also shown that part of the explanation for high US costs is the fact that the prices per unit of various medical services – for example, an hour of a physician's time or an average day in an acute-care hospital – are higher in the United States than in other countries (Anderson et al. 2005). In part, these high prices reflect the inherent weakness of competition for patients as a force for keeping prices low. Without informed third-party support, sick people cannot be expected to be effective in comparing the quality and prices offered by different producers, rendering competition relatively ineffective.[27] [28]

26 For a careful analysis comparing US and Canadian administration costs, see Woolhandler, Campbell and Himmelstein (2003).

27 In the US market for hospital services, the lack of effective price competition may have led to the establishment of too many hospitals and the acquisition of expensive specialized equipment in smaller hospitals with a relatively low number of patients being treated for rare conditions.

28 Another US cost-increasing factor has been the relation between healthcare and the legal system. As the courts have been willing to award large payments to patients with adverse outcomes, and more lawyers have developed expertise in obtaining such settlements, doctors and hospitals have tried to reduce the likelihood of being sued by recommending advanced but expensive treatment methods, even for patients with relatively mild symptoms and relatively low probabilities of adverse outcomes.

Table A1: Conventional Health Outcome and Access Measures, Canada and Selected OECD Countries, 2000-2009 Average.

	Outcomes					Access	
Country	Life Expectancy at Birth, total pop.	Life Expectancy at Age 65, male-female avg.	Infant Mortality, deaths per 1,000 live births	Deaths from Cancer, per 100,000 pop.	Potential Years of Life Lost, all causes, per 100,000, female and male combined	Physicians per 1,000 pop.	MRI Machines per million pop.
Canada	79.8	19.0	5.3	171.0	3,479.0	2.2	5.4
US	77.4	18.1	6.8	159.3	5,000.2	2.4	24.3
Netherlands	79.3	18.1	4.6	179.8	3,095.4	2.6	8.3
UK	79.0	18.3	5.1	173.4	3,526.6	2.3	5.4
Germany	79.3	18.5	4.0	161.6	3,472.4	2.8	N/A
Australia	80.6	19.6	4.7	153.5	3,242.3	2.8	4.4
France	80.1	19.7	4.1	164.6	3,705.5	3.3	4.1
Japan	82.1	20.7	2.8	140.9	2,751.9	2.0	39.5

Note: The potential years of life lost is an estimate of how many years a person would have lived if they did not die prematurely. These deaths are considered preventable with the intervention of the health system. Hence, a lower figure is deemed a more desirable outcome.
Source: OECD Health Data.

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