PNWER CONFERENCE

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Presentation By:

Donald J. Philippon, PhD CHE
Professor, Health Policy & Management
University of Alberta, Edmonton AB
Canada

Health Policy Debate in Canada and United States

- Very different health policy contexts
- Yet we both face many similar challenges
- Both can learn from each other
- Both can learn from experience in other countries

Lessons from other Countries Limitations

- We are products of our history
- Different constitutional arrangements
- Different priorities and social values
- Differing Geography and Population Distribution

Ultimate Goal of Health Policy

- To achieve best health outcomes for our population
- But most of the factors affecting health status lie outside the health system

Key Health System Factors

- Access to health services
- Quality of health services
- Cost of health services
- Innovation in health services

Country Basic Facts

Country	Pop. (Million)	Size (km^2)	Size% of Canada	Pop. Density
Canada	33	9,997,140	100%	$3.1/km^2$
USA	301	9,629,091	96%	$31.0/km^2$
Australia	20	7,600,300	77%	$2.4/km^2$
UK	59	244,110	2.5%	$236.2/km^2$
NZ	4	268,680	2.7%	$13.6/km^2$
Sweden	9	449,964	4.5%	$19.8/km^2$
Netherlands	16.5	41,526	.41%	$450.0/km^2$

Constitutional Responsibilities
CANADA

- Federation – Type of Government
- BNA Act 1867, Constitution Act 1982
- Federal and Provincial/Territorial Governments

CANADA
Federal and Provincial Responsibilities

Provincial

- Constitutionally responsible for delivery of health care

Federal

- National criteria
- Transfer of funds to provinces
- Direct responsibility for certain groups (e.g. Treaty Indians)

Note: Not one single all encompassing health care system, rather, 13 distinct but interlocking provincial and territorial plans and Federal Government

National Criteria

1. Public Administration
2. Comprehensiveness
3. Universality
4. Portability
5. Accessibility

Current Issues – Canada

- Waiting Lists
- Pharmaceutical Policy
- Primary Health Care
- Home Care and community services
- Health Workforce
- Patient Safety and Quality
- Organization and governance of health systems in the provinces

Constitutional Responsibilities
AUSTRALIA

- Federation – Type of Government
- Constitution Act 1901
- State and Territorial Responsibilities
- Evolution of Commonwealth Responsibilities

HEALTH SYSTEM - AUSTRALIA

National/Commonwealth Government

- Overall Policy, Evaluation, Funding Role
- Direct Role:
  - Physician/medical services
  - Pharmaceutical Benefits
  - Aged Care
  - Funding Health Science training
  - Health Insurance subsidies
- Health Care Agreements with States
- Health Human Resource Planning
- Coalition – Liberal/Conservative until 2007
- Labour Gov't since 2007

Current Issues – Australia

- Sustainability – financing, growing expectations, equity of access, health outcomes
- Medicare – universal, but not for everything
- Role of Federal and State Governments
- Private Sector Engagement
- Performance, Safety/Quality, Accountability
- National Health and Reform Commission

HEALTH SYSTEM – NEW ZEALAND

- **One Government for Country (Unitary)**
  - 1840 Treaty of Waitangi with Maori – Bi-Cultural
  - 14.5% Maori, 79% European, 7% Asian/Pacific
- **Experiment with Market Reforms**
  - Government Service – 1938 - 1989
  - Early 1990's – market Purchaser – Provider model
    - 4 Regional Purchasers
    - 23 Crown Health Enterprises
- **Health System Reform 2000**
  - 2000 Retreat from market orientation –"democratic deficit"
    - 21 District Health Boards (elected)
    - All funding to DHBs including Physician payments
    - Purchaser – Provider split within DHBs
    - 80 Primary Health Organizations (PHOs)

HEALTH SYSTEM – NEW ZEALAND
National Government

- **Accident Compensation Corporation**
  - All accidents and injuries
  - No Fault Scheme
  - Workers' comp, prof liability
  - Motor vehicle accidents coverage
  - Provides block funding to MOH
  - Also specific funding to DHBs

Current Issues – New Zealand

- New Government review
- Variability in a decentralized system
- Sustainability of Funding
- Productivity
- Workforce Capacity
- Health Inequalities

Constitutional Responsibilities
SWEDEN

- Unitary – Type of Government
- Division of Health Responsibilities
  - National Government
  - County Councils 21
  - Municipalities 290

- Swedish National Health System
  - Principles – Power from the People

HEALTH SYSTEM – SWEDEN

“All public power proceeds from the people”

National Government

- **Overall Policy, Funding, Evaluation**
- **National Initiatives**
  - National Guarantee on Wait Times
  - Drug Benefit Scheme
  - High Cost Protection for Patient Fees

HEALTH SYSTEM – SWEDEN

"All public power proceeds from the people"

County Councils

- **21 Councils - predominant role in health care delivery**
  - 3 serve over 1.0 million each
  - Most serve 250 – 300 K

- **Council Structure**
  - Member elected on Party lines
  - Assemblies and Executive Boards
  - Stockholm County Council 149 members

- **Council Resources**
  - Revenue
    - 87% Income Tax Levy
    - 4% Fees, 9% Grants
  - Purchaser-Provider Split

HEALTH SYSTEM – SWEDEN

"All public power proceeds from the people"

Municipalities

- **289 Municipalities**
  - 191 serve pops less than 25K
  - 13, 274 elected members/party lines
- **Mandate in Health**
  - Nursing homes, long term home care
  - Housing
  - Social versus medical need
  - Split services – Rehab, home care

PRIVATE FACTOR – SWEDEN

- Tradition of User Fees
  - Fees for primary care, specialist care, inpatient care
  - No fees for persons under 20
  - Fees range from $15 - $55 CDN/day/visit
- High Cost Protect at $900 SEK/yr ($160 CDN)
- Av Cost $400 - $600 per family/yr (incl Drugs)
- Very Few have Private Insurance

Current Issues – Sweden

- Sustainability
- Role of County Councils and Municipalities
- Integration of Services
- Quality of Care

Constitutional Responsibilities
UNITED KINGDOM

- England - Unitary Government
- National Health Service, 1947
- Evolution of Delivery Models – England
  - 13 Reorganizations since 1947
  - From Government Service to
  - Regional Health Authorities to
  - Market Reforms 1991 – 1998
    - GP Fund Holding- Purchaser-Provider Split (91- 98)
  - Blair Reforms 1998 – 2007
    - NHS Hospital Trust & Primary Care Trusts (PCTs)
    - Strategic Health Authorities (SHAs) – now 10
    - Primary Care Trusts (PCTs) – now 150
    - Hospital, Mental Health, Emergency Trusts
    - Foundation Trusts
    - Central Accountability Agencies

HEALTH SYSTEM - UNITED KINGDOM

National Targets & Directions

- 4 hr wait in ER (A&E) – Dec 2005
- Elective wait time – 6 months by Dec 2005, then 18 months
- Choose & Book – 5 choices
  - www.chooseandbook.nhs.uk
- 15% of service to independent providers

Current Issues – UK (England)

- Darzi Report (2008)
- Drivers to Improve Quality
  - Performance Management
  - Consumers
  - Regulation
  - Markets & Quasi Markets
  - Clinical Leadership

Constitutional Responsibilities – Netherlands

- A Constitutional Monarchy
  - Kingdom of Netherlands included Caribbean Islands of Aruba and Netherlands Antilles
  - Constitution of Netherlands only applies to European part
- A Decentralized Unitary State
- A Consociational State
- Netherlands New Health System – Jan 2006

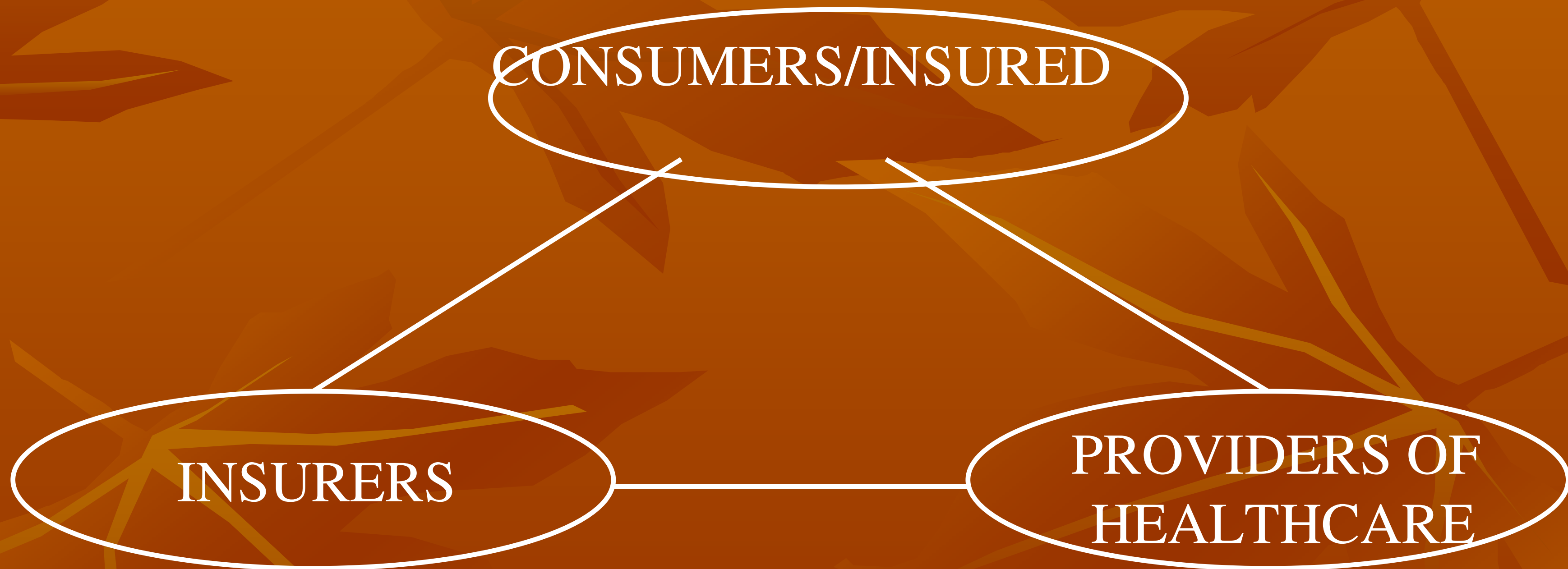
Health System – Netherlands
Key Concepts

- Equity and solidarity
- Public regulation, private delivery
- Consensus Decision Making

Health System Financing – Netherlands

- Pre- January 2006
  - 70% population covered by Sickness Fund Pools
  - 30% population covered by Private Insurance
  - Exceptional Medical Expenses Act topped up funding
  - Additional Insurances supplemented funding
- Financing Distribution Pre – January 2006
  - Sickness Funds & Private Insurance 47%
  - Exceptional Medical Expenses 48%
  - Additional Insurances 5%

Netherlands – Policy Trilogy



Netherlands Reforms 2006 Reforms Principles

- Market competition within a Regulated System
- Universal accessibility with Private Insurance
- Insurers must carry standard package but can develop options
- Consumers have Free choice of Private insurance companies
- Insurance Companies cannot refuse applicants
- Insurance companies pay providers
- Insurer can selectively contract with providers
- Insurer and Provider negotiate prices, volume, quality
- Performance Related Payment System DBC for Hospitals

Netherlands Reforms – Key Features

- Mandatory Insurance for Population
  - 50% income related; 50% paid by employer
  - Premium allowance for low income groups
  - No premium for persons under 18
  - Government Regulation of Insurance industry
- Risk Adjustment System
  - Gov't funding to cover high cost clients
- Increased Focus on Quality
  - Better Faster Program

Current Issues – Netherlands

- Sustainability – Universality/solidarity, Affordability/cost, Quality
- Fine tuning the regulated competition model
- Capital Funding in Private Insurance System

Comparative Health Systems

	AU	SW	NZ	UK	NL	CA	US
Population-mil	20	8	4	59	16	33	301
% Pop Over 65	12	17.2	12	16.0	14.6	13.5	12.6
% GNP*	9.5	9.1	9.0	8.3	9.2	9.8	15.3
Per Cap HExp$US	3,126	2,816	2,343	2,724	3,034	3,326	6,401
% Public*	67.5	85.3	78.7	83.4	62.5	69.9	45.0
% Private*	32.5	14.7	22.3	16.6	37.5	30.1	55.0

*OECD Data, 2005 edition (2003) exp %GNP 2007 Data OECD

USA 15.3%, $6401

Health Data 2001

(*Netherlands added with later years data)

	Life Expectancy at birth (years)		Infant Mortality (per 1,000 live births)	Health Spending as % of GDP	Physicians per 1,000 population
	Male	Female			
Australia	77.9	83.0	5.2	9.2 %	2.5
Canada	76.7	82.0	5.3	9.7 %	2.1
Germany	74.7	80.7	4.5	10.7 %	3.3
United States	74.1	79.5	7.0	13.9 %	2.7
Japan	78.1	84.9	3.1	8.0 %	1.9
Netherlands*	77.8	82.6	4.4	9.2 %	3.7
France	75.5	83.0	4.6	9.5 %	3.3
Sweden	77.5	82.1	3.7	8.7 %	3.0
UK	75.7	80.4	5.5	7.6 %	2.0

Source: OECD

Comparative Health Systems

	AU	SW	NZ	UK	NL	CA	US
Life Expectancy	83.3 78.5	82.8 78.4	81.7 77.5	81.1 76.9	81.6 77.2	82.77 78.0	80.4 75.2
Infant Mortality	5.0	2.4	5.1	5.1	4.9	5.3	6.8
% GNP	9.5	9.1	9.0	8.3	9.2	9.8	15.3

IHE Handbook, 2008 (2005 data)

Health Outcomes
(OECD Rankings – 24 Countries)

	AU	SW	NZ	UK	NL	CA	US
Health Outcomes [1]	6	6	16	16	20	20	20
Health Promotion [2]	10	1	5	15	3	15	20
Health Status [3]	10	5	16	19	2	5	20

[1] Mortality rates – lung cancer, myocardial, stroke
[2] Non-medical factors – body weight, tobacco & alcohol consumption, traffic accidents, immunizations
[3] Infant mortality, life expect, Disability – free life expect, self rep health status
Source: Conf Bd of Canada, 2004 Report: Understanding Cost Drivers…

Health Outcomes (OECD Rankings – 24 Countries)

	AU	SW	NZ	UK	NL	CA	US
Overall Weighting	31	37	N/A	29	32	32	22

[1] Weightings based on 29 indicators from three main categories – Health Status, Health-care outcomes, Heath-care utilization and performance

Range: Highest 45 Japan, Lowest 16 Poland

Source: Conf Bd of Canada, 2006 Report: Healthy Provinces, Healthy Canadians: A Provincial Benchmarking Report

What we can Learn From Australia

- Co-existence of private and public systems while maintaining universal coverage
- Good pharmaceutical controls

What we can Learn from New Zealand

- Engagement of Aboriginal Population
- Control of Pharmaceutical Expenditure
- Model for Primary Health Care
- How to handle health care costs arising from accidents of all types and reducing liability costs

What we can Learn from UK/England

- Driving National Initiatives
- Placing power in Primary Health care
- Balanced pharmaceutical strategy that achieves reasonable cost control, good access to drugs and encourages pharmaceutical sector

What we can Learn from Sweden

- Using community resources and primary care into moderate demand for health care – good community supports for individuals using a broad view of health determinants
- Maintaining individual responsibility within a publicly funded universal system

What we can Learn from Netherlands

- Incorporation of Private insurance within a universal system
- Creating market forces to increase access, improve quality and achieve cost control

Window of Opportunity - USA

- Current recession illustrates the vulnerability of a totally insurance/employer based system
  - Impact on citizens losing jobs/insurance
  - Cost to employers – Wall Street Journal, lJuly 13
- Political will among "Middle Class"
- Don't repeat Canada's mistakes on Single Payer – suggest more comprehensive approach
- Look a Netherlands model if you are to retain private insurance

Opportunity for Canada

- Need in increase productivity in the system – a recessionary period makes this easier
- Look at experience in other countries
- Look at effective models of integrated care, some of these are in the USA
- Much work needed on primary care models, chronic disease management and pharmaceutical policy