Healthy Incentives: Canadian Health Reform in an International Context

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Preface

Introduction

FOR YEARS, POLITICIANS in the U.K., Germany, France, Australia, New Zealand, the U.S., and Canada have been extolling their respective health care systems as second to none. They have pictured other countries standing in awe at how their nation had stormed ahead to lead the world in this great endeavour. From this lofty perch, it was difficult to see the deficiencies emerging at ground level.

A combination of fiscal developments and systemic shocks has revealed deep and widening cracks in the edifice of state-sponsored medicine as it has evolved in these countries. The recognition that there are problems has led to an international search for alternatives. This document discusses an approach to the reform of the health care sector in Canada that reflects an awareness of the problems as well as the solutions that have been proposed and, in some cases, implemented elsewhere.

The most obvious motive behind the current push for health care reform in Canada is fiscal. Canada's national debt is high relative to most other OECD nations, and there is pressure from financial markets on both the federal and provincial governments to do something about it. Since health care has been the largest and fastest-growing item in all provincial budgets, it is understandable that considerable attention should be focused on cuts to health care funding. It is equally understandable that this concerted effort to control health care costs should be

encountering a considerable backlash as citizens fear the loss of one of the most cherished services on which they rely.

There is another aspect of the problem that is seldom discussed but has broader implications. This is the fact that the health care sector is the largest single employer in the country and the source of some of the most satisfying and rewarding jobs in our society. From "high tech" to the caring professions, from research and development to the most pedestrian tasks, the health care sector is one of the key elements contributing to the economic prosperity of our country. As the population ages, even more economic activity will reside in this sector.

Ordinarily, the prospect of future economic growth of this kind would be a source of great exuberance and rejoicing. However, because health care in Canada is organized as a function of government, the cost of providing it is viewed as a problem. In fact, recent estimates by the Office of the Superintendent of Financial Institutions Canada indicate that there is an unfunded liability associated with Medicare of over $1 trillion.[1] That is, with the current system in place, and with the current sources of funding, and given the ageing of the population, there will be a shortfall in current dollar terms of at least $1 trillion. The obvious conclusion for a government manager is that "we must not permit these costs to materialize."

We find this approach to the health care sector inappropriate. First, it is wrong because it would, if followed, choke off the most important source of economic growth that can be anticipated from the changing structure of the population and the resulting changes in the life-cycle structure of economic demand. Second, we think that government attempts to choke off such a natural development and expression of consumer needs will not be successful and will lead to an increasing pursuit of health care options outside Canada. Third, to the extent that restraints are successful at slowing domestic spending on health care, they will also slow the growth of the economy and the expansion of the government's tax base, making the maintenance of health care programs even more difficult.

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1 Office of the Superintendent of Financial Institutions Canada, Social Insurance Programs Division, "Health Care Cost Actuarial Projections," June 4, 1996.

And there are already problems with our health care system. Waiting times for many operations and diagnostic tests greatly exceed medically acceptable norms, according to an annual survey of Canadian specialists. Waiting times for cancer radiation treatments are three times longer than those for identical conditions in the United States and significantly longer than oncologists think medically acceptable. The supply of technology in Canada greatly lags behind the United States and there are increasing risks from the loss of some of our best younger physicians and specialists as salary caps become the norm.

In many provinces, a health care reform process is already under way. The main objective of the reforms is to save money as noted, but also to attempt to ensure that the economies are permanent. Thus far these reforms, as far as we can determine, have involved alterations, in some cases fundamental, in the structures of institutions delivering health care. While in certain cases some consideration has also been given to incentives, for the most part this has not been done. Regionalization, for example, seems to be the new cost containment grail, but there is little evidence that regionalization of effort has in any way changed the incentives for health care sector participants.

However, the debate over health reform is more than a debate about scarce financial resources and horizontal or vertical integration in the structure of costs. It is a debate about patient choice, provider choice, the provider-patient relationship, quality of care, and even type of care. It is a debate about a system which provides all of the wrong incentives to patients, providers, administrators, bureaucrats, and everyone involved. It is a debate about a system which does not cater or adapt to the needs of the people working within it or those being served by it.

We are not indifferent to the problems of the public sector deficit. Rather than cut the deficit by simply controlling total health care costs, however, we propose to reduce the public sector cost by creating incentives for those who can afford to do so to opt out of the public sector health care budget. This approach reflects our judgement that the problem is not primarily that too many dollars are being spent on health care, but rather that there is no opportunity for those who would like to spend more to do so.

This book focuses on the health care system in Canada along two sight lines. The first is evidence from other countries about how their health care systems are functioning and what reforms they are pursu-

ing. The second is the requirements for policy change in Canada, using the province of British Columbia to illustrate many specific policy details. The reform proposals that emerge are intended to provide a restructuring of incentives to ensure that the choices made by system participants are "economic" in the sense that they reflect the alternative uses to which resources might be put.

One outcome of this exercise might be to also reduce the total cost of the system. Cost containment is not our muse, however, and we are concerned that such an approach to health care might adversely affect the growth and future prospects of our economy, and is in fact already adversely affecting the quality and quantity of health care available to all Canadians. We believe that the proposals contained in this document address the economic, quality, and quantity issues related to health care in Canada.

A solution denied

While governments have been cutting back on funding for increasing demands for care, they have made it virtually impossible for Canadians to voluntarily pay more for their own health care. Against the wishes of some provinces, the federal government has taken the view that it violates the central principles of socialized medicine to permit people to spend more of their own money on increased access to the health care system. In spite of the fact that Canada continues to sell health care to citizens of other countries on the grounds that this earns extra resources for the sector, and in the face of the expressed willingness of many Canadians to spend their own money either in Canada or abroad, the federal government refuses to permit citizens to enhance their access to care.

The central argument for this stance is that doing otherwise would produce a "two-tiered" health care system with one standard of care for the wealthy and another, lower standard of care for the less wealthy. Any suggestion that there should be a privately based component of the health care system produces an outcry that such an action would be elitist and unfair. The evidence for such a claim is never produced and we know of no study that actually produces evidence that "two-tiering" would cause such problems. On the other hand, there is considerable evidence that no such bifurcation of care would be produced. In this

book we examine evidence from other functioning health care systems which allow for private options.

There are a number of reasons for seriously considering the addition of a private component to Canada's national health care system. The most obvious one is that we are running out of the ability to provide public funds for anything. Even those who prefer the public health care option must surely recognize that private financing is preferable to curtailment of service.

Another important reason sees the addition of a private health care tier as part of a general move to introduce competitive incentives to a system which at the moment has all the features of a monopoly. Indeed, restructuring the incentives for health care providers is a more important innovation than two-tiering and can be undertaken without the private option. We will examine how this can be done. We will also consider a plan for restructuring the entire health care system from diagnostics to drugs.

The plan—summary of contents

This book is divided into two parts. The first part presents a survey of the evidence about the functioning of health care systems in a European and Australasian context. The second contains a comprehensive review of the Canadian system and a work plan for renewing publicly funded health care with elements of privatization and a thoroughgoing overhaul of incentives for health care consumers and providers.

The debate about two-tiered medicine in the U.K.

The first part opens with two papers that are intended to form a debate about the structure of Britain's National Health Service on which the Canadian system was modeled. The two participants are Stephen Pollard, then Research Director of the Fabian Society, the ideological rootstock from which publicly supported universal health care grew in the United Kingdom, and Dr. Tim Evans, Public Affairs Manager of the Independent Healthcare Association. Given the different points of departure of these British experts, we had expected a pitched ideological battle over whether the private option within the British health care system was a constructive or destructive force. What we got instead was

two complimentary pieces, one delving into the history of private finance for medicine in the United Kingdom and the other providing a contemporary view of the essential role played by private medicine and the political indestructibility of the internal market structures which have been introduced into the NHS—including the once controversial concept of physician fund holding.

Both of these authors essentially agree that within the general context of a publicly financed health care system ensuring access for all citizens there is still a need for private options. Rather than seeing the private option as some sort of anomaly, both authors point out that the private approach to health care insurance and delivery is the natural and original state of this industry. Moreover, both agree that the monopoly state-provided health system introduced after World War II is now a kind of anachronism.

This is a particularly important point for those who would seek a new direction for Canadian health care. It must not be forgotten that when Justice Hall held his commission in the mid-1960s, the product of which would be Canada's national health care system, he was overwhelmingly motivated and inspired by what he found in the United Kingdom. Now if Justice Hall were going to the United Kingdom in 1996 to look for models, he would find a system that is very explicit about the need to involve both public and private options; a system in which market forces are relied on to extract performance from public health care providers; a system in which competitive incentives are directly engineered to encourage more effective use of resources. Justice Hall would, in effect, find the kind of system that is sketched out in the second part of this volume—a plan for a national health care system that relies very much on the current British model as opposed to the one that he and his fellow commissioners observed in the 1960s.

One of the most important historical lessons of the public/private debate in the United Kingdom is the recognition that discussion no longer turns on a solely private health care system or a solely public one. Rather, the debate is about the extent to which the incentives in a privately oriented health care system produce superior results to those which can be achieved in a monopoly single-provider public sector model. The key is how to take advantage of the former in the reform of the latter.

Perhaps the most astounding finding of the paper by Stephen Pollard is that whoever holds power in Britain will essentially have to maintain the current health care reforms because they have proven so popular with the patients served by the system. A Labour government would not dare dismantle the reforms because of the political cost. Astute politicians operating in the Canadian context would do well to pay close attention to this British evidence.

Lessons from a survey of Europe

The third paper in Part I, written by Paul Belien of the Centre for the New Europe, provides an interesting overview of the structure of health care systems in Europe from which Canadian reformers can draw interest and inspiration. Two key inferences from the European experience seem to be clear.

The first is that there is no necessary relationship between the existence of a private health care alternative and a lowering of the quality of health care available to the average citizen. In fact, Mr. Belien points out that while the Swiss health care system has always been private and there is no real public alternative, the health status of residents of all social classes is superior to that exhibited in Britain. The French and German health care systems both encourage access to private care for significant fractions of their populations without any obvious negative impact on general access to treatment. In fact there is some evidence to suggest that the availability of the private option actually enhances the care available through the public system by competitive pressure.

An equally fascinating aspect of the Belien paper concerns the treatment of risk in the various European systems. A common concern already noted here is that ageing populations will ultimately make universal public health care unaffordable. In those European countries which have explicitly taken this factor into account, no such escalation in health care costs is likely to occur. In these systems, citizens make investments in health care accounts that accumulate against the time when their advancing years will require higher expenditures. This is a characteristic of many of the private health care options available in Europe and here again, there is much to be learned for structuring a future Canadian health care model.

Belien also reminds us in his essay that one of the great advantages of relying on more privatized health care institutions is that they more rapidly and accurately process new information about diagnostic procedures and cures and provide direct guidelines to people involved in the health care system about what their decisions cost and thus what the implications may be.

In the fourth paper, Margit Gennser canvasses the incentive and disincentive structure that influences behaviour in the health care system. The fact that Swedish physicians are in effect salaried employees of the state has had a fairly predictable effect on productivity. As Gennser points out, Sweden's physicians have very low productivity, seeing on average only six to 12 patients per day.

Gennser's rendition of developments in Sweden echoes the point made by Paul Belien to the effect that administrative responses to problems in the health care system have produced, not solutions, but more problems. Gennser points out that those who have been badly affected by such developments in Sweden include residents of extended care facilities who, because of attempts by both hospitals and counties to shed costs, are constantly shunted back and forth between extended care and acute care hospitals each of which is the responsibility of a different level of government.

The most intriguing aspect of Margit Gennser's exploration of the Swedish system, however, is her review of the administrative records of investigatory commissions to determine the extent of their expressed concern about patients. As Gennser points out, she was able to find only two references to the patient in these extensive investigations of the Swedish health care system and that, she says, is its Achilles heel—namely, that the system is centred, not on the needs of the patients, but on the fiscal needs of government, the administrative needs of institutions, and the income requirements of health care providers.

The paper on Germany's health care system by Volker Ulrich surveys in depth the structure of his country's health insurance system and provides many interesting insights on a number of topics that are of pressing concern in Canada.

First, on the issue of whether a private option adversely affects the quality of care available to public sector patients, the German situation offers no evidence that such is the case. About 10 percent of Germans are covered by private insurance, and while these patients must have in-

comes above 5,500 Marks a month or roughly $60,000 a year, there is no evidence of any deleterious impact on the health care provided to those whose incomes are lower. The fact is that German doctors cannot usually run a practice on the basis of private patients alone, since they represent only one in 10 Germans.

Ulrich also provides evidence on another emerging Canadian health care policy, namely reference-based pricing for pharmaceuticals. The objective of reference pricing is quite benign in aiming to reduce the cost of prescriptions without affecting the quality of care. The idea is that a government committee can designate one drug out of a range of drugs that are used for a particular purpose and that one available in government subsidized pharmaceutical programs. While the intention is laudable, the evidence from Germany, according to Ulrich, is that the objectives of reference pricing are thwarted by changes in prescribing practices by physicians and increases in such other health costs as increased visits to physicians and increased hospital admissions.

The great reference pricing debate

The issue of reference pricing for pharmaceuticals is the main focus of two papers which put at odds the head of Pharmac, the body entrusted with the administration of reference pricing in New Zealand, and Dr. Alister Scott, a gastroenterologist and recently retired President of the New Zealand Medical Association, who has been an opponent of the introduction of market-based solutions to health care difficulties.

One of the most interesting aspects of the debate between Scott and Pharmac's David Moore is the extent to which Moore seems to regard reference-based pricing as a David's slingshot to redress an imbalance of power between a small country like New Zealand and Goliath, the "overseas giants who could buy the [N.Z.] islands outright with just the money they spend on marketing." It is interesting to contrast Moore's focus with the concerns of Alister Scott, which centre on the therapeutic and medicinal impact of the reference pricing regime.

There are, however, many attractive aspects of the recent New Zealand reforms in health care, and the second part of this book, which turns specifically to the Canadian case, attempts to incorporate lessons from the experience of New Zealand and the European countries presented in this book.

Focus on Canada

Part II contains our examination and evaluation of the situation in Canada both in a historical context and in comparison with other OECD countries. A review of health care developments from Confederation to the present shows that most changes in the provision of care were dictated by political expediency as opposed to identified medical requirements. It is a tale of how the federal government used its superior spending power to usurp responsibilities which belong constitutionally to the provinces. While the standard verdict is that this permitted the development of health care to a much greater degree than would have been the case if the provinces were left to their own devices, the reality involved overconstruction of hospital beds, detailed meddling by the federal government in the affairs of provinces, and the erection of a mythology about health care in Canada that simply does not stand up to scrutiny.

Within the OECD, Canadians give their health care system the highest approval rating, but this approval appears to be based on erroneous conclusions about what the system provides and how it compares with what is offered by systems in other countries. In this context, an important part of the initial discussion is the detailed consideration of the five principles of the *Canada Health Act*. As we discover, many of the provisions are and always have been mythological rather than substantial. Facing this reality may be the highest hurdle in the move towards a solution for Canada's health care system problems. Canadians need to begin to recognize the frailties of the present health care system before meaningful improvement can be achieved.

This section goes on to make some interesting comparisons of health care data from a number of OECD countries. The results are both fascinating and puzzling. We examine the connection between health status and health care spending; we ponder the wide variations in the number of visits to physicians that citizens of different countries make in the course of a year; we ask whether Canada has too many doctors and nurses and whether the decline in good health life expectancy here is typical of that within the OECD. These data reflect only a tiny percentage of the comparative information available, but the answers to the questions raised make for an interesting background as we search for solutions to the problems of the health care sector. It becomes obvious in

these deliberations that no single country can claim to have "the best" system. All, including Canada, have strengths and weaknesses, and all can learn from the others.

Next, we examine issues in primary care. A brief discussion outlines some demographics of health care workers and illustrates the wide variety of professional and technical skills that contribute to this important sector of the economy. Three major issues in primary care are then examined in more detail. First, we examine, and find wanting, the widely held belief that one of the Canadian health care system's underlying problems is too many physicians seeing too many patients too often. Second, we briefly examine the contentious issue of how best to remunerate primary providers; many of the accepted truisms regarding this topic are erroneous. Third, we look at another contentious primary care topic: pharmaceutical costs. Once again, conventional wisdom regarding this topic is at best misleading and at worst downright wrong. The cost of pharmaceuticals has increased over the past 20 years, but the benefits and cost savings resulting from newer drugs have also escalated remarkably—a factor seldom mentioned by those who focus only on the direct cost of drugs. A discussion of British Columbia's reference-based pricing program reveals evidence that it will not only fail to achieve savings, but will almost certainly produce a substantial increase in costs to taxpayers.

The focus of Part II then turns to the hospital sector in Canada, which consumes 38 percent of total health spending and 48 percent of taxpayer spending on health. Hospitals in British Columbia, and in fact in most of Canada, are so heavily regulated and controlled by government that they are effectively government bodies. The chapter contains a brief discussion of performance measures for hospitals and compares some of these parameters with those of other countries. It also refers extensively to the report of the Health Services Utilization Working Group[2] and reveals that half or more of the work being done in acute care facilities is either unnecessary or could be done more effectively elsewhere.

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2 The Health Services Utilization Group for the Conference of Federal/Provincial/Territorial Deputy Ministers of Health, *When Less is Better: Using Canada's Hospitals Efficiently*, June 1994.

Part II then goes on to review hospital budgeting and suggests that the present "global" budgeting system is inefficient, wasteful, and sends all the wrong signals to hospital management. Difficulties associated with the labour sector are illustrated using the Royal Columbian Hospital, a community hospital in New Westminster, British Columbia, as an example. A simple measure such as reducing labour pay rates to the same as those for private sector unions doing the same work in the community would have saved the hospital about 4 percent of its budget in 1994. The final paragraphs in this section describe the unhappy consequences of the attempt to invoke the changes outlined the 1991 report of the *British Columbia Royal Commission on Health Care and Costs*. It is a story of political and bureaucratic bungling, deteriorating service, increasing waiting times for treatment, patient and provider discontent, and a justified public apprehension that the system is both out of control and at risk of collapse.

The second section of Part II outlines our proposals for improving the system with a view to ensuring quality health care for all Canadians regardless of ability to pay. We discuss some general principles and express our opinion that the most positive contribution the federal government could make toward improving health care in Canada would be to repeal the *Canada Health Act.* A discussion of the much-misunderstood concepts around to the words "private," "private sector," and "privatization" follows, along with some general thoughts on the appropriate role of the "private sector" in health.

The paper then goes on to introduce the concept of separating purchasers and providers—a fundamental principle essential for the development of health care in Canada. Separating purchasers and providers is the first step in bringing competition into the system. We describe the creation, control, and management of regional purchasing agencies—bodies that should be created for the sole purpose of purchasing health care for the public in their regions. We also provide an outline of their specific tasks and duties.

Finally, we offer specific recommendations for the primary care sector and the hospital sector. We note that considerable improvement could be achieved in the primary sector by introducing physician budget holding, a mechanism whereby the physician holds a budget for providing specified services to all the patients on his or her roster. The concept was pioneered in Britain where it is known as "fundholding"

and was quickly taken up by the New Zealanders. The operation of the scheme is discussed, with its advantages and potential shortcomings, and a brief review of the New Zealand and U.K. experiences is included. This system has proved itself economically sensible and is now politically popular in the United Kingdom. The result has been an improvement in the care available to patients, including reduced waiting times for surgery and improved access to diagnostic tests.

This is followed by an examination of an alternative known as "medical premium accounts," a version of the medical savings accounts that have been used to good effect in the United States. This approach is used to simultaneously empower health care consumers and reduce the cost of providing care. This amendment to the current publicly-funded health care system would eliminate the sharp dividing line that currently exists between conventional and complementary health care as well as giving consumers and providers an incentive to economize on the use of the health care system.

The book's final pages are devoted to "Fixing the hospitals." To date, most of the attention of hospital reform advocates has been directed towards institutional reform. Health care decisions have been decentralized or regionalized, hospitals have been merged to reduce administrative costs, and private clinics have been tightly regulated or even outlawed. What is most surprising about these reforms, however, is that they so slavishly mimic reform movements that have been shown not to work in other jurisdictions.

The reforms we propose rely on the positive British and New Zealand experience with the introduction of what in Britain is called the "internal market." Essentially, the concept is that the key to efficient management of the health care system is the incentives for participants. Accordingly, what is required is to reform the incentives for hospitals, not their institutional structures. When the incentives are improved, institutions will reform themselves along economically efficient lines. Without reform of the incentive system, however, nothing meaningful will be accomplished, since institutional reforms take no account of changes in individual behaviour.

In this context, we introduce three concepts. First, that the regional purchasing agency concept be brought to the purchasing of hospital services, thereby separating purchaser and provider, and bringing the beginnings of competition to the system. Second, many of our public

hospitals must be privatized to bring the benefits of private sector management to their administration. Third, the system must be structured in such a way as to permit private and public sector facilities to compete on a basis of equality for the right to provide service to both public and private sector patients. Finally, we suggest how the contentious issue of labour relations should be addressed.

Canadians urgently need to take a long, hard look at their health care system. There is much good contained in it, but there is also much that can be improved. Too often we look to the U.S., see only the weaknesses of their health care system, and perceive it as the only alternative to our own. This is incredibly myopic. The reality is that there are 25 OECD countries, many of which, including the U.S., offer vibrant, practical, and affordable alternatives to much of what Canada does now.

The Fraser Institute is pleased to offer some of the best recent ideas from these other countries as a contribution to the debate about the future of health care in Canada. However, the authors of this study have worked independently and their views do not necessarily reflect those of the members or trustees of The Fraser Institute.

—William McArthur, M.D., Cynthia Ramsay, and Michael Walker

About the Authors

Paul Belien is the Research Director for The Centre for the New Europe—a Brussels-based public policy research institute. Mr. Belien has been trained as a journalist and holds a degree in social and European Law. He worked for many years as a journalist both in Belgium and the Netherlands, and is currently a regular columnist for a Belgian financial and economic magazine. He also writes frequently for *the Wall Street Journal, Europe*. He has also written a number of articles and papers on the problems of the European welfare state.

Tim Evans, Ph.D., is the Executive Director of Public Affairs for the Independent Healthcare Association, U.K. He is a former Assistant Director of the Foundation for Defence Studies and a policy researcher at the Adam Smith Institute. A political sociologist by background, he has lectured on social policy to post-graduate students in the Department of Economics at London Guildhall University and taught the Economics of Privatization at the American College in London. In 1991 he became Chief Economic and Political Advisor to the Slovak Prime Minister, Dr. Jan Carnogursky, and was head of the Prime Minister's Policy Unit. In 1993 he obtained his doctorate from the London School of Economics and today deals with the public relations and political affairs of the UK's independent health and social care sector. A committed Libertarian, he gives regular guest lectures on police privatization to the Strategic Command Course at the UK's premier Police Staff College—Bramshill. The

views he expresses in this book are not necessarily those of the Independent Healthcare Association or its members.

Margit Gennser is currently a Member of the Swedish Parliament. She holds a Masters of Business Administration from the Stockholm School of Economics and Lund University. She was a lecturer at Lund University in Accounting and Business Administration from 1963 to 1972, a publisher at Hermods Studentlitteratur from 1965 to 1970, and owned her own consulting firm from 1970 to 1985. She has published more than ten books in accounting, business administration, and costing (1964 to 1973), and books about wage earners' funds (1976, 1978), local council politics (1982), and privatizations (1985).

Ms. Gennser held the position of local Councillor from 1976 to 1982 and MP for Malmo since 1982. She chaired the Government Commission on the Supply of Pharmaceutical Products from 1992 to 1994 and has been the Riksdags Auditor since 1988.

David Moore, General Manager, Pharmac, New Zealand has been involved with New Zealand's health reforms since 1992. He was an economist in the Strategic Health Policy section of the former Department of Health, later becoming manager of the Drug Tariff section, Pharmac's predecessor. When Pharmac was created in July 1993, Mr. Moore was chosen to head the new company. Prior to his involvement in the health sector, his career included investment banking, management consultancy, and policy development. David Moore has a diploma in health economics, NZ Stock Exchange diploma, and a Master of Commerce degree from Auckland University.

William McArthur, M.D., is a Visiting Fellow in Health Policy at The Fraser Institute. He is also a practising physician who specializes in palliative care in Vancouver. He was the first Chief Coroner for British Columbia, and prior to that spent 24 years as a fighter pilot/physician/research scientist in the Canadian Forces. While with the federal government his responsibilities included supervising aeromedical research and developing policies in a wide variety of areas. He also served on numerous national and international committees concerned with medical and health issues.

Stephen Pollard is Head of Research at the Social Market Foundation, the U.K.'s leading independent public policy think tank. He was previously Research Director of the Fabian Society, England, the world's oldest, and the British Labour Party's independent, think tank. A regular newspaper columnist and TV broadcaster, he is the author of a number of pamphlets. He was Secretary to the Committee of Enquiry which drafted a new constitution for the Labour Party. He writes frequently on education and health, and is the author of "Towards a More Cooperative Society: Ideas on the Future of the British Labour Movement and Independent Health Care." The views he expresses in this book are his own and are not necessarily those of the Fabian Society or its members.

Cynthia Ramsay is Health Economist at The Fraser Institute, which she joined in 1993. She is co-author of the Institute's annual waiting list survey, "Waiting Your Turn," and has written various articles contributing to the national health care debate. Prior to joining the Institute, Ms. Ramsay worked at Statistics Canada as an analyst. She holds a master's degree in Economics from Simon Fraser University.

Alister Scott, M.D., is a gastroenterologist working in private practice at the North Shore Hospital in Auckland, New Zealand. He graduated in Medicine from the University of Otago, New Zealand, in 1960. He was the NZ University Travelling Scholar in Medicine in 1965 and a Nuffield Foundation Fellow in 1967-68. He was a senior lecturer in the Otago and then the Auckland Medical Schools between 1968 and 1977. From 1991 to 1994 he was Chairman of the New Zealand Medical Association, representing the profession and championing the interests of the patient to the government during the health restructuring that occurred at that time. He has continued to act as a commentator on health service organization since his retirement from that post, and as an informed critic of the New Zealand health reform has been invited to write on the New Zealand experience and speak to various national and international audiences.

Volker Ulrich, Ph.D., studied economics and statistics at the University of Mannheim. From 1983 until 1988, he worked as a research assistant in the Faculty of Economics and Statistics at that university. After finishing his doctoral thesis on the development of price, quantity, and quality in

the health care sector in 1988, he worked as a researcher and teaching assistant. In 1995 he completed his second (habilitation) thesis on demographic impacts on the public budget. At present, he is assistant professor at the University of Mannheim. His research concentrates on the fields of health economics, public finance, and applied econometrics.

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Part I: Health Care Systems in Europe and Australasia

Britain's NHS—Coping with Change

Stephen Pollard

THE BRITISH LABOUR PARTY is committed to ending the "internal market" and abolishing "fundholding"—the central planks of the Conservative reforms of the National Health Service (NHS). A clear enough statement of intent, some might think, but these so-called commitments are effectively meaningless when one understands their context. Labour's attitude to the provision of health care if it formed a government is in no way predictable from its attitude in opposition.

> The history of workers' cooperatives, the friendly societies and the unions from which the Labour Party sprang is one of individuals coming together for self-improvement and to improve people's potential through collective action. We need to recreate for the 21st Century the civil society to which these movements gave birth . . .[1]

The main feature of the British Labour movement has always been its objective of combining the equity principle with opportunity for the

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1 Tony Blair, MP, May 24, 1994: speech to the Institute of Economic Affairs.

individual within a wider society committed to providing a decent standard of living for all of its members.

Although the Labour Party has begun to break with the postwar agenda of a massive, exclusively state-provided, universal welfare state, a great deal of work remains to be done if Labour is to convince the electorate that its programme is attractive and relevant to their needs in today's society.

A further quote, this time from one of Labour's most innovative thinkers and the Chairman of the House of Commons Select Committee on Social Security:

> The starting point for the Left needs to be the acceptance that, politically, welfare issues are fast becoming part of a new ball game. Consumers will willingly listen to right-wing schemes promising more consumer choice if that is all that is on offer. The fightback from the progressive Left must come from a reexamination of the roots of the welfare state.[2]

Today, the Left rarely speaks about the individualist socialist welfare tradition or the crucial role it played in developing the wealth-creating capacities of millions of ordinary people before the establishment of the universal welfare state. Until recently, only a handful of academics and intellectuals sought to remind the world of this tradition's approach to health and welfare policy.

The 19th Century in the U.K. was by no means simply about "bourgeois," laissez-faire values. Existing alongside these values was a formidable working class alternative which aimed to replace the hated Poor Law[3] with viable, individual-oriented and community-based forms of health and welfare provision. Through the trade unions, workers would win the wages necessary to sustain a decent existence, and

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2 Frank Field, MP in the *Sunday Times*, July 22, 1990.

3 The English Poor Law was a creation of the 16th Century that established a secular and legal obligation to relieve the destitute. National legislation was put in place in the 1600s after experimentation on a local level throughout the 1500s. The legislation required local justices together with churchwardens to assess and levy a poor rate on all householders. With the funds raised, the aged were to be relieved and provided, if necessary, with cottages, poor children were to be apprenticed, and the able poor set "on work."

through the friendly societies they would organize their own welfare services—social insurance, medical care, even housing loans.

Contrary to a great deal of modern mythology, the 19th Century witnessed a variety of rapidly growing and highly successful institutions aimed at elevating citizens out of hardship. Friendly societies and savings banks played a key part in a broad movement which prided itself on providing individuals with efficient, effective, and sustainable forms of welfare.

By the time the Labour Party was formed in the early 1900s, the British socialist movement was a broad-based coalition of many different shades of opinion: utopians, cooperatives, friendly societies, trade unions—all distrustful of a strongly centralized state. However, in line with a great deal of sociological thought at the time, a new strand of socialism was emerging which argued for the establishment of new moral communities based on occupational membership to replace a traditional moral order which had already broken down in the Industrial Revolution. From 1880 on, a new generation of statist Fabian and Marxian socialists began to influence the wider Labour movement and pull it towards the ideas of state welfarism.

Towards the end of the Victorian era, British socialism began to take on a more European flavour and the Labour movement began to accept the ideas of collectivism and the centralization of power.

The modern welfare state began with the National Insurance Act of 1911. The Act introduced a compulsory insurance system which undermined the working class self-help movement. Workers no longer needed to arrange their own affairs as best they could: the state would do it for them.

Furthering the gains made by the state during the early part of this century, it was the Beveridge Report published in 1942 that first proposed the establishment of a fully comprehensive, universal welfare state. Of all its recommendations, the creation of the National Health Service was by far the most important.

The 1944 White Paper "A National Health Service" had three core aims:

1. to ensure that everyone in the country, "irrespective of means, age, sex or occupation," should have equal opportunities to secure the medical care they needed;
2. to provide a comprehensive health service covering all aspects of preventive and curative medicine;
3. to divorce the care of health from questions of personal means and to provide the service free of charge, apart from certain possible charges in respect of appliances.

These laudatory aims—which should remain the governing framework for any reforms to the NHS—were given statutory form in the *National Health Service Act* of 1946. Under the provisions of this Act, the Minister of Health was empowered to take any hospital that he thought appropriate into public ownership. These hospitals would be organized under Regional Health Boards into a comprehensive system of health care that would be free at the point of delivery.

At its inception, it was widely believed that the NHS would, with a few unimportant exceptions, become the sole provider of health care in the country. There was little doubt that the private sector would be wiped out. However, while Whitehall expected that there might be an initial demand for spectacles, false teeth, and the treatment of other common ailments, and that costs would soon diminish with health improvements, these assumptions proved to be very misguided. The Attlee Labour administration which introduced the NHS failed to fully understand the economic argument that when a good is offered at zero price at the point of service, there is no limit on demand.

Over the intervening years, problems with the NHS have increasingly focussed on such matters as cost, demand, producer sovereignty, consumer powerlessness, and ineffective management structures.

Politicians across the political spectrum now increasingly accept that these problems, which run across the welfare state, are the consequence of the state's inability to effectively target and respond to individual needs. As recently remarked by Sir Gordon Borrie (now Lord Borrie), Chairman of the Commission on Social Justice set up by the Labour Party in 1992 to consider the future of the welfare state:

> There is a pervasive sense across the U.K. that current [welfare] institutions and assumptions are inadequate to new challenges.... For those on the Left, the need for reform stems from

> the failure of the system to meet its objectives—above all, the elimination of want and the extension of economic opportunity.[4]

Significantly, he went on:

> Today, the keystones of the Beveridge welfare state—full employment (for men), the nuclear family, and the expertise of Whitehall professionals—are under strain. We are living through an economic revolution of skill, technology and competition that is transforming the nature of work. We are living through a social revolution of women's life chances that calls into question long-standing assumptions about social security and social services. And we are living through a political revolution, in which unaccountable power is increasingly being questioned; people are not willing to be passive recipients of services, but want to be decision makers in their own right.[5]

Throughout the rest of the European Union, Labour's socialist partners more readily accept the view that it is often best if people are encouraged to be "decision makers in their own right." This is particularly pertinent to health care.

Under the recent socialist government in France, a full range of health care services was actively provided by professionals working in both private and public sector institutions. French hospital medicine is characterized by this same duality: some 33 percent of all hospital care is provided by the private sector (50 percent of which is profit making and 50 percent non-profit making).[6]

Spain's recent socialist government had no problem accepting the independent sector's provision of much-needed hospital services. It oversaw a healthy mixture in which 31 percent of all hospital beds were privately owned.

In Belgium, politicians across the political spectrum treat as normal the idea that out of a total of some 77,000 hospital beds, the private sector accounts for a clear majority of 48,000.

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4 *The House Magazine*, January 31, 1994.

5 *Ibid*.

6 All figures for European Union health care are taken from *Hospital Services in the European Community*: Leuven, Belgium, Hospital Committee of the European Community, 1993.

In recent years, Greece's socialist government has introduced new legislation in an attempt to switch its national health policy away from a centralized administration towards a more decentralized and individually oriented system—to allow private health care organizations to play a more active role in supplementing services provided by the statutory authorities.

Across Germany, the Netherlands, and other countries, the story is the same. Continental socialists find little time for the politics of narrow-minded statism which has in recent decades characterized British Labour's approach to health care. In countries such as France, Spain, Belgium, and Greece, socialists readily accept the complementary benefits that can be derived from actively involving the independent health care sectors and putting them to good use in the interests of empowering all people.

If Labour is to put forward a credible social and economic policy—if it is to facilitate greater health care spending without simply increasing taxes—it should examine the approach used by its socialist colleagues abroad and accept the benefits to be derived from an enhanced British independent health care sector.

There is a myth that any form of health provision from outside the NHS is by definition "tainted" with capitalism and private profit. In fact, nothing could be farther from the truth. Today's non-NHS health care providers in the U.K. include a wide range of charitable and religious providers who, rather than actively undermining public health, help to promote it. Independent suppliers of health and community care services not only provide useful measures of quality against which state provision can be checked, but often encourage new and innovative care models.

Whereas twenty years ago, independent acute care was used only by a tiny minority, the most dramatic increases during the last couple of years have occurred among those classified in the Registrar General's social groups D and E—the very poorest members of society and the bottom of the social scale. With over 14,000 beds and total annual spending of £2 billion, this sector makes a massive contribution to the U.K.'s health and welfare. Caring for thousands of people in need every week, it should not be ignored or opposed by a future Labour government but seen as an ally in the struggle to deliver effective health care.

Instead of being inextricably tied to the ideas of state collectivism, British socialists would do better to rebuild an integrated economic and social welfare policy which fully utilizes the principles of cooperation and recognizes individual aspirations. While the NHS and its professions derive their power from the state and state-imposed regulatory uniformity, citizens are vulnerable in the face of powerful "top-down" structures which inevitably tend to serve supplier interests. To empower citizens and reverse this process, the simple principles of democracy and political accountability have to be recognized as inadequate when it comes to the complex needs of millions of individuals. Bureaucratized committees, politicized inquiries, and endless review bodies tend to be inherently conservative and unresponsive to change. Using taxpayers' money and monopoly suppliers, modern governments and their agencies inevitably lack the information and incentives needed to respond to the subjective desires of the millions of individuals they are attempting to serve.

Instead of relying solely on the state, progressive left-of-centre governments should provide citizens with individually tailored welfare products that are appropriate and responsive to their needs and desires. To revitalize and give meaning to the concepts of community and citizenship, socialists should return to the tradition of providing individually tailored cooperative services. Given the economic, technological and demographic shifts now emerging across the international economy, our health and welfare services are in dire need of new, innovative, and practical policy proposals. The formidable problems associated with dependency, adverse demographic trends, poor resource allocation, and inadequate accounting and research spell challenges for the welfare state which socialists cannot afford to ignore.

As Frank Field argues: "The fightback from the progressive Left must come from a reexamination of the roots of the welfare state."[7] The Left must recognize that the socialist tradition of self-help and cooperation gives the movement a powerful historical precedent for providing efficient, effective, and empowering health and welfare services from the "bottom up."

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7 *Sunday Times*, July 22, 1990.

This is not to argue for the recreation of a 19th Century when a large proportion of society was left unprotected and vulnerable in the face of uncompromising capitalism. These ideas are intended to complement the existing structure of the welfare system, not to undermine it. This is especially so in the case of the universal health care provision, irrespective of an individual's ability to pay, that has been available since Nye Bevan's creation of the NHS—a cornerstone of the civilized society that the U.K.'s next Labour government will seek to foster.

The Labour Party should formally recognize the role of non-governmental organizations in health care provision and incorporate them into its vision for the future. If Labour welcomes the use of private finance in building a proper transport system—as it now does—why should it not do the same for the provision of health services?

The age of demand-led government departmental budgeting has long gone. But with money now recognized by Labour to be as scarce as other resources, New Labour, as the party has now been de facto renamed, is no longer a "tax and spend" party. State/non-state cooperation offers an opportunity for Labour to increase the supply of services and reduce the constant demand for funds from the taxpayer at the same time.

What, in this context, will New Labour's attitude be in government to the quasi-market-led reforms introduced by the Conservatives? Trust hospitals and the internal market are, in some form, here to stay, whatever some might like: for one thing, the administrative costs of further restructuring are too huge to contemplate. The issue then becomes how to make them work best in the interests of those without the financial means to look after themselves. Just as with private schools in the U.K., so with private health insurance: those who can afford it, have it, and those who cannot afford it, want it but are denied access.

If Old Labour had won the 1987 election, the NHS reforms would not have been enacted. The administration of the NHS, and not merely the concept, was one of the great boasts of the Labour Party—a national service, centrally controlled, with whatever uniformity the Ministry of Health could facilitate. The fact that this very administration was inefficient by almost any criterion and, as Nye Bevan, the author of the NHS, put it, "there is nothing socialist about inefficiency," was not a cause for concern. Sure, there was room for improvement, but only by tinkering

and smoothing out difficulties. Restructuring would not have been seen as necessary.

Thus, when Mrs. Thatcher surprised even her own Health Secretary during the 1987 election campaign by talking of the need for administrative reform, the Labour Party was extremely hostile. Any such change, even if proposed by a Labour supporter, was seen as an unnecessary threat to the integrity of the NHS. Coming from the Tories, however, it was seen as nothing less than an attempt to privatize the service. These accusations were hurled even before the shape of the reforms was known. For a party that was, at that stage, still generally hostile to the role of markets, the NHS reforms only came as confirmation that the Tories were up to no good and that the only way to preserve the wildly popular notion of an NHS equally available to all was to oppose all of them root and branch.

Labour has now moved on to acceptance of the market. The party now accepts, as stated explicitly in its new statement of aims and values adopted in April 1995, that the market is a good thing. In recent years, the impact of reality on most policy areas has been overwhelming. Labour will not renationalize the utilities—gas, water, and electricity—not merely because the money is not there to do it, but because the leadership no longer wants to do it. However, the party remains blinded by its fundamentalist beliefs in the areas of health and education. Labour's quasi-religious faith in the immorality of non-state health care provision and the metaphysical perfection of the NHS administration means that its health thinking has yet to be struck by reality. On Day One of the next Labour government, however, reality will force Labour to rethink its health policy position.

Purchaser-provider split: hospitals hawking their services in the NHS marketplace

Until very recently, Labour was opposed to the purchaser-provider split as being integral to the hated NHS reforms. The overwhelming evidence from within the service, however, has been that the split works. It is more efficient, makes possible the spending of greater resources on health care itself, and makes the provider more accountable to the purchaser, who now has real purchasing power. Many of the people point-

ing this out have been solid Labour supporters or advisors such as Julian Le Grand of the London School of Economics.

Party policy has now changed, not by professing a new revelation, but by an end to attacking the split in speeches and documents. So it is that a matter of months after the party's then spokeswoman went on record as committing Labour to scrapping the split, no Labour official will criticize it. They will argue that it needs refining, but they will grudgingly concede that the purchaser-provider split will be retained in some way. The question is: what way?

Labour now acknowledges that the split has benefits but insists that it be made compatible with "strategic health planning" and subject to proper democratic control and accountability. In terms of practical change, this statement is virtually meaningless. The party will say virtually nothing on this issue and when in office will maintain the status quo.

NHS trusts: hospitals operating as individual entities

Something similar to Labour's conversion on the purchaser-provider split is at work on the subject of the trusts. Initially, of course, Labour opposed all the new trusts as "privatizing" the NHS. As separate legal entities, trusts could be sold off to the private sector and so the NHS itself could be privatized. The devolution of administration would become more and more accepted and other players would enter the market as health care providers within the NHS just as the mutual provident associations and, indeed, many nursing homes had already done.

Since Labour is intrinsically trusted by the public to deal with the NHS, there is room here for Labour to move where the Conservatives cannot. Here again, however, Labour rhetoric has been blind to the reality. Until very recently, the party was formally opposed to the existence of trusts; there was no place for separate legal entities in the provision of health care in the NHS; trust status should be abolished and trust hospitals returned to "communal" control.

Now the trend in Labour thinking is away from attacking trust status per se and towards attacking the composition of trusts as part of "the new magistracy"—the "Quangocracy," to quote Labour advisor John Stewart of Birmingham University. (A Quango is a "quasi-autonomous

noon-governmental organization.") Labour's thinking is now directed towards addressing the "accountability" of trusts rather than their right to exist.

Labour argues that the present system is undemocratic and inefficient: decision making is fragmented and requires greater coordination among trusts. There is some truth in this. It is likely that future Labour policy will involve some kind of machinery for elected positions on trust boards, possibly through the appointment of local councillors or representatives of community groups.

Fundholding: giving GPs their own budgets for buying care

Labour's main concern is the current "two-tier system" in which a patient whose GP happens to be a fundholder gets a head start. The party has therefore committed itself to "end fundholding" and replace fundholders with "commissioning GPs." These are meaningless terms. Everything depends on how "fundholding" is defined. If you reform the status quo and give it another name, you can claim to have abolished it whereas in reality you have refined it. This is an example of how Labour must satisfy two different constituencies—its members' wishes and the demands of common sense. If one of the perceived problems with fundholding is that those who are not fundholders are left behind, two approaches are possible: abolition and extension. Now a simple map of marginal constituencies which Labour needs to win overlaid with locations of fundholding practices amply demonstrates that the party cannot commit itself to abolition. Fundholding is popular with those who benefit, and the party will not wish to alienate them. Thus, there is only one possible approach: extension in some form.

In government, Labour will enact "abolition" by making the concept far more flexible: all GPs will be fundholders. Practices wishing to carry on pretty much as now will be able to do so. Those that do not will be grouped with other practices and pool their administrations. In June 1995, Labour committed itself to the "abolition" of fundholding. One of the first acts of the Labour government will be its extension.

It should be clear that Labour's policy in government will, if anything, involve extending the current reforms. Labour can do some things, because it is implicitly trusted to look after the NHS, which the

Conservatives can never do because they are implicitly distrusted with the NHS. The longer into government one looks, the easier it becomes to see Labour taking the Conservative reforms farther than the Conservatives would dare. Labour could and perhaps will move towards further "devolution" of responsibilities to the trusts, and it could justify this as part of its programme of devolving power back to communities.

In the long term, this devolution of power within the NHS could open up the possibility, now attacked by Labour as privatization, of non-state providers such as mutual provident associations entering the NHS market. The exponential growth over the next decade of private health insurance schemes arranged by trade unions for their members will make this devolution even more likely.

But this is speculation. At this stage, Labour is fundamentally opposed to private insurance. In a world of wishes, Labour members would outlaw it overnight. In reality, however, Labour tolerates private insurance as an evil it cannot abolish, either legally or because many of its supporters use it. The idea of working with the private sector—profit making or not—repels almost all members of the Labour Party. Although there is historical precedent in the very origin of Labour for cooperation between the state and non-state sectors and there is an economic need for such cooperation, most Labour members dismiss the idea, not intellectually but purely because it entails working with the non-state sector.

Previous Labour governments have always been guided by pragmatism rather than ideology. The next one will be, if this does not sound too strange, ideologically inclined to be pragmatic rather than ideological. A U.K. Labour government will have little financial alternative to pragmatism.

Working Class Patients and the British State: an Historical Perspective

Tim Evans

FOR MANY ACADEMICS AND POLITICIANS in the United Kingdom, the story of the British National Health Service (NHS) goes back to a White Paper published in 1944.

To really understand the NHS, however, how it came about and how it has performed since its inception, we have to go back to the turn of the century and its intellectual and institutional roots. Only through this process can we truly appreciate the impact of the NHS over the years as well as its current problems.

Working class patients and the medical establishment: life before the NHS

Long before our postwar age of state planning and nationalization, British socialists were popularly acclaimed for their identification with

the principles of communitarian fraternity, mutual cooperation, and self-help.[1]

Cooperatives, friendly societies and trade unions joined to form a successful welfare network dedicated to the provision of effective, efficient, and highly popular health and welfare services. Fulfilling the goals of material liberation, the movement was founded on the voluntary aspirations of citizens and grew at a dramatic and accelerating rate.

It was when trade unions actively encouraged and enabled working people—as individuals—to take direct control of their lives that the Labour movement not only grew but attracted wide affection and support.

In 1801, F.M. Eden estimated that there were about 7,200 societies with a total of 648,000 members in Britain. Other estimates suggest that this number had grown by 1816 to at least 925,000.[2]

Throughout the 19th Century, trade union ideas and influence spread. By 1851, for instance, organizations such as the Amalgamated Society of Engineers were overseeing tens of thousands of members, each paying a shilling a week. In return, members received a full range of benefits including allowances for sickness.

Significantly, the rate of growth of the friendly societies over the preceding thirty years had been rapid and was accelerating. In 1877, registered membership in friendly societies stood at over two and three quarters million. Ten years later, it was over three and a half million and increasing at an average rate of at least 90,000 members a year. By 1897, membership reached 4.8 million and was increasing at an average of 120,000 a year. By 1910, the figure had reached 6.6 million, having in-

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1 For an introduction to the tradition of cooperative socialism, see Evans, T., *Socialism Without the State: The Reemergence of Collective Self-Help*: London, Libertarian Alliance, 1994. Also see Pollard, S., Liddle, T., and Thompson, B., *Towards A More Cooperative Society: Ideas on the Future of the British Labour Movement and Independent Healthcare*: London, Independent Healthcare Association, 1994.

2 F.M. Eden, "Observations on Friendly Societies for the Maintenance of the Industrious Classes during Sickness, Infirmity, Old Age and Other Exigencies," 1801, cited in Godsen, P.H.J.H. *Self-Help: Voluntary Associations in Nineteenth Century Britain*: London, Batsford, 1973, p. 12.

creased at an average annual rate since 1897 of some 140,000 members a year.[3]

It is important to remember that these figures simply reflect memberships "known" to the government. Many societies preferred to avoid even the minimal interference of the British state and simply "failed" to register.

Asked in 1892 what proportion of the working classes were insured against sickness through a building society or a trade union, the Chief Registrar of Friendly Societies answered that of 7 million male industrial workers, around 3.8 million belonged to the registered friendly societies, while at least 3 million belonged to those which remained "unregistered."

Significantly, at the end of the century, the Chief Registrar of Friendly Societies stated:

> It remains one of the great glories of the Victorian era that… welfare has been established in a very large degree by the labours and sacrifices of working men themselves, and by the wise and judicious legislation which has permitted and encouraged their endeavour in the direction of self-help.[4]

By 1900, total funds held by various U.K. provident institutions amounted to nearly £400 million, and by 1911 between nine and nine and a half million people were covered in one way or another by various forms of insurance.

In 1910, the British Prime Minister, Lloyd George, wishing to further extend the benefits of this movement, decided to introduce an act of Parliament that would have covered those people who could not afford the required weekly contributions for insurance coverage.

On its way through the House of Commons, however, the original bill was radically transformed by powerful vested interests hostile to working class mutual aid. The organized medical profession, the British Medical Association (BMA), had long resented the dominance of the medical consumer and particularly resented working class control of

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3 For more on this historic movement, see David Green, (1985) *Working Class Patients and the Medical Establishment*: Aldershot, Gower/Maurice Temple Smith, 1985, pp. 89-107.

4 Gosden, *op. cit.*, p. 259.

what it called "medical gentlemen" (i.e., the doctors). Similarly, the commercial insurance companies had long disliked the competition of the non-profit friendly societies and saw the 1911 National Insurance Bill as a unique opportunity to undermine them.

The unhappy outcome of this legislation, initially intended to extend the benefits of friendly society membership to all citizens, was a victory for the commercial insurers and the BMA. Indeed, through this Act, they achieved a very considerable transfer of wealth and power from the relatively poor working class to the professional middle class: between 1911 and 1915, doctors' average incomes doubled in real terms.

It is shocking to think of all those market-based 19th- and early 20th-century mutual and friendly society health care providers and then to think that a mere forty or fifty years later, Douglas Jay, the middle class Fabian minister in the 1945 Attlee government asserted, as if self-evident, that

> in the case of nutrition and health, just as in the case of education the gentleman in Whitehall really does know better what is good for people than the people know themselves.[5]

It is important to understand that the National Health Service of the late 1940s was the logical next step of a middle class Fabian and Marxian-inspired agenda which sought to rationalize and centralize power in the hands of the state. When the NHS was finally created, many doctors opposed universal health insurance, but it was too late. Key groups within the political class supported the idea and were determined to legislate it.

Furthering the gains made by the state during the early part of the century, the 1944 White Paper, itself entitled "A National Health Service," had three core aims:

1. to ensure that everyone in the country "irrespective of means, age, sex or occupation" should have equal opportunities in securing the medical care they needed;
2. to provide a comprehensive health service covering all aspects of preventive and curative medicine; and

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5 Douglas Jay in Gollancz, V., *The Socialist Case*: London, 1947, 2nd ed., p. 258.

3. to divorce the care of health from questions of personal means and to provide the service free of charge—apart from certain possible charges in respect of medical appliances.

These commendable aims were given statutory authority in the NHS Act of 1946. Under its provisions, the Minister of Health was empowered to take any hospital into public ownership as deemed appropriate: as soon as the Act came into force, the state took possession of 3,118 hospitals and clinics with 388,000 staffed and 57,000 unstaffed beds.[6]

The National Health Service: from welfare to welfare state

Since the creation of the NHS and the nationalization of 1948, governments of all political persuasions have attempted to limit the supply of NHS health care and thus contain expenditures. Indeed, for most of its history, certain NHS health care services have actually not been provided without limit and "free" at the point of service. While the circumstances prompting the imposition of limits in the early years have changed, it is interesting to note that the fundamental challenges facing the NHS have not. The NHS in its historic form will always present governments with the same challenge: that of managing a service which is based—in the public's mind at least—on the promise of unlimited health care free at the point of service.

It did not take the 1945 Labour administration long to realize that the NHS was not, as had initially been expected, going to reduce the demand for health care. While a number of experts and academics had popularized the view that there might be an "initial surge" in demand for spectacles and false teeth and the treatment of ailments that previously had gone untreated for reasons of cost, it soon became clear that this theory did not match the reality of experience.

Initially, the 1944 White Paper had estimated that the NHS would cost taxpayers £132 million a year. However, this estimate was swiftly revised to £152 million a year in 1946 and again to £230 million just before the Act came into force in July 1948. In its first full year of operation

6 John E. Pater, *The Making of the National Health Service*: London, King Edward's Hospital Fund for London, 1981, p. 148.

(1949-50), the NHS actually cost taxpayers £305 million and required supplementary funds of £98 million.[7]

The early estimates of expenditure were ultimately inaccurate because the government assumed that the NHS would account for a small and stable share of public spending and its projections were based on extrapolations of prewar spending levels focussed on cheap preventive measures.

The inaccuracy of the estimates can be ascribed to a number of factors. The first is that the early cost projections assumed roughly constant demand in spite of there being no price constraints, the service being "free" at the point of use. Secondly, contemporary social and medical developments exacerbated the problems created by the absence of price constraints on demand: medical advances were dramatically expanding the type and range of health services which could be made available to consumers.

In many ways, the NHS was designed to provide a style of health care more appropriate to the 19th Century than to the 20th. Improvements in health had been secured through immunization, better sanitation, and nutrition. These measures were largely cheap, easy to administer, and subject to large economies of scale. The 20th Century, however, has seen the development of treatments for a range of degenerative conditions. Most of these conditions have tended to require a range of costly individual actions and medications. Crucially, effective treatments for degenerative conditions have not lowered health costs in the way that the eradication of conditions like scabies and rickets did.

Rationing in the NHS

Charging

The British government realized early on that it could not afford to provide health services that were entirely free at the point of use. Although this was one of the founding principles of the NHS, it was actually abandoned within five years of the 1944 White Paper. In 1949, an amending Act was passed to allow a one-shilling charge for prescriptions. After

7 See Rudolf Klein, *The Politics of the National Health Service*: London, Longman, 2nd ed., 1989, p. 35.

the Conservative victory of 1951, further charges were introduced for prescriptions, spectacles, and dental treatment. Indeed, it was as far back as 1956 that the present scheme of levying prescription charges by number of items prescribed was first introduced.

Rationing by cash limits

The other main check on demand was a more or less deliberate rationing of supply—by scarcity rather than price. While doctors working in NHS hospitals had at first been encouraged to treat their patients according to need and not to be deterred by financial considerations, the imposition of cash limits soon turned them into dolers-out of scarce resources.

More than minimal care was denied to cases where there was little chance of successful recovery, particularly to young children or the elderly with serious complaints. Indeed, health care for everyone else was also sparing by international standards. In the late 1970s, for example, coronary artery bypass operations were performed about ten times more frequently in America than in Britain, and where these did not increase life expectancy they tended to reduce pain. While American doctors respond to complaints about pain, British doctors tend to pay more attention to probable increases in life expectancy or improvements in "quality of life," which are not always synonymous with an absence of serious discomfort.[8]

Rationing by queue

The health care supply has been rationed still further by queuing. Crowded waiting rooms are common in most practices and out-patient departments. Queues have become a fact of life for in-patients, often with long waiting periods even for priority operations. In the 1980s, after years of reforms designed to cut waiting lists, the median wait for a hernia repair was more than ten weeks: it was 14 weeks to have a cataract treated. The waiting times for many other less urgently required operations have been measured in months.

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8 Henry J. Aaron and William B. Schwartz, *The Painful Prescription: Rationing Hospital Care*, Washington, D.C.: Brookings Institution, 1984.

Rationing by exclusion

Certain health services have never been provided by the NHS, reducing the demand on its resources. Most forms of cosmetic surgery have rarely been available and face lifts, liposuction, hair transplants and sex-change operations have never been provided except when deemed necessary for basic health reasons or as part of some other form of treatment. Other services have been provided on a minimal basis: for example, most psychiatric services and the treatment of infertility and drug and alcohol abuse.

Recent NHS reforms: towards a mixed health economy

Contrary to the popular view that the NHS exists to provide "free" and virtually unlimited health care resources, history demonstrates that the supply of NHS services has always been strictly limited.

Indeed, it had become obvious by the mid-1980s that the old, heavy, top-down structures of the centralized NHS could no longer suffice. Desperate to contain spiralling costs, Mrs. Thatcher's government embarked on an ambitious review of health care policy, and in 1987, the internal market, mixed economy, and purchaser-provider strategies began to emerge as favoured options.[9]

Under the new system introduced in the early 1990s, the NHS has been divided between purchasers and providers and hospitals have been given independent trust status. General practitioners are now free to manage their own funds, which are allocated on the basis of how many clients they attract. Importantly, these GP Fundholders, as they are known, are free to spend their money with either NHS trusts or private providers.

Signalling an important departure from the postwar world of largely uncosted, bureaucratic and producer-led health care, today's

9 For a detailed overview of the NHS reforms see Holliday, I., *The NHS Transformed*: Manchester, Baseline Books, 1992. For more about the ever-increasing pressures on UK state health and social care see Bourlet, J., *Rationing and the Future of UK Healthcare*: London, Independent Healthcare Association, 1994.

NHS is slowly moving towards a more open and honest world in which consumers recognize that there is no such thing as "free" health care—although we still have a long way to go to reach that destination.

The U.K.'s independent health care sector

While the U.K. is famed for its NHS, less is known of its private or independent health sector. Indeed, there has been a tendency for governments and others to neglect the contribution this sector makes to the health of the nation.

Today, the U.K.'s independent health and social care sector employs nearly 450,000 people and provides over 400,000 beds for treatment and care. For every two people the NHS employs, the independent sector now employs one.

The sector's turnover is roughly £13.1 billion per year or 24 percent of all health care spending. Available services include: acute hospital care, long-term nursing and residential care for the old or mentally ill, acute psychiatric care including drug and alcohol abuse rehabilitation, and health screening. Of all health research and development, 69 percent is funded independently of the government.

The independent sector provides 20 percent of all elective surgery, including, for example, 20 percent of all coronary heart bypass operations and 30 percent of all hip replacements. The operations performed range from the simple to the very complex. Of the surgical procedures reported in a recent survey, 25 percent were classified as "major" or "major complex" and 27 percent were classified as "minor." The remaining 48 percent were described as "intermediate."[10]

The independent sector provides 74 percent of all long-term nursing and residential care and the sector is diverse, offering nursing, convalescence, respite and rehabilitation care to a wide range of client groups including the elderly, the elderly mentally ill, the physically disabled, and children and adults with learning difficulties. Some homes offer specialist care in the fields of head injury or challenging behaviour.

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10 See Laing, W., *Norwich Union Healthcare Report: UK Private Specialists' Fees—Is the Price Right?*: Eastleigh, Hampshire, Norwich Union, September 1992.

The independent sector is moving into other innovative forms of care, including domiciliary, day, and respite services which enable people to be cared for in their own homes as well as providing relief for caring relatives.

Again, the proportion of psychiatric services provided by the independent sector is growing rapidly. There are now 69 independent acute psychiatric units in the country, a sixfold increase since 1980. About 28 percent of consultant psychiatrists admit patients to independent-sector facilities and virtually all acute substance abuse services are now provided independently.

Ten million people can't be wrong!

Medical care in the independent sector, as in the NHS, has to be paid for. It is clear, however, that taking out insurance against medical costs is not now, as it once was, a luxury of the rich. Around 6.7 million people have medical insurance and a further 3 million have health insurance which pays out cash benefits when they are ill and in need of treatment. Together, 9.7 million people have some kind of medical or health insurance. This is more people than belong to trade unions or regularly attend church. Indeed, there are yet more people who simply pay for care as and when they require it. In terms of total expenditure, independent health and social care is comparable to all consumer spending on air travel.

Ten million people are taking it upon themselves to help fund care in the U.K. today. This includes many ordinary families just seeking the best for themselves and their children. In the Southeast of England, the most economically active part of the country, nearly one quarter of the population has medical insurance. People in the U.K. are clearly willing to spend their money on their own health care and a system that discourages them from doing so merely places a greater burden on the NHS. Indeed, any government committed to increasing health and social care spending, in the context of the current fiscal restraint, has to look seriously at non-governmental expenditure as the only viable way to do so.

International Comparisons	UK Avg.	EU Avg.	OECD Avg.
GDP on Independent Health Care	1.1%	2.0%	3.8%
GDP on Public Health Care	6.0%	6.3%	6.1%
Total Public and Independent Health Care Expenditure at Market Prices	7.1%	8.3%	9.9%
Source: OECD, 1992.			

Today, it would require something in the order of a 3 percent or 4 percent increase in the basic rate of income tax simply to replace current private spending for the NHS and other statutory Local Authority services. However, even this figure understates the true cost of health care, as it does not take into account the corporation tax, value added tax, and other taxes paid by independent health and social care organizations which would otherwise be lost to the public purse. Realistically, an increase in the order of 5 percent on the basic income tax rate would be required to replace independent health and social care with government spending.

Towards a challenging future

Today, the focus on equity that characterized most British and OECD social policies during the expansive period of the 1950s and 1960s is giving way to a more realistic emphasis on efficiency. If there is a unifying theme to U.K. domestic politics and to public sectors worldwide, it is a gradual move away from the top-down society of command and control and towards a new era of bottom-up diversity, plurality, and mutual cooperation.

In the U.K. today, the NHS is progressively moving away from the provision of dentistry and long-term care. The private sector is growing and doing an increasing amount of business, not only with private individuals but with the NHS itself.

With an ageing population, the progressive rise of consumerism, and the globalization of technology, the NHS will have to change still

further and become an ever more market-driven institution. Indeed, most health systems in the developed world are on the verge of an economic and technological revolution which is as yet poorly understood and even less prepared for by their political masters.

In the U.K. today, we have the second-highest number of Internet and information superhighway connections outside the United States. However, our nation-state culture is such that we still talk in terms of the "British Medical Association," the "U.K. General Medical Council" and, of course, the "U.K. Ministry of Health." As we move towards the 21st Century, the question arises whether these inherently statist bodies are really ready for an age of real-time global communications and telemedicine in which consumers will be able to access advice and guidance from anywhere in the world at any time. In the near future, global enterprise will overrule the traditional idea of state health care within particular geographic boundaries.

Fifty years after the creation of the NHS, reality and history are beginning to catch up. In the 21st Century, historians and ordinary people will judge such institutions as the NHS harshly, and ask why our forebears did not continue with the market-driven health and welfare institutions that were fast emerging in the pre-nationalization era of the 19th and early 20th centuries. Indeed, as we look back and review U.K. health care policy over the last century or so, it is a question that many people will find increasingly difficult to answer.

Lessons from Britain's National Health Service

Stephen Pollard and Tim Evans
moderated by Michael Walker

Michael Walker: I'm sure that people here will have some questions by way of elucidation to find out more about what exactly has happened in the U.K. It wasn't clear from either of your presentations exactly what fraction of residents or citizens have opted for the private care. You spoke about the number of operations and what not, but what percentage of people have actually bought private insurance?

Tim Evans: Roughly 17 percent of the U.K. population have some form of private medical or health insurance.

MW: That's quite an escalation in the last few years, isn't it?

TE: It is indeed. Around 10 percent of the population have private medical insurance, and there are probably 7 percent or 8 percent of the population who are members of health insurance schemes—if they become

ill, these pay a lump sum or an amount of money each day for health treatment. Increasingly, however, the National Health Service is itself providing private health care. A number of NHS hospitals actually have what we call private pay-bed units and many of the latest insurance packages pay out benefits for you to go into these.

Stephen Pollard: I have one brief comment to make, which is that the greatest rate of growth in the purchase of private insurance is among the poorest groups in society. The reason why it is being taken up by these groups is that people want more control over how their health services and their health care are provided. As a party to the left of centre, I think we should be concerned with giving all people that access to increased choice.

I also want to remark briefly on the fact that you were surprised that there was not so much of a debate. I think it's actually quite symptomatic of how, in the U.K., the rhetoric of political debate is totally at odds with the reality of political debate. If you had to pick one issue on which you would say the Labour Party and the Conservative Party are divided, 99 out of 100 people would say the health service. If you actually talked to advisors in the health service, it's very difficult to find any who disagree with the concept of the internal market within the health service.

It's much easier to find people who disagree that we should embrace the private sector, but I'm convinced that within a year or so of the next Labour government, fiscal reality will provide no other alternative. If you're committed, as the Left is in Britain, to increasing total spending on health care, there's two ways of doing so—through taxation or not through taxation. If you can't do it through taxation, because the reason the Labour Party keeps losing is because people think they're going to increase taxes, you have to find another way of doing it—i.e. not through taxation.

In other words, the Labour Party could increase total spending on health by assisting people to take up their own private health schemes. I think that pretty soon the Left will come round to this view, especially once they get over the myth that private medicine is necessarily some form of evil capitalism that is out to destroy the state. It's not—it's mutuals. In the U.K., the great majority of private medicine is non-profit making.

MW: Please comment on a government which has a stated policy to eliminate private clinics, surgery centres and other for-profit medical enterprises.

SP: I have a pretty bizarre idea perhaps, and this doesn't apply to health care exclusively, it applies to almost everything. I'm not concerned with where a service comes from, how the service provider operates. I'm concerned with what the service is, and I apply this argument to the provision of electricity and gas in the U.K., and the provision of telephones and so on. I don't care if the supplier makes a profit out of it: what I do care about is that the service is what ordinary people want and that ordinary people who aren't just well-off have access to it.

So if we can arrange a structure involving profit-making medical provision and make it available to people regardless of their ability to pay, then so what if they make a profit out of it? I don't understand this concept at all, that you can't make money out of health care. In theory the state should make money out of it—the state should run the health service in such an efficient way that it can reduce taxes and reinvest in health care provision. If the state can do it, then why can't the private sector?

TE: I will just say very briefly that a lot of people in the West argue that we have an ageing population and that some state health care systems are going to go into a crisis because of that. I'm a sociologist and somewhat sceptical of these demographic arguments. I don't think they're clear-cut either way, so for me the jury is out.

But I think Stephen's touched on something very interesting, and I think it is something which does increasingly threaten the supply of health services from the state side. And that is the rise of consumerism. It is a simple feature of our life that as more private wealth is accumulated, people have ever more leisure time, they travel more, they have better food, they expect more, and the same principles are being applied in the area of health and long-term care, social care as we call it in the U.K. I think it's that consumerism which will threaten state health care.

MW: One of the arguments used very potently in Canada is that the best physicians will join the private system and then they will skim off all of the easy procedures—the things that are not technically difficult to do.

Tim said that a significant number of fairly major procedures were being done in the private system in Britain, and I'm wondering if he could comment on that.

TE: At the moment, the Labour Party argues that because there is a danger of the private sector luring the best doctors away from the public system, the private sector should have a levy placed upon it. This argument stems from the fact that the training of doctors in the U.K. is funded by the state. It is a bizarre argument: are we really going to say that anyone in a modern economy who is educated by the state—which certainly is everybody if we're talking about university education—should have to pay some kind of levy for going to a state university? Indeed, are we really saying that sociologists paid by private industry should have a levy placed upon them because they had state educations?

I would like to see a world in which all providers are in fact in the independent sector. I personally would like to see the NHS become a funding mechanism for the poorest people in our society, people who cannot afford some form of mutual or private health care. I would like to see a market in which independent hospitals can employ doctors and, just as with any other profession, the best people could go to the best institutions, etc.

The real problem is that we've been trying to live a lie for decades. We've been telling people that health care can be free, which I think both Stephen and I would agree it can't. The state has said it could look after you from the cradle to the grave—well, it can't. We've just got to say that a market in health care, or certainly a market on the providers' side, in which institutions can attract the best people and there are incentives to raise standards—that has got to be the way forward.

For me, the argument for equity not only ends up with levelling down, but is actually dishonest. I also think that equity is impossible. I've never seen a society where equity, if you mean equality, has ever been reached.

When I worked in Eastern Europe, the party had its own cars, its own shops, its own benefits. In Moscow, party members had their own lane to drive down the road. This is an extreme example, but wherever individuals are—if they're in a free society and if they have liberty, they're going to do the best they can for themselves. They will do better

for themselves in the long run in the honest world of consumerism than the dishonest world of politics.

I think that I would respect politicians who were prepared to actually be honest with the public and tell it like it is. Sadly, there aren't enough of these people around. On that note—it's a very serious point—I really admire Stephen and congratulate him and the organizers in his party for the battle they are engaged in.

SP: Here is where there is some disagreement between Tim and myself. I don't want to see the National Health Service replaced by private medicine. I want to see that the NHS works. There are problems of efficiency, there are areas in which it doesn't work—in terms of consumer powerlessness, for example—but I'm convinced that if the current reforms the Conservatives have put into place are given enough time, we can have the best of both worlds.

We can have a state system, which is actually more efficient than the private sector in many areas, that can operate for the vast majority of people and in the vast majority of cases, and in addition to that, people can opt to pay for extra care. I don't see any problems with that, but the state still has a considerable role in this area.

MW: There is a great fear in Canada that if you move towards this private option people at the bottom are going to be very badly dealt with. Has the existence of a private system in the U.K. helped or hindered people at the bottom?

SP: If the NHS is left being responsible just for long-term geriatric care for the poor, and if these people are the only ones who contribute to the NHS because everyone else has gone off to the private sector, that will cause great problems, obviously. But if everybody still pays taxes, which are collected progressively, then I don't have any problems with saying to people: "You've got this money that's left after the state has taxed you, spend it as you wish."

Why would it be my business to tell people how to spend their money? I think the overwhelming evidence is that, in fact, a public-private system does improve the care given to everybody in society.

MW: How do socialist governments respond to the charge that money should not let people jump ahead in the queue?

SP: The key thing is that we all pay taxes, at least in Britain we all pay taxes. We all pay what Keynes referred to as our subscription to a civilized society by paying taxes, and if we use those taxes to have a proper health care system, however we run it, then I don't see what the objection is to people—once they've paid into that pool so that we do have proper health care available to all—opting to use their extra money as they wish.

There's also the simpler argument which Tim outlined in his presentation. The independent sector in Britain at the moment contributes an enormous amount of money to health care provision in the country. If we weren't to have that, what would we do? We would either have to increase taxes or we'd not have that extra health care. To me, both of these are non-starters, so let's look at the way the real world actually works.

There's a debate going on in Britain in the moment about private pension provision, and the Fabian Society has done a lot of work on how a party of the Left can take on board what it is that ordinary people are saying they want, which is to have control over their own pensions rather than simply have a state-run pension system.

One of the ways to do this is to say if you can afford to pay the premiums, fine, get on with it; if you can't afford to pay the premiums, then the state will step in and do it for you, which is what the 1911 *National Insurance Act* was supposedly all about. It was about an insurance system that happened to be administered by the state.

But the world has moved on since then, and people want to have direct control over how their money is spent—they don't want to have a bureaucrat deciding it for them. They want to have what they consider to be control through the private sector.

TE: What would have happened if the 19th- and early 20th-century models had been allowed to progress? To me, there are two extremes in the debate. There's the Soviet model at one end and then there is the completely deregulated free-market model at the other end. The latter is the model we had in the United Kingdom in the 19th Century. I believe we would have done a lot better to keep on that path.

I have problems with rules insofar as I have problems defining the different categories of the poor and the rich, etc. I also have problems with who would decide on these definitions and how they would change over time.

These philosophical questions, while interesting, are not in fact as relevant as some people might assume, because I don't think that sort of question is going to loom, certainly in the case of the U.K. It's not going to be a part of our political reality, certainly for the next twenty years or so. At the moment, we're moving away from the rather dishonest fantasy world of the postwar socialist era to a more pragmatic and empowering world in which individuals will have more choice. I don't believe for a moment that the state is going to pull out of health care in the next ten to twenty years: I don't think we're going to be that lucky. But we've got to deal with the more pragmatic issues.

MW: Quite apart from philosophy, however, are the people at the lowest end of income distribution better off now than they were 15 years ago in the United Kingdom?

TE: Yes.

MW: Given the current world of fiscal realities, is it possible to have a quality public health care system? What does the Fabian envisage for private health care providers?

SP: Is it possible to have quality health care provision by the state? Yes, absolutely it is, and we've got it in Britain, but that doesn't mean you can't do things in addition. Why not have both? The health service is not in crisis in Britain, it's that the electorate doesn't want to spend any more of its money on taxes to pay for the health service: it would rather buy cars or go on holiday. But it is willing to pay what it pays now, so let's find a way of building on that.

If we want greater health care provision, if we want to go beyond what the state is offering now, then people should decide if they want to spend their money after taxes on cars, holidays, or private health insurance, or whatever. I think that you can have a quality universal state health care system, which is what we have at the moment, but that in addition, you can use the private sector.

TE: It has been mentioned at this conference that some people believe that if the private sector were involved in delivering health care in Canada, somehow this would destroy the public sector system. I come from a different angle. I think public sectors are very good at going into crisis and destroying themselves. The benefit of private sectors is that often they find a way out of crisis. So I would recommend that Canadian governments move to more of a partnership with an emergent private sector and allow the private sector to flourish.

Why can't the state fund private institutions which are competitive and innovative? Stephen gave us a very good overview of the way socialist governments across Europe fund health care: they use public money, taxpayer's money, but they use a range of private institutions. The beauty of this world is that it is more flexible; it enables you to cope with anything that might emerge in the future.

If we in the West are up for a demographic crisis, then this kind of purchaser-provider split will have educated and prepared people for it, because onto that you can graft various forms of private insurance. But it's very difficult to go from a purely state system to a purely market-driven system. You've got to have a transition, and that is why I favour the sorts of policies that I know are being developed by The Fraser Institute at this time.

MW: In Canada, the burden of costs has shifted from the federal level to the provincial level, and certainly from the provincial level to the private level. Although private health care spending in this country has grown to 28 percent of all health care spending, what kinds of initiatives might come from governments in the future with respect to the provision of health care?

TE: It's certainly the case that British state expenditure on health care has gone up dramatically. Local government, as we call it, has had a lot more work to do. The central government has placed more statutory requirements for local authorities to provide all kinds of services, and indeed that is feeding through at the bottom level.

In the United Kingdom at the moment, if you have assets of more than £8,000 and need long-term care, those assets are taken and you have to pay for the care you receive. This has come as quite a shock, par-

ticularly to the generation which paid into the system and expected the government to provide care from cradle to grave.

I suspect that governments will try to find a way to politically legitimate more private involvement. The Labour Party can do that with the claim that private health care grew from the 19th-century roots of British socialism, and it could go along that path and talk about mutuals and cooperatives and friendly societies. Stephen mentioned that he would like to see and indeed expects trade unions to involve themselves in health care over the next ten years. This can be sold to the public in very socialist or quasi-socialistic ways.

The Conservatives, of course, tend to talk about efficiency, improving costs. The British health minister recently came up with a wonderful phrase—the better you cost, the better you care. So whether you talk about empowerment, communitarism, self-help, trade unions, or whatever, whether you talk about cost efficiency, marketization, privatization, or whatever, what we're realistically looking at is more individual responsibility.

We've got the public-private mix being encouraged by the govern-ment's private financial initiative, by the private sector putting capital projects together, etc. We have market testing, which is a method by which services in hospitals and the public sector are put out to tender. There is competition within the private sector: catering and laundry have already gone to the private sector. There are a variety of public policy approaches which can enable you to marketize or mutualize health care.

SP: The Conservatives are implicitly distrusted with the health service. Anything they do, even if they increase spending, is regarded as an attack on the health service. It's just a fact of British politics. For example, when the Conservatives introduced tax relief on private medical care for pensioners three or four years ago, this was lambasted by Labour as another step along the slippery slope to privatization. If the Labour party were to do this, and half of this comment is flippant but half of it is actually quite genuine—if the Labour Party were to advocate increasing tax incentives for the private sector to get involved in health care provision, then the idea would be looked upon that much more favourably by the public. Anything the Labour Party does is regarded as nurturing the health service. These are the practical politics that are vital in this de-

bate.

MW: I'd like to get a perspective from the patient's point of view. If I had asthma or a brain tumour in England, what would distinguish the private from the public system from the patient's point of view?

TE: I can actually talk about this from a personal point of view. Last year, my father had a problem and he went to his state doctor, who said: "Take some tablets, go away, and come back again in a couple of weeks." He went back in a couple of weeks and the doctor said: "Oh, well, it hasn't cleared up. At some point we'll have to do a blood test. Come back in the next couple of days: get an appointment at the desk." A couple of days later he returned and they had moved the appointment back. I said: "Let's just forget this: let's go to a private doctor, my private doctor." So off we went, and the private doctor said: "You know, you should have a blood test immediately." Luckily, my father was okay, although he had to have an operation.

This point I think is illustrative. The National Health Service is very good once you can get into it. If you have a serious problem, if you can get past your GP and actually get into a hospital, then there isn't a tremendous shortage of scanners and all kinds of things in the public system. It's getting into the system that is often problematic. The NHS is very good once you get into it. In practical terms, people go to the private system because they're admitted into the system very quickly and they're treated as individuals, not as numbers. There is a tendency for rationing in the NHS which you just don't get in the private sector. The private sector is also more personal and more consumer friendly.

SP: Very briefly, I think Tim's story is an example of bad doctoring rather than of the NHS being at fault. However, I agree completely with Tim that once you get into the NHS everything is really rather splendid: the thing is that the GP is a gatekeeper and you have to go through your GP to get into the system. The GP is supposed to decide how important your case is.

I too have a personal example, as it were. A few years ago, I started walking into walls and spilling things and missing my mouth when I was drinking. I went to my GP, who said that I needed a brain scan. "We'll have to arrange this immediately," he said. "Immediately"

turned out to be in three weeks, so that afternoon I drove to the local hospital and paid for it privately. It ended up that there was nothing: it was some kind of virus. I discovered that the GP thought I had multiple sclerosis, but because there was such limited access to brain scans within the health service, I would have simply had to wait. They were being used to capacity: there just weren't enough scans. Because I had the ability to write out a cheque, everything was okay.

As a socialist, this is what disturbs me. The answer is not necessarily that you should just buy more brain scans for the health service. This is, of course, a necessary condition, but it's not sufficient. A party on the left should be concerned with insuring everybody in the health service, not only people like me who have the wealth to write out a cheque. Everybody who needs health treatment should have access.

MW: I can't let this pass without telling a Canadian story along the line of scans. There was a case in Toronto several years ago where a chap brought his dog to his veterinarian because he was bumping into walls and having trouble drinking and things. The vet said that the dog needed a CT scan to find out what was going on inside his head. The fellow said, "Good luck, I've been waiting for a CT scan for myself for weeks." The vet responded that the dog could get a CT scan that night. The fellow asked, "What do you mean?" and the vet explained that he'd bought a certain amount of after-hours time at the hospital to scan pets.

It was okay for the guy to pay to have the CT scan done on his dog but not okay for him to pay to have the CT scan done on himself, because this would violate the essential principles of the *Canada Health Act*. Of course, the publicity that immediately surrounded this event ensured that neither the man nor his dog could get access to the CT scan . . .

Let's focus on the area of GP fundholding for a second. It was rammed down the throats of the British people in a sense because there weren't really any evaluation studies performed in the area of GP fundholding, and just now the evidence is starting to roll in. The question is the extent that GP fundholders act in an efficient manner and provide a better, more comprehensive product to the public in terms of consultant services, primary care services, pharmaceutical products, etc.

Why would a Labour government feel it necessary to extend GP fundholding to the rest of the population when consumers, if they were

receiving a better product, would sign up with the GP fundholders, thereby forcing the rest who are losing their patients to become fundholders in order to keep their patients? In other words, why would the government take the heavy-handed approach a second time instead of letting the market determine the extent to which GP fundholding does or does not expand?

SP: The Labour Party is committed, whatever that word means, to abolishing fundholding, so I'm having to go to the opposite extreme in order to convince the party that you actually do need to let the market work. The problem the party has with fundholding at the moment is that we have a two-tier system in Britain and you get better service if your GP has the financial clout to ensure that you get it. And what about those patients who, for geographical reasons perhaps or for the ideological reasons of their doctor or whatever, do not have a fundholding doctor? My answer to that is pretty straightforward: make everybody a fundholder and you remove the two-tier aspect of fundholding.

All fundholding is about is ensuring that the purchaser has greater authority over the provider. It's simply about making sure that the internal market exists and that it works properly. If you accept the purchaser-provider split as a good thing, as the Labour Party basically does now, then I think it's logically necessary that you also accept GP fundholding.

So although the party is committed to abolishing it, the language is actually pretty slippery. We say that we want to abolish fundholding and that we want to replace it with "commissioning." I can't spot the difference between the two concepts. So I think that under a Labour government we'll have an extension of rather than an end to the Conservative reforms.

What Can Europe's Health Care Systems Tell Us About the Market's Role?

Paul Belien

The race for the bottom in Europe

THERE ARE MANY LESSONS CANADA CAN LEARN from European health care reforms. For one thing, these reforms are going in the wrong direction. Pressures on health spending have led European countries where prescriptions were traditionally free, like Germany, to introduce price regulating legislation. They have prompted countries like Belgium, where the choice of doctors has traditionally been free, to consider restricting this freedom. Governments talk a lot about introducing market mechanisms into the system but, although they use the word "market," what they are really aiming for is managed competition, controlled and regulated from above by governments themselves.

Hospitals, doctors, and health care insurers are pressured by the authorities, sometimes under threat of heavy penalties, to lower the cost of treatment. The patient has no say in this whole process. The result has

often been that health care providers opt for the cheapest patients, those who are not sick at all or suffering only from minor ailments, while neglecting the ones who are truly ill and need expensive treatment.

It is rather discouraging to watch the different European governments copy each others' mistakes. Approaches applied in one country are often picked up in others, and the goal is always the same: to cut costs. The question is: do we have to cut costs? It is true that health care funding is a problem everywhere. But instead of cutting costs, why not attract more funding toward the system—private funding, that is—by reducing government regulation? The general trend, however, is in the opposite direction.

In markets with a free supply of services and spontaneous competition, prices decrease because of consumer pressure. Consumers have a real say. Since they demand, choose, and pay for a service, that service had better be good and reasonably priced. In managed competition, however, consumers have no say. The competition we get is a competition to cut costs by lowering the quality of care. The customer has no options. Cost control also often means the curtailment of health care services. We can see this tendency all over Europe, and the result is that Europe's health care systems are gradually beginning to resemble each other in the low level of quality they provide and their high level of government interference.

Different forms of health care financing

Europe has many different health care systems, but all of them are facing the same problem—exploding costs. The financial dimension of these health care systems is where the problems arise. When we look at European health care systems from this angle, we notice that Europe has three types of systems.[1]

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1 In 1993, National Economic Research Associates (NERA) published *Financing Health Care with Particular Reference to Medicines*, a multi-volume report on health care systems in Western nations. Volume 1, *Summary and Overview*, is devoted entirely to a tour of the different health care systems. (NERA: London, U.K. and White Plains, N.Y., 1993.)

Single payer

First, there are the so-called single payer systems. In these systems, health care is paid for and organized by governments at either the national or the regional level with money from income taxes. Canada has this type of system: so do Britain and the extreme north and south of Europe—the Scandinavian and Mediterranean countries. This type of system guarantees access to health care for everyone. All citizens are insured, belonging to the largest possible insurance pool, namely the nation or province as a whole. The main problem with these systems is that the health care budget is set by government. If this budget does not cover the costs of health care needs, waiting lists appear, care is rationed, and quality of care deteriorates as money becomes scarcer.

Social insurance—sickness funds

The second type of European system is the social insurance-based or multiple payer system. These are the systems of central and western Europe: Germany, Austria, France, Belgium, the Netherlands, and Luxembourg. In all of these countries, citizens are required to join private, non-profit organizations called sickness funds. Membership in a sickness fund is compulsory, but people are free to choose their funds. They pay a premium to whichever fund they choose based on a percentage of their wages. The premium operates like a payroll tax.

Every country has its own type of fund. Belgium, for example, has ideological sickness funds: one for socialists, one for liberals, one for Christian Democrats, and so on. Actually, it makes no difference which fund you belong to: the premium is the same for every fund and is set by the government. The coverage is the same, too.

France has professional funds; Germany has regional funds, professional funds, and company funds. Unlike Belgium, Germany has premiums that vary within a certain range. The same is true for the Netherlands, but these ranges are not very extensive in either country.

All over Europe, sickness fund systems have run deficits which governments have had to balance with money from general taxation. As a consequence, the theoretical distinction between health care systems financed completely out of general taxation and sickness fund systems financed from a percentage of members' wages is becoming obsolete. In Belgium, only 55 percent of the financing for sickness funds still comes

from payroll contributions, while 45 percent is government subsidies from general tax revenue.[2] In effect, Belgium has already become a 45 percent single payer system, and the government regulates the health care sector as any government does in a single payer system.

If we look at cost control, the ways countries have organized their systems do not seem to have made much difference: they have all seen their costs rise over past decades. Recently, the average annual increase in European health costs has been 4.1 percent.[3] The striking thing is that it has made absolutely no difference whether a country has a single payer or a sickness fund system. It would therefore not make much sense to change from a government-run single payer system to a social insurance-based sickness fund system, or vice versa, in the hope of lowering costs.

The private insurance option

All systems exhibit the same deficiencies. Everybody knows about the waiting lists in Canada and Britain, which have single payer systems, but the Netherlands, with a sickness fund system, has waiting lists too. In single payer systems, the governments set health care budgets, but they do so nowadays in the sickness fund systems of Germany, France, and Belgium as well. Everywhere, governments are rationing health care. Everywhere, the quality of care patients are getting is diminishing. The only patients unaffected by declining care quality are the privately insured.

In many countries, it is illegal for patients to leave the government or sickness fund system and purchase private health insurance, but there are notable exceptions. Private insurance-based systems form the third type of health care system found in Europe—so far only in Swit-

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2 "Chapter 3: Belgium" in *Health Care in Europe: The Finance and Reimbursement Systems of 18 European Countries*: Nationale Raad voor de Volksgezondheid: Zoetermeer, Netherlands, 1993.

3 Andersen Consulting, "Health Care Survey in Belgium, Denmark, France, Germany, Italy, the Netherlands, Norway, Spain, Sweden and the United Kingdom." The results of this survey were presented to the press in Copenhagen, Denmark, on June 18, 1993. See J. Van Overtveldt, "Dokters in Management," in *Trends (Roularta)*: Zellik, Belgium, June 17, 1993.

zerland, where the system is totally based on private insurance. This means that premiums can differ substantially, but the government reduces inequities by handing out subsidies to certain risk groups, paying a percentage of their premiums. Because of the Swiss govern-ment's budgetary problems, these subsidies have gone down lately.

Many Swiss insurance companies are now experimenting with American-style health maintenance organization (HMO) schemes. The Swiss have also discussed the introduction of bonuses: if a patient does not use any health services in a given period, or remains below a set care expenditure, part of his insurance premium is reimbursed as a bonus. This discourages the overconsumption of health services and encourages patients to seek out cost-conscious physicians. Because it is the patient who drives this system, however, cost cutting will never be achieved at the expense of quality.[4]

Germany and the Netherlands, though their systems are based largely on sickness funds, also have a large number of privately insured citizens. In Germany, 10 percent of the population is privately insured. The figure in the Netherlands is 35 percent. At a certain income level, people in Germany are free to opt out of the sickness fund system and take out private health insurance. They pay a premium based on the age group to which they belong when they join their insurance plan. In return, they get high-quality medical care. Now that the sickness fund system is under heavy financial pressure and the quality of care is going down, more and more Germans who are legally able to leave their sickness funds are doing so.

The Netherlands separates catastrophic and ordinary care

In the Netherlands, as noted, about a third of the population is privately insured, and the number is rising. Like the Germans, the Dutch can opt out of the public system, though at a lower income threshold than in Germany. The Netherlands have a very interesting health care system that combines single payer and sickness fund systems with private insurance. The Dutch differentiate between so-called "catastrophic"

4 P. Zweifel, *Bonus Options in Health Insurance*: Dordrecht, Boston, and London, Kluwer Academic Publishers, 1994.

health care, which is very expensive, and common health care. They have a compulsory, government-regulated single payer system for expensive health risks and a sickness fund system for the other risks. Catastrophic health insurance is mandatory and paid for out of income taxes. Only for non-catastrophic risks can one opt out of the sickness fund system. In this case, people can choose either to have no insurance at all or to take out private insurance for specific health risks.

Dealing with risk in private insurance plans

Private insurance-based health care systems are often criticized because not every citizen is insured. Some people with very high individual risks cannot pay the premium, which is based on risk. The Swiss have countered this drawback by giving government subsidies to higher risk groups so that everyone, even high-risk individuals, will be able to get insurance. The Dutch have mandatory insurance for expensive health treatments in a government-run single payer system which covers high-cost medical procedures and long-term care. For these costly risks, the citizen is in the largest possible insurance pool—the entire nation. For non-catastrophic illnesses, a citizen of the Netherlands can be privately insured but, as the very high risks are not covered by private insurance, the premiums are affordable for everyone.

The German private system also pools risks. Privately insured Germans pay premiums that reflect the health risks of their age groups. When a person buys private insurance, he pays the premium for the age group to which he belongs. Once insured, an individual's insurance premium is never increased as a function of age. Even as he grows older, he will still pay the premium for the age group he was in when he joined the insurance plan. The premium can only be raised to reflect general increases in health care costs affecting all age groups. Because the premium you pay will always be the premium of the age group you were in when you bought your insurance, it is in your interests to insure yourself as young as possible. If you start to pay when you are young and your health risks are low, you pay less and benefit over a longer period. The fact that you benefit or capitalize longer makes you an interesting customer for the insurer.

Risk categories based on age—not health status

Unlike the American system of private health insurance, Germany's is based on insured age groups rather than individual risk. This allows everyone to acquire affordable health insurance. Insurers are not permitted to refuse clients. Contrary to the American system, the individual provides his own coverage, not the employer: losing a job in Germany thus does not mean losing health coverage. In the American private health insurance system, coverage is collective but premiums are calculated on individual risk. In the German private insurance system, coverage is individual but the premium is calculated on collective risk. German premiums will therefore never become exorbitantly high.

Pay as you go versus funding and the economic opportunity

The problem with both the single payer and the sickness fund systems is that they are financed on a pay-as-you-go basis. There is no capitalization in these systems. It is the young and healthy of today who are paying for the health care of the sick and elderly through either income taxes or deductions from their wages. As the population ages, these pay-as-you-go systems are coming under pressure because the numbers needing health care increase relative to the numbers of people paying for that care. Debt accumulation in a welfare system financed on a pay-as-you-go basis is affordable only if there is a sound demographic evolution.

People investing in their own future health care

Capitalization systems—like many private insurance systems—are immune to this threat. In these systems, an individual pays today for his own needs later. The money he pays is set aside: it is not spent on the sick of today, but is invested and generates new capital to be spent later for the contributor's own health needs.

Health care costs are rising everywhere, no matter what system nations use. Costs rise everywhere for the same two reasons: ageing popu-

lations and the huge costs of developing new cures. In a system based on capitalization, both problems can be neutralized. The ageing of the population is not a problem because the health care the elderly receive is paid for with money they themselves set aside many years ago.

Capitalization, health care, and economic growth

Money is available for developing new cures because premiums in capitalization schemes are not buried by the insurance companies or hidden in a stocking: the money is put into a bank account and invested in growth sectors of the economy. In fact, health care could be such a growth sector: there is nothing wrong with a society devoting more of its resources to health care. Indeed, this even appears to be an indicator of a country's prosperity. The richer and more developed a society becomes, the higher the percentage of GDP it seems prepared to spend on health care. This pattern is accentuated as the percentage of elderly in a society grows.

The health care sector has other economic benefits too: health care jobs are mostly proximity jobs which are immune to direct foreign competition. Consequently, a growing health care sector would lower the level of unemployment. Furthermore, the health market cannot be saturated because people will always want to avoid death and pain for as long as possible.

In short, health care can become one of the most promising growth sectors of our economy. It is economic madness to try to curb growth in this sector, and yet this is exactly what governments all over Europe are desperately trying to do. They are doing this because nowhere in Europe are governments willing to give up control over health care. Because they do not want to give up control, they have to finance the systems, which they cannot do because of their enormous budgetary problems and lack of capital. The health care sector is in need of capital but governments, unable to provide it, are cutting costs instead of allowing the markets to provide the necessary investment.

Are there cost-control lessons Canadians can draw from Europe?

Apart from examining the ways in which the privately insured health care systems of Europe—Switzerland, 10 percent of Germany, and 35 percent of the Netherlands—have responded to the challenges of increased demand for health care, it would not be advisable for Canadians to look to Europe for lessons in reforming the Canadian health care system. It is true that private insurance-based systems also have their problems, but these systems act as very interesting laboratories for health care reform. They are consumer-driven and they are trying out some different, interesting ideas like medical savings accounts, health care vouchers and bonuses. These systems leave room for experimentation.

If people want to join an HMO system that restricts them to certain HMO-approved doctors they can do so, but by paying somewhat higher premiums they are also free to reject that option. In these systems, patients have choices: the single payer and sickness fund systems rob them of choice. The same is true of the providers—hospitals, doctors, and pharmaceutical companies. In the single payer and sickness fund systems, governments are interfering more and more in the business of health care providers.

Price controls on pharmaceuticals

This interference started with price controls in the pharmaceutical sector, but when price controls failed to work, governments moved on to control the numbers of prescriptions doctors could write. At present we have government officials comparing each health care provider's prescribing behaviour with some average behaviour and punishing providers whose patterns deviate from that norm. In view of the fact that such an approach eliminates any innovation in the use of drug therapy by practitioners to deal with difficult situations, the objective of the policy is mediocrity in the strictest sense of the term.

In this quest for mediocrity, governments learn from each other. In Germany, drug prices had been free for many years until, in 1989, refer-

ence pricing was introduced.[5] Large shifts in prescribing behaviour occurred that resulted in increased total drug spending. The government was forced to add volume control to price control. Finally, doctors were threatened with substantial loss of income if their prescribing exceeded a certain level. The result was that drug prescriptions diminished but referrals to hospitals and specialists went up.[6] The money the government was able to save in one area was largely lost to the increased spending its actions provoked in other areas.

Politicians in other countries, however, only noticed the drop in German drug expenditure and paid no attention to rising costs elsewhere in the German health care system. They decided to adopt the German measures in more or less similar forms. Although the approaches may differ, they all share the view that drug expenditures have to be controlled. France introduced so-called negative recommendations to tell doctors what they were allowed to prescribe and what they were not allowed to prescribe. These recommendations were made compulsory and doctors risk heavy financial penalties if they go against them.[7] Now Belgian politicians are considering similar measures.

Approaches that work

To be fair, we have to acknowledge that some recent efforts to curb health care costs in Europe have been successful. These measures have succeeded to the extent that they allowed more market influence into these systems. This has been the case in Britain and the Netherlands. In Britain, the introduction of some forms of competition (for example,

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5 B.M. Maassen, *Reimbursement of Medicinal Products; Law, Administrative Practice and Economics of the German Reference Price System*: Zellik, Belgium, CNE, 1996.

6 J. von der Schulenburg, G. Matthias, and O. Schöffski, *Referral and Hospital Admission by Primary Care Physicians in Germany Following Implementation of the Public Health Reform Act*: University of Hannover, Germany, Institute of Insurance Sciences, July 1994.

7 C. Le Pen, "Drug Pricing and Reimbursement in France: Toward a New Model?" Paper presented at the Tufts University European Center conference on "Cost-Containment; Health Care Reforms and Pharmaceutical Innovation," held in Talloires, France, on July 20, 1995.

competition among hospitals) has led to a better allocation of resources within the National Health Service. In the Netherlands in the past, as is still the case in Belgium today, all sickness funds used to deliver the same services at the same prices with the government financing their deficits. When Dutch sickness funds were allowed to compete, however, we saw improvements in their financial situation and the quality of the care they provided.

But these measures have still not gotten to the root of the problem. Although they resulted in temporary financial improvement,[8] they have not reversed the trend towards bankruptcy in health care systems owing to circumstances beyond government control such as demographics. The problem remains that health care systems operating on a pay-as-you-go basis cannot be sustained if the percentage of elderly people needing more health care is constantly rising in relation to the numbers of the young and healthy.[9] This is especially true if deficits are swelled by such other factors as shifts in disease patterns and medical innovations that increase the list of effectively treatable illnesses.

When politicians look at health care, they often make the mistake of not being humble enough. They simply do not have enough information to enable them to organize and control the whole system. They aim for cost control and hence focus so much on costs that they forget what health care is all about, namely health. When we discuss health care reform, we should bear in mind that we must focus on health rather than health care per se. It is important to make this point: a country can have excellent health care accessible to everyone, but its people may be less healthy than those of a neighbouring country with less accessibility to health care.

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8 European governments, so intent on cost control, succeed in somewhat slowing the increase in their health spending. This explains why the gap between the U.S. and European spending levels widens as time goes on. For a comparison, see Schieber, Poullet and Greenwald, "Health Care Systems in Twenty-four Countries," in *Health Affairs*, Fall 1991.

9 "Ageing Populations, Pension Systems and Government Budgets: How Do They Affect Saving?" OECD, 1995.

How important is health policy?

Health policy is, of course, a determinant of health, but access to health care seems to be less important than some people think. In 1948, Britain became one of the first countries to provide every citizen with the same access to health care. Switzerland, on the other hand, had rejected compulsory health insurance back in 1902 and still maintains its system of competing private insurers. One would expect the poor in Britain to be healthier than the poor in Switzerland, but such is not the case. It appears that in Britain, even after fifty years of equal access under the National Health Service, health is still very dependent on social class: in Switzerland, however, where health care is privately financed, health does not appear to be related to wealth.[10] Often, differences in national traditions, consumer habits, and general culture can explain such divergences.

Apart from access to health care, there are many other determinants of health: genetic factors, exogenous factors (such as climate or level of environmental pollution), socioeconomic factors, and life-style factors. The importance of all these has been examined in a Dutch study.[11] The study shows, for example, that although Germany has far better health services than Greece, Greeks tend to be healthier than Germans. This seems to have something to do with the Greek diet that consists of plenty of fruit and vegetables and limited animal fat.

When using international comparisons as a tool for health policy, all health determinants should be taken into consideration. This is a difficult exercise. The Dutch study concludes quite bluntly that, at present, national health data cannot be compared at the international level because of the abundance of factors influencing health. Nevertheless, we notice in the health sector that political decisions implemented in one country often mirror those of other countries without consideration of all the data such as cultural differences. It is no wonder that the results are not always what the politicians expect them to be.

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10 P. Zweifel, *Health Care Reforms and the Role of the Pharmaceutical Industry; Proceedings of a European Workshop:* Basel, Switzerland, Pharmaceutical Partners for Better Healthcare, 1995.

11 Schaapveld et al., "The European Health Potential: What Can We Learn from Each Other?" in *Health Policy*, vol. 33 (1995).

Even at the national level, politicians suffer from a lack of knowledge regarding health. We may well wonder whether policy makers will ever be capable of taking all the determinants of health into consideration. Will they be able to centralize all of the relevant information? And do they know enough to assess the decisions they make?

Freidrick Von Hayek received the Nobel Prize for Economics in 1974 for his work on information in society. According to Hayek's view, political decision makers will always suffer from lack of knowledge because it is simply impossible to centralize all knowledge and formulate collective goals accordingly. Hayek claims that only the market can help us in this respect because the market is primarily a medium of communication. The market conveys information about how individuals behave in accordance with the knowledge they have about their own situations.

It is interesting to examine experiences with health care reform in the light of Hayek's insights. If we compare attempts at health care reform in Europe over this past decade, we can see that many reform measures have had unintended consequences which have had to be dealt with by improvisation and more regulation. There have been attempts in many countries to introduce certain market mechanisms into health care, but in general the role of the market has actually been diminishing. In many countries, and certainly in Belgium, there is a tendency towards more regulation instead of less. Controls on doctors have grown tremendously. The same is true of hospitals. Governments talk a lot about introducing more competition into health care systems, but the competition they propose is always managed competition, regulated from above.[12]

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12 This is also the conclusion of J.W. Hurst in his study on health care in Belgium, France, Germany, Ireland, the Netherlands, Spain, and the United Kingdom: "Reforming Health Care in Seven European Nations," in *Health Affairs*, Fall 1991. As Hurst sees it: "All seven countries have adopted global budgets for public expenditure on health care and firm policies for making such budgets stick. It seems that central governments feel that only they can balance the marginal benefits with the marginal costs of extra public spending on health care."

Where to from here—insights from the European experience

As the finances available for maintaining health care decrease and the consumption of health care increases, the public seems more and more interested in equity—access to health care—rather than efficiency, or health itself. If we want to fix our welfare state health care systems, the only way is to abandon our pay-as-you-go financing policies. We should be opting for decentralized systems in which patients are empowered and free to choose the health care package they think will best serve their needs. This requires a strongly deregulated system with many health care options. For catastrophic illnesses, for example, risks could be pooled on a national basis through mandatory insurance, and those who are too poor to pay their premiums should be able to get government subsidies. Generally speaking, however, patients should be made into responsible consumers who are capable of making their own choices. The private systems of Switzerland, Germany, and the Netherlands might offer some valuable insights here.

Sweden's Health Care System

Margit Gennser

Swedish attitudes about health care

TO UNDERSTAND THE SWEDISH SOCIAL security and health care system, the historical perspective is important. A traditional strong state bureaucracy and citizens' natural acceptance of state planning in their lives explain a lot about the structure of the Swedish health care system.

Between 1958 and 1963, a government commission investigated health care in Sweden's county regions.[1] In its report, the commission held that expenditures on education and health care would greatly increase, as would expenditures in other areas of the economy, and that these increases could produce problems in the manufacturing sector. Total health care costs were 1.8 percent of GDP in 1946: by 1960 the figure had increased to 3.5 percent of GDP, and the commission expected it to grow to 4 percent or 5 percent by 1970. This growth in health care expenditures had to be accepted, according to the commission. It pointed

1 SOU 1963:21, *Sjukhus och öppenvård*: Swedish government report on "Hospitals and Open Care."

out one major benefit of increased expenditures—less loss of production due to illness.

The commission estimated the benefits of providing health care at about 5 billion crowns a year, somewhat less than US$1 billion. However, it also pointed out that the expansion of the health sector would create financial problems. In times of low economic activity, incomes would shrink and the costs of health care would remain high. In the commission's opinion, though, investments in the health sector should be used to create work: "If rising total costs for the health care sector were to be accepted, it was necessary . . . to maintain economic efficiency." Planning and rationalization were looked on as important factors, along with medical innovation and research. It was recommended that economic expertise be secured for the health care sector: the commission also wanted resources put into the collection and analysis of health care statistics.

Increased educational requirements for nurses, doctors, and health economists formed a major element of the commission's report: so did different models of organization. For example, which level of the public sector should be responsible for the health care system: the central state, county regions, or local councils? What is more, should the responsibility for health care be the same for every kind of health care? The answer to the last of these questions was "Yes," even if standardization could not be implemented at once.

The consumers, the patients, and their wishes were not really a major focus of the commission's discussions. The patient was looked on as an object of the state health care system. In the whole of the commission's report, there are only two places where the patient is even discussed. First, a member of the Social Democratic Party stressed that patient fees ought to be low and the same for both in- and out-patients. The Conservative commission member remarked that it was necessary that all patients receive the same care regardless of age.

Sweden's health care sector before the reforms that began in the 1960s

The Swedish health care sector was small compared with countries like Great Britain. The costs of health services were borne partly by the state (district doctors and mental hospitals), partly by the social insurance

system, partly by taxes (county and/or local council income taxes), and partly by patient fees. The organization of the health care system was not integrated. In many ways, it reflected the special circumstances of a geographically large country with a small population.

Hospitals were managed by the bigger towns and county regions. Private hospitals were rare: in 1950, they provided only 2,600 of a total 58,000 beds for somatic care.[2] Heads of clinics in hospitals were allowed to treat private patients, and hospitals had private wards. By the end of the 1950s, the hospitals started to phase out both private wards and the senior physicians' privilege of serving private patients.

During this time, the majority of doctors were employed in the public sector: 20 percent were state-employed district doctors (general practitioners), 7 percent were district doctors employed by local councils, and about 47 percent were employed by hospitals managed by local councils (towns) or county regions. Doctors in private practice constituted about 25 percent of the total.[3]

In the 1950s and even more during the 1960s, physicians were well paid compared with other professionals. From the late 1940s on, the blue collar unions and Social Democrats pursued a wage policy of solidarity with low-paid workers. The ideological goal was to gradually decrease the wage disparities between higher-paid groups like physicians and the blue collar workers. Now this goal could be reached in different ways—raising the educational requirement for physicians, abolishing the fee-for-service system in the public sector, trimming rewards to doctors in private practice by limiting the fees they could charge, and so forth. The commission proposed all of these measures.

The county regions and the Swedish health care model

The purpose of many of the political decisions made in Sweden during the 1960s was to create larger government administrative units. The local councils were examples of this. In the 1950s, Sweden had 2,500 local councils: twenty years later they had been merged, leaving only a cou-

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2 *Ibid*.

3 *Ibid*.

ple of hundred. Whereas the old local councils were managed by laymen and administrative staffs were small, the reform created a new type of bureaucracy and also a new type of career politician.

The new local councils were to implement a new building and housing policy and also create a new comprehensive school system. In order not to overload the local councils, it was thought necessary to have the county regions manage the integrated health care system. Changes in various laws and regulations created a health care model which was founded on the following principles:[4]

1. The ultimate goal of public health laws is "that the population should be in good health." Preventive care is therefore included in the Swedish health care system.
2. Important to the health care system are the principles of "justice" and equal "availability." All patients should have the same access to care and no patient should be discriminated against on the basis of age. Patient fees should be the same across the whole country.
3. The county regions have responsibility for health care planning. Democratically elected politicians decide the scope and direction of health care services.
4. The county councils can impose income taxes.
5. People living in a county must receive their health care in that county.
6. The county is responsible for both the financing of health care services and the production of health services.

The integrated county model (*"landstingsmodell"*) health system was shaped by the following changes in different laws and regulations:[5]

4 SOU 1993:38, *Halsovården i framtiden—Tre modeller*: Swedish government report on "Health Care for the Future—Three Models."

5 *Ibid*.

1960 Private beds in hospitals were abolished. Counties were made responsible for open care.

1970 A single fee was decided on for public care. (Today there are different fees in the range of 80-150 kroner.) Publicly employed doctors were salaried. All pharmacies were bought by the state and a state monopoly of pharmacies was founded.

1975 Private doctors were permitted to work for the social insurance system. The fees they could charge and the number of patients they could see were regulated.

1983 County councils were requested, by law, to take responsibility for all kinds of health care (*Health and Medical Services Act*).

1985 County councils were given the right to control the establishment of private practices.

Problems in the Swedish health care system

The cost of the Swedish health care system is comparable to that of countries with similar standards of living. From 1980 to 1990, health care costs increased by 145 percent and the productivity of the sector fell.[6] GDP was nearly constant during the 1980s, but the numbers of people employed in the Swedish health care sector rose from about 300,000 in 1980 to 370,000 in 1990: the number of assistant nurses increased by 600 percent, doctors and nurses by 200 percent, and secretaries by 300 percent between 1975 and 1990.[7] A reasonable conclusion would be that the health care sector did not use its capacity optimally. There are figures that show large differences in health care costs per capita and discrepancies in the costs of the same operation in different clinics.[8]

6 *Ibid*.

7 *Ibid*.

8 *Ibid*.

Some 75 percent of health care is financed by county income tax and 25 percent is financed by the state through a per-capita state contribution that is calculated from the regional tax base and demographics (age groups, for example). County regions were not allowed to raise taxes between 1991 and 1994. From 1991 to 1993, the growth of the economy was negative and county tax bases diminished: the financial situation has thus been insecure in the counties for the last four to five years.

To try to fend off these financial problems, the government and the counties have made some administrative changes. For example, long-term care is now a responsibility of the local councils and not county regions. When the acute care of a patient is complete, it is the local council which has to pay if the patient still occupies a hospital bed. As hospital beds are expensive, local councils are eager to move patients out of hospitals to nursing homes or home care. The Department of Social Affairs is now aware that elderly patients are often moved too fast from hospitals and that the standard of care for these patients is not satisfactory.[9]

Another of the problems with reorganizing long-term care is financial. Local councils define "living in a nursing home" as "living in one's own home." The result of this definition is that the local council can charge US$300 to US$400 and sometimes more for "rent"—very high rent indeed for a small room or in some cases only a bed in a nursing home. Financial problems can result if, for example, in a married couple, the husband has to be transferred to a long-term care facility and he has high pension benefits while his wife has low pension benefits. The "rent" is calculated on his income with very little regard for her situation. Cases have been reported in which patients have had to pay US$1,100 a month for inferior facilities.

The county councils have both benefited and suffered from the reorganization of long-term care. Productivity in hospitals has increased, yet at the same time the fixed costs invested in hospitals and personnel for long-term care remain to be paid.

The shift of long-term care responsibility from counties to local councils has not been the only big change over the last few years. The

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9 Socialstyrelsen, *Ädelreformen, Årsrapport 1995*: Swedish Department of Social Affairs 1995 Annual Report on local councils and their responsibility for elderly long-term care.

government has also implemented changes in the state contributions system. These changes benefited the northern part of Sweden but have created problems for the large specialized hospitals in Stockholm, Gothenburg, and Malmö. During the last three years, these hospitals have run up very large deficits. To cope, politicians have introduced new administrative systems that looked promising at first but which have failed to solve the administrative problems. In Malmö's hospital, for example, the financial situation has deteriorated and the hospital administration can only be described as unacceptable. There are considerable discrepancies between budgeted and real costs and nobody can explain why they exist. The politicians, pressured by the need to cut costs, are asking for more savings: the staff cannot cope as they have no acceptable analysis of the hospital's real financial situation and they have no guidance concerning what types of care, or what quality of care, to provide under cost restraints.[10]

The Swedish health care system is a planned system, and problems arising in it are all too often met by new organizational or administrative changes. Workers in the health care sector have been living with turbulent working conditions for a long time. The motivation and morale of health care personnel is falling. Over the last year, more than ten of the top managers of the larger hospitals have resigned from their positions, as have many heads of clinical departments, due to conflicts between financial demands and the ethics of the medical profession.

The centre/right position on the Swedish health care system

The scope for choice in the Swedish health care system has always been small. The Conservative Party wanted to introduce more choice into the system but they had no support from the coalition government. This centre/right government (1991-1994) appointed a commission[11] to look into three health care models: an insurance model (planned national

10 Audit of local government in Malmö: interviews, 1995.

11 SOU 1993:38, *Halsovården i framtiden—Tre modeller*: Swedish government report on "Health Care for the Future—Three Models."

model), a reformed county-regional model, and a model akin to the British General Practitioner Fundholding model.

The commission did not complete its investigations. The only report published was one written by experts who were not allowed to make any recommendations. Discussions about choice were limited to the possibility of consumers (patients) choosing their doctors and hospitals. The possibility of consumers choosing among different insurance companies or insurers was thought to be irrelevant and therefore not aired.

The new Social Democratic government is only interested in a reformed county model. A new commission to examine the system is working very slowly, and it appears that no reforms will happen before 1998, with the exception of changes in the regulations pertaining to pharmaceuticals.[12]

How much choice is there in the Swedish health care system today?

In some county regions, mostly ones with earlier Conservative majorities, there are opportunities for patients to choose between different hospitals in the county and sometimes between different hospitals in neighbouring counties. Patient choice of this kind is promoting competition.

However, the private wing of the health care system is in bad shape. Physicians can establish new practices only with permission from the county, and no doctors over age 65 are allowed to have reimbursed private practices. The result is that they cannot sell their practices. Of course, doctors can work outside the public health care system entirely. Patients have to pay the full costs, and for some specialties this is still possible.

Pharmaceuticals are now paid for by the social insurance system plus a patient fee. A government commission has proposed that, in future, counties be made responsible for reimbursing the entire cost of prescription medicine. It is highly unlikely, however, that counties will

12 SOU 1995:122, *Reform på recep*: Swedish government report on "Prescription Reform."

agree to pay for medicine prescribed by doctors who are not in the public system. This will make the cost burden too heavy for most patients of private practitioners. Private sector involvement in health care delivery will certainly decrease in the coming years, as will patient choice.

What can other countries learn from the Swedish health care system?

1. Choices for the middle class in the towns have diminished since the 1950s. One cannot get into a private clinic except in Stockholm and Gothenburg, and it is only the very well-to-do patients who can afford private hospital care. Patients have little consumer choice.
2. Productivity in hospitals has fallen sharply since the 1970s, when doctors began receiving fixed salaries and not a fee per patient.
3. Productivity in hospitals has increased recently only as a result of diminishing financial resources. The productivity of district doctors can be extremely low—it is not unusual for a doctor to treat an average of only six to 12 patients a day.
4. Long-term care reform has increased the number of available beds, but the quality of care for elderly patients is not satisfactory.
5. A worker with a wage of US$20,000 pays about US$3,000 a year in taxes for health care. A scientist at Astra with a salary of US$50,000 has to pay more than US$7,000 in taxes for health care, plus a fee of at least US$22 for prescription medicine or consultation with a doctor.
6. When Sweden was a rich country in the 1970s, there were few restrictions on the introduction of new medical methods, new pharmaceuticals, etc. Now the environment is different, and there is a tendency to block or restrict the availability of specialized care in order to save money. Some new medical procedures are introduced as standard later than they are in other countries. For example, while bypass operations were standard (with overcapacity) in Switzerland in 1983, patients in Sweden had to wait more than a year for bypass operations.
7. Waiting lists have become a big problem. "Care guarantees" have reduced the waiting list problem temporarily in the past,

but these problems began reappearing during the last few months of 1995.

Conclusion

Problems arising in Sweden's planned health care system have usually been met by new organizational or administrative changes. Changes of this kind have tended to make things worse. The changes are expensive and time-consuming; any improvements in cost-effectiveness are hard to measure when big changes are made; and the motivation and morale of the medical profession are adversely affected when these people are not included in the decision-making process. Sweden has yet to recognize that organizational change alone is not enough and that a planned health care system will always be very vulnerable to variations in the government's financial circumstances.

Health Care in Germany: Structure, Expenditure, and Prospects

Volker Ulrich

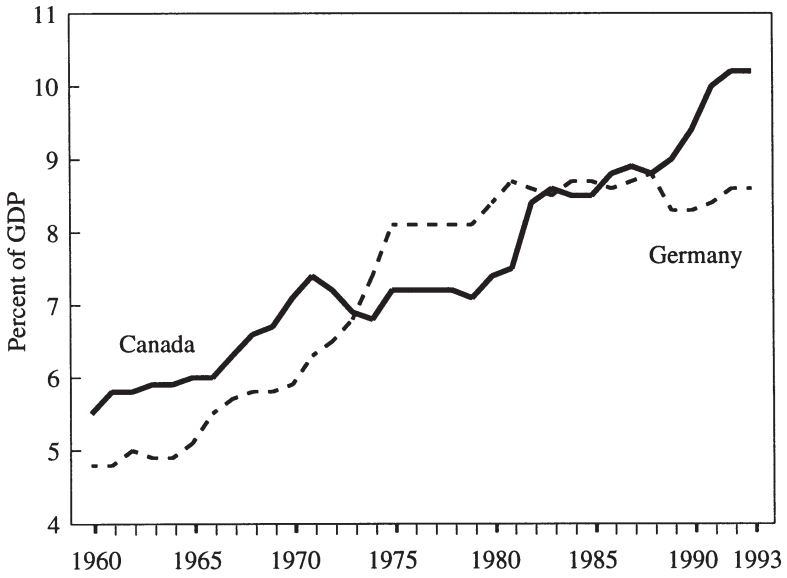
Introduction

GERMANY'S CENTURY-OLD UNIVERSAL HEALTH insurance scheme represents a midpoint in the spectrum of systems that countries have adopted to protect their populations against the financial consequences of illness. Established by Otto von Bismarck in 1883, the German system has been continually extended since to reflect the changing array of diseases and technological progress.[1] Germany today has a comprehensive health care system covering nearly all costs, even including long-term care since 1995.

The German health care system has long been viewed as a model that controls costs and provides nearly all of its citizens with coverage

1 Henke *et al.*, 1994a, p. 7.

Figure 1: Total Health Expenditure as a Percentage of GDP



Source: Calculated from OECD data, 1995.

while also maintaining a separate private market to reflect supply and demand for health services.[2] However, the experience of the last three decades has shown that the German system is also faced with mounting health care costs and a steadily increasing share of national income being spent on health care.

As figure 1 shows, German health expenditures as a share of GDP have nearly doubled over the past three decades. In 1960, the share was about 5 percent, whereas the corresponding figure in 1993 was approximately 9 percent. Canadian health expenditures as a share of GDP show a similar time trend, although Canada has devoted a higher share of GDP to health care than Germany, except between 1975 and 1981. It is interesting to note that the shares have been diverging since the end of

2 Henke *et al*., 1994b, p. 252.

the 1980s. In Germany, various cost containment measures have been able to rein in spending, while in Canada the corresponding expenditures have been rising.[3] To control health care costs, the German government enacted two major health care reforms in 1989 and 1993 aimed at reducing the structural deficits of the current system.[4]

This paper outlines the basic structure of the German health care system, analyzes the development of health care expenditures in Germany, and concludes by outlining possible solutions for Germany's health care problems.

Structure of the German health care system

Coverage

In Germany, health insurance is one of the four branches of the social insurance system,[5] the other three branches being accident insurance, retirement insurance, and unemployment insurance.[6] Entitlements of the health system are generous and benefits include primary care, hospital care, dental care, rehabilitation, and preventive care. Even long-term care is now covered by a pay-as-you-go scheme under the umbrella statutory health insurance (SHI) system.

Approximately 88 percent of the German population are insured with one of the compulsory SHI sickness funds (table 1). This is the case

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3 Comparisons of different health care systems depend to a considerable degree on the international classification of health care expenditures. For further details see OECD 1993, p. 13.

4 The last two major pieces of health care legislation are the 1989 and 1993 *Health Care Reform Acts*. They consist of short-term cost containment policies and long-term structural policies. See also the section below on "Regulating the pharmaceuticals market."

5 Hoffmeyer 1994, p. 425.

6 Accident insurance is work-related and paid exclusively by employers. The other three branches are financed by contributions from employees as well as employers. More specifically, benefits are financed by an income-related payroll tax, half of which is paid by the employee and half by the employer.

Table 1: Health Insurance Coverage of the German Population: Selected Years

Year	Population (1000s)	Statutory Health Insurance		Private Health Insurance		Other Coverage[a]		No Coverage	
		1000s	%	1000s	%	1000s	%	1000s	%
Old Länder									
1970	60,924	53,531	87.9	5,697	10.3	1,013	1.6	684	1.6
1980	61,516	55,565	90.3	4,611	7.5	1,203	1.9	137	0.2
1990	63,062	54,361	86.2	6,935	10.9	1,669	2.6	97	0.2
1992	64,706	56,306	86.7	6,967	10.8	1,488	2.3	215	0.3
New Länder									
1991	15,941	15,659	98.2	82	0.5	166	0.7	83	0.6
1992	15,732	15,443	98.2	172	1.1	101	0.6	17	0.1

[a]Insurance for students until 1974, police and military forces, recipients of public welfare, veterans, etc.

Source: Sachverständigenrat für die Konzertierte Aktion im Gesundheitswesen (1994), Sachstandsbericht, Gesundheitsversorgung und Krankenversicherung 2000, Baden-Baden.

with all blue collar workers, white collar workers below a certain income level (1995: DM 5,850 per month), farmers, students, and the unemployed, as well as the family dependents of all these groups. At the same time, over 10 percent of the population are fully covered by private health insurance (PHI). These people are employees with incomes above the assessable ceiling and self-employed persons who have the choice of opting out of the SHI system to join a private insurer.[7]

The remaining 2 percent of Germans are mainly civil servants for whom the government pays financial assistance. Only 0.3 percent of the

7 Pohlmeier and Ulrich 1994, p. 349.

population have no insurance coverage at all, and these uninsured are mainly persons with incomes above the opting-out limit who have decided not to carry health insurance. There is no person in need who is not covered by statutory health insurance.[8]

It is obvious from these figures that the German health insurance system is dominated by SHI, with private insurance available to a minor component of the population, more specifically high-income earners. In this context, we should mention that about 4 percent of statutorily insured individuals carry additional insurance with private companies, mainly to guarantee qualitatively better care in the event of an in-patient stay. In this sense, Germany has a two-tier system, though the SHI system is clearly predominant.

Participants

The key participants in the German health care system can be characterized as follows:[9]

1. *Patients,* who are members of statutory or private insurance funds;
2. Statutory sickness funds as well as their state and federal associations (table 2). There are about 1,300 autonomous sickness funds in Germany with some 51 million members. The sickness funds with the largest membership are the local funds, which geographically cover the entire country and act as collecting tanks for people for whom statutory insurance is compulsory (i.e., with incomes below the threshold) and the white collar workers' substitute funds operating nationwide;
3. *Private health insurers*, numbering about 115 in Germany. The 50 companies operating nationwide are joined in the Association of Private Health Insurers and represent the whole private health insurance market, since more than 99 percent of the yield from contributions is apportioned to these companies. Apart from these 50 companies, there are 65 smaller private associations and

8 Henke 1990, p. 253.

9 Hoffmeyer 1994, p. 432.

Table 2: Number and Type of Sickness Funds and Private Health Insurance Companies

Old Länder 1993	New Länder 1992	Characteristics
257	13	Local sickness funds
673	157	Company-based funds set up by large companies
145	31	Crafts funds set up by crafts organizations
19	3	Agricultural
7	6	White collar workers' substitute funds, operating nationwide
8	5	Blue collar workers substitute funds, operating nationally or regionally
1	1	Sailors' fund for seamen
1	1	Miners' fund for miners
51	—	Private health insurers

Source: Bundesminister für Arbeit und Sozialordnung, *Bundesarbeitsblatt* (Ministry of Labour and Social Affairs, Labour Bulletins), various issues.

relief funds which offer mainly supplementary insurance and operate on a solely local basis;[10]

4. *Ambulatory care*, provided predominantly by office-based physicians with resources allocated by collective bargaining between participants (medical associations and sickness funds). The government merely defines the legislative framework for the bargaining process;[11]

10 Verband der privaten Krankenversicherer 1994, p. 10.

11 Henke et al. 1994b, p. 256.

5. *Hospitals,* far more integrated with the administrative system than the ambulatory facilities. The need for and financing of hospitals are determined by state governments: sickness funds cover only current costs;[12]
6. *Pharmaceuticals producers*, numbering approximately 1,200 in 1993 and ranging in size from pharmacies selling drugs under their own names to roughly three dozen multinational companies marketing their products globally. The 10 largest pharmaceutical producers account for 24 percent of sales through pharmacies. In comparison with other industries as well as foreign pharmaceutical markets, the German pharmaceutical market has a fairly low level of producer concentration. This is not true, however, if we look at the sales of particular therapeutic classes, which often have a rather narrow oligopolistic structure. At the end of 1993, 649 hospital pharmacies and 20,648 registered retail pharmacies were selling pharmaceuticals.[13] For retail pharmacies, there are two important rules: first, pharmacists are not allowed to own more than one pharmacy, and secondly, a pharmacy must be owned by a pharmacist. These rules preclude the formation of pharmacy chains; and
7. The final key players in the German health system, the *Ministries of Labour and Social Affairs in the states* and the *federal Ministry of Health*. On the one hand, the government specifies the legal framework for the SHI system, and the major part of sickness funds' benefits are provided according to this legal framework. On the other hand, the insurance providers are self-governing and possess the administrative autonomy to negotiate with the medical and hospital associations.

An interesting aspect of German health care policy is its approach to controlling expenditures. The revenue-oriented control policy introduced in 1977 has put a "brake on an uninterrupted growth of expenditure."[14] Service financing is subject to sickness fund budget constraints:

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12 Henke et al. 1994b, p. 256; Hoffmeyer 1994, p. 451.

13 Ulrich and Wille 1996, p. 3.

14 Advisory Council for the Concerted Action in Health Care 1994, p. 19.

sickness funds are not permitted to incur debts or keep profits. Revenue-oriented expenditure control aims to stabilize the contribution rate in the SHI system and thus reduce ancillary wage costs in Germany which are relatively high compared with other European countries, the United States, and Japan.

The recent reforms impose controls on health care spending not only through this revenue-oriented policy but also by global budgeting, which sets budget caps on nearly all SHI treatment services. Both instruments—revenue-oriented expenditure control and budget capping—apply only to SHI. These strong regulatory measures can be seen as a timely model for controlling health care expenditures, but they are no substitute for an outcome-oriented health care policy. For this reason, contribution stability and global budgeting can be seen as a type of interim solution that gives politicians time to develop better incentive structures.

Basic Principles

The values underlying the SHI system can be characterized by three principles basic to a social market economy:

- self-administration,
- social partnership, and
- solidarity.

Self-administration means that health care purchasers and providers operate as self-managing private organizations under public law. The second basic principle, social partnership, assumes that both employers and employees share the burden of financing health care. The last principle, solidarity, means that the economically stronger members of society support the weaker members. "It is difficult to imagine circumstances in which it would be politically acceptable to abandon these general principles as part of health care reform policies."[15]

By contrast, the basic principles underlying the PHI system are the following:

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15 Hoffmeyer 1994, p. 434.

- insurance principle,
- principle of equivalence, and
- personal precaution.

The insurance principle stands for a risk-related contribution rate, i.e. a contribution rate that reflects the medical history of the insured individual. This rate is determined mainly on the basis of age and sex. Under the second principle, equivalence, the contribution rate reflects desired level of coverage without any cross-subsidization. Personal precaution means that each individual is responsible for his or her health capital and points to the relevance of lifestyle variables.

These basic principles have created a very important difference between the two types of health insurance. The PHI system has diversified contribution rates, while in the SHI system, benefits are financed by an income-related payroll tax. In 1995, the average SHI contribution rate was 13.2 percent of labour income, half paid by the employer and the other half by the employee, income being liable to contribution only up to DM 70,200 a year—the assessable income ceiling for 1995. Now unlike PHI premiums, these payroll taxes are independent of individual, medical, or social risks. This means that the relationship between the contribution rate and demand for services is weak, prompting the illusion that medical care is free. Copayments are limited to such items as eyeglasses, physiotherapy services, dentures, prescription drugs, and a per-diem copayment for hospitals. Currently, copayments as a portion of total health expenditures under statutory health insurance approach the 10 percent mark. The high degree of coverage of health care services, with the weak connection between costs and individual payments, generates inflationary effects since both physicians and patients have incentives to maximize the amount of services.

Individuals who voluntarily join a private insurance plan are normally not allowed to re-enter the SHI system if the cross-subsidization effects of SHI change to their advantage.[16] Exceptions are allowed for individuals experiencing periods of unemployment, who are automatically insured by a local sickness fund. For both privately and publicly

16 This may be the case if the number of family dependents increases or if the individual becomes a bad risk for PHI insurers.

insured individuals, the choice of health insurance company is independent of the employer.

Delivery of services and flow of funding

Ambulatory care

Germany draws a sharp distinction between hospital-based and office-based physicians. Office-based general practitioners provide the population with ambulatory care, prescribe drugs and medical aids, and serve as gatekeepers for specialist referrals and hospitalization. Over the past three decades, the total number of physicians has been steadily increasing (see table 3). In 1993, more than 266,000 physicians were working in various positions in the German health care sector. The number of office-based physicians was 89,000, which indicates a physician/population ratio of 1.18 per thousand inhabitants in the western part of Germany. Approximately 90,000 doctors were employed by hospitals.

For care provided to SHI members, physicians are reimbursed on a fee-for-service basis according to a point value scale, the so-called German Uniform Evaluation Standard. This evaluation scale is used for both statutory and private sickness funds. The fee schedule fixes relative prices in terms of point scores assigned to specific services. Price levels (point values) are determined through independent negotiation between the federal and regional organizations of the sickness funds and the corresponding doctor organizations. Although sickness funds and private insurers use the same fee schedule for remunerating ambulatory services, they have different point values. This leads to higher prices for the same services in the PHI system as compared with the SHI system.

Another difference between the SHI and PHI systems is that the physician does not know exactly how much he will earn from his services to SHI patients. The sickness funds and physicians' associations negotiate a fixed budget for ambulatory services every year. This means that the monetary value of a single physician service may decline if physicians are performing too many services in any one category. At present, the price level (point value) is approximately DM 0.09 for local

Table 3: Number of Physicians in Various Positions in the Western States of Germany, 1970-1993

Number of Physicians	1970	1980	1990	1993
Office-based	2,528	3,639	3,540	3,200
Office-based and licensed to treat sickness funds patients (Primary care physicians)	25,539	24,980	29,834	24,945
Office-based and licensed to treat sickness funds patients (Specialist physicians)	20,763	31,158	41,877	50,824
Employed by hospitals	35,066	67,964	96,203	91,468
In public service or other occupations	8,877	11,711	23,800	40,890
Not practising	11,208	24,672	47,324	45,000
Total	103,981	164,124	242,678	266,327

Source: Sachverständigenrat für die Konzertierte Aktion im Gesundheitswesen (1991), Jahresgutachten und (1994), Sachstandsbericht, Baden-Baden.

insurance funds and DM 0.11 for substitute funds. The variation results from the different budgets they have negotiated.

By contrast, physicians treating privately insured patients do not suffer from budget caps. Physicians accredited in the PHI system are paid on a fee-for-service basis. These doctors are also allowed to charge fees above the corresponding SHI fees—from 1.7 to 3.5 times the levels paid by the SHI system.[17] The 1993 *Health Care Act* limits the growth of the SHI ambulatory budget to the increase in income of statutory sickness fund members and thus in effect introduces a budget cap for ambu-

17 Hoffmeyer 1994, p. 448.

latory services. In the medium term, it is planned to remunerate physicians, not for each service, but in line with service categories.

Hospital care

In 1992 there were 3,590 hospitals in Germany, 3,104 in the west and 486 in the east. These can be divided up into hospitals for the acutely ill, special hospitals, and hospitals for long-term illness. As compared with other SHI treatment spending, hospital expenditures have grown disproportionately over the last three decades. This growth is explainable by several factors—medical, technological, and economic. For example, more diseases can now be treated in hospitals, and technological progress has created new diagnosis and treatment possibilities. Economic factors include oversupply of beds, extensive lengths of stay, and retrospective reimbursement methods.[18]

Hospitals can also be divided into the publicly owned and privately owned—private voluntary or private proprietary. Each of these three groups owns approximately one-third of all German hospitals. Almost one-half of all beds are provided by publicly owned hospitals, with one-third in private voluntary hospitals and 20 percent in private proprietary institutions. The owners of public hospitals are states, municipalities, and cities. Private voluntary hospitals are run by churches or other charitable institutions and the proprietary hospitals belong to private companies.[19]

The traditional remuneration basis for hospitals in Germany is a per-diem rate which is uniform within a hospital and independent of actual diagnosis, amount of care, or length of stay. Rates vary between hospitals depending on size and structure and thus on spectrum of services. The general per-diem rate inevitably leads to tremendous cross-subsidization across medical departments in hospitals. Further, the care-intensive first days in hospitals are subsidized by the last days, which involve mainly "hotel services" instead of expensive treatments. The uniform per-diem rate covers only the hospitals' operating costs: investment expenditures are financed by state governments.

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18 Henke et al. 1994b, p. 257.

19 Hoffmeyer 1994, p. 451.

The 1993 *Health Care Act* introduced several changes in hospital financing. The dual concept of financing, i.e. separate funding of operating and investment costs, was maintained, but the long-standing principle of fully reimbursed operating costs was abolished. Hospitals today bear the risk of not covering their operating costs and their owners have to pay for any deficits. On the other hand, hospitals are allowed to keep any surpluses. Also in 1993, the general per-diem rate was replaced by fee-per-case payments and lump-sum hospital rates. The fee-per-case rates are special rates for well-defined patient groups such as chronically or mentally ill patients or infants in neonatal care. The lump-sum rates are payments for specialized treatment services, e.g. cancer treatment or organ transplants. The new regulations aim to improve efficiency in the in-patient sector, mainly by basing hospital funding on a prospective remuneration system. Between 1993 and 1996, the *Health Care Act* introduced global budgeting as an interim solution linking hospital expenditures to the income growth rate of SHI members.

Pharmaceutical sector

Retail pharmacies get their pharmaceuticals from wholesalers and not directly from manufacturers.[20] However, manufacturers do distribute medicines directly to hospital pharmacies. Methods of distribution and price determination differ completely for retail and hospital pharmacies. Manufacturers often offer hospitals special rebates to entice training doctors to use their products, hoping for advantages from that connection when they set up their own practices later on.

At the manufacturing level, drug prices can be set to reflect prevailing market conditions. However, wholesaler markups are determined by federal law: the maximum markup will vary inversely with a manufacturer's price to produce a diminishing profit curve. Similarly, a retail pharmacist can add another fixed markup to the wholesaler's price. This regulation leads to uniform drug prices in retail pharmacies throughout the country.

The 1989 *Health Care Act* introduced reference pricing for various types of drugs. Reference prices are administratively fixed reimbursement levels for medicines with identical or similar properties. If an indi-

20 Henke et al. 1994b, p. 258; Hoffmeyer 1994, p. 459.

vidual wishes to obtain a pharmaceutical priced above the reference level, he or she has to pay the difference between this market price and the official reference price. The efficiency of reference pricing has been a source of controversy, especially because these prices are set by a commission that does not include pharmaceutical industry representatives, only representatives of the sickness funds and physician associations.

Copayments and global budgeting are two other features of funding in the pharmaceuticals market. Copayments were introduced in 1970 in the form of prescription fees, and the copayment structure has changed frequently since then. The 1993 *Health Care Act* introduced copayments that reflected the package sizes of prescriptions: small packages carry a copayment of DM 3, medium packages DM 5, and large packages DM 7. The 1993 Act also introduced a budget for drugs prescribed by office-based physicians. This budget was set at DM 24 billion for the year 1993, roughly corresponding to 1992 pharmaceuticals spending. If prescription costs exceed the budget, the physicians have to pay for the overrun the following year up to a total of DM 280 million. If pharmaceuticals expenditures exceed the budget by more than DM 280 million, the pharmaceuticals industry is responsible for a further DM 280 million. The budget for medicines has been kept at a comparable level for the years 1994 and 1995.

Expenditure analysis

In 1992, total health expenditures amounted to roughly DM 400 billion: 88 percent of this amount was spent in the western part of the country and 12 percent in the east. The former German Democratic Republic is still in the process of adopting the laws and regulations of the West German health care system. Table 4 shows east-west expenditure ratios by treatment type. On average, the per-capita spending level in the east rose from 49 percent of the western level in 1991 to 72 percent in 1993. There are, however, substantial differences when it comes to specific treatments. For dentures, expenditures in the east were 50 percent above the western level. The lowest expenditure ratio found was that for primary care: here, eastern per-capita expenditures were still 40 percent behind the western level, indicating that the primary care model in the east had not fallen as far behind the western model as had other treatment types.

Table 4: East-West Comparison of Expenditure (per capita, pensioners included)[a]

Type of Treatment	1991	1992	1993[b]
Treatment by physicians	42.3	53.1	60.9
Treatment by dentists	58.9	80.3	83.9
Hospital care	55.1	66.0	71.8
Medicines	55.2	69.6	91.9
Medical aids	37.9	57.8	67.3
Dentures	71.1	136.8	145.2
Total[c]	49.1	65.2	72.3

a) Eastern value as a percentage of Western value.
b) Preliminary results.
c) SHI expenditures for health excluding expenditures which cannot be divided into treatment types.
Source: Bundesminister für Arbeit und Sozialordnung, *Bundesarbeitsblatt* (Ministry of Labour and Social Affairs, Labour Bulletins), various issues.

Table 5 shows developments in share of spending by treatment type in the SHI and PHI systems since 1970. Actually, the last year for which the Federal Statistical Office provides information is 1991.[21] The division into 10-year periods shows that structural shifts in SHI occurred mainly between 1970 and 1980, when the shares of primary care (treatment by physicians and dentists) and pharmaceuticals declined and the shares of hospital care, medical aids, and dentures substantially increased. The larger drop in the PHI share of pharmaceutical spending as against SHI was mainly due to the existence of copayments in PHI,

21 There is another database administered by the Ministry of Labour and Social Affairs: however, this data set does not allow for a comparison between SHI and PHI expenditures as it contains information on SHI expenditures only.

Table 5: Expenditure Shares of SHI and PHI by Types of Treatments: Old Länder[a]

Type of Treatment	Share	1970	1980	1990	1991	Growth Rate 1970-1991
Treatment by physicians	SHI	22.8	17.6	17.6	17.1	379.3
	PHI	15.8	15.8	15.9	16.0	427.8
Treatment by dentists	SHI	7.1	6.3	5.9	5.8	422.8
	PHI	1.4	3.9	7.2	7.0	2,444.2
Hospital Care	SHI	25.3	30.0	33.4	32.9	729.7
	PHI	24.9	29.9	31.0	30.9	547.7
Pharmaceuticals	SHI	17.1	14.3	15.7	15.6	482.6
	PHI	12.1	6.6	6.4	6.3	174.3
Medical Aids	SHI	1.9	3.7	4.1	4.1	1,325.3
	PHI	2.1	3.7	4.1	4.2	932.5
Dentures	SHI	3.4	8.3	3.5	3.6	577.9
	PHI	2.2	0.8	4.2	4.3	926.6
Others[b]	SHI	22.4	19.8	19.2	20.7	—[c]
	PHI	41.5	34.3	31.2	31.3	—[c]

[a]Percentage share of total health expenditure.
[b]Administrative expenditure, preventive care, and rehabilitation health care costs.
[c]The growth rate for this category is not calculated because of its mixed character which restricts interpretation.

Source: Author's calculations based on Statistisches Bundesamt (Federal Statistical Office), 1994.

which made the demand for pharmaceuticals more price-elastic as compared with SHI.

By contrast, PHI and SHI have similar remuneration systems for hospital care, which is why hospital care expenditure as a share of total spending increased by approximately the same amount from 1970 to 1980 for both insurance types. Subsequent cost containment policies mainly hardened the budget structure of the German health care sector. As long as health care resources are not allocated through markets, it remains an open question whether a fixed budget structure produces an appropriate and desirable level of health care spending.

When analyzing the PHI figures, it should be kept in mind that differences between the publicly and privately insured and different risk structures impede comparison of the SHI and PHI systems. For this reason, our analysis focusses on the two systems' expenditure structures. In the PHI system, spending on primary care and pharmaceuticals declined as a share of total health spending, whereas the shares of hospital care, medical aids, and dentures grew: a similar trend is seen in the SHI figures. In contrast to SHI, however, PHI spending for dentures and dental care increased substantially: this can be explained by the relatively strong regulation of these treatment types in the SHI system. Another interesting difference concerns pharmaceuticals: while SHI showed only a moderate decline in spending in this sector, the corresponding PHI figure was nearly halved. Analysis also reveals that both SHI and PHI face similar problems with hospital care, which accounts for approximately one-third of all health care spending. What this tells us is that the hospital sector should be the focus of future health care reforms.[22]

Regulating the pharmaceuticals market

As already mentioned, the recent health care reform acts enshrine two major policies:[23] short-term cost containment and long-term structural change. The short-term policy aims at keeping the contribution rate con-

22 In Germany, this is a difficult task because the state governments have authority over the hospital sector and not the federal government which generally puts the reform measures into effect.

stant and can be characterized as a revenue-oriented expenditure policy. The long-term reforms have a broader goal of providing more market-oriented incentives in the health care sector.

With regard to pharmaceuticals reform, reference pricing was introduced in the 1989 *Health Care Act* for three groups of pharmaceuticals:[24]

- group one, pharmaceuticals with identical active substances;
- group two, drugs with pharmaceutic-therapeutic equivalent active substances, especially with chemically related ingredients; and
- group three includes medicines with comparable therapeutic effects, particularly drug combinations.

The Ministry of Health originally hoped that 80 percent of all drugs would be covered by reference prices by the end of 1992 and forecast net savings of DM 2 billion.[25] Actual developments did not meet these expectations. By January 1, 1993, reference prices had been fixed for:

- 86 substances from group one,
- 12 substances from group two, and
- 3 substance combinations from group three.

At present, reference prices cover only 45 percent of total SHI pharmaceutical expenditures and net savings are estimated at DM 1.1 billion.[26] It is expected that the reference pricing system will soon reach its limit as an expenditure control instrument.

The main criticism of the reference pricing system is that it takes only the price component into account, leaving quantity and structural components aside. Table 6 shows that rises in pharmaceutical prices covered by reference pricing had only a small impact on pharmaceutical sales over the last seven years. In each year except 1989 and

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23 Erbsland and Wille 1994, p. 847; Henke et al. 1994b, p. 260; Münnich and Sullivan 1994, p. 22.

24 Erbsland und Wille 1994, p. 849.

25 Erbsland and Wille 1994, p. 849; Hoffmeyer 1994, p. 464.

26 Henke et al. 1994b, p. 258; Hoffmeyer 1994, p. 464.

Table 6: Components of Expenditure Growth in SHI Pharmaceutical Market

Year	Growth in Sales (%)	Growth in Numbers of Prescriptions (%)	Growth in Prices (%)	Structural Component		
				Total (%)	Inter-Drug Effect (%)	Intra-Drug Effect (%)
1987	6.8	3.7	0.7	2.3	0.4	1.9
1988	8.5	4.1	1.4	2.7	0.8	1.9
1989	0.8	-3.5	1.0	2.9	0.0	2.9
1990	6.5	5.3	-0.1	1.3	-0.4	1.7
1991	10.8	3.8	1.5	5.1	2.5	2.7
1992	9.8	3.2	2.0	4.3	1.8	2.5
1993	-14.5	-10.4	-3.9	-0.8	-0.9	0.1

Source: Schwabe and Paffrath (1988 to 1994).

1993, the number of prescriptions rose faster than the pharmaceutical price index.

Savings from regulating the prices of medicines were partly offset by substitution effects as physicians altered their prescribing behaviours. Table 6 shows that numbers of prescriptions and the structural component both showed positive growth in all years but 1993. The structural component consists in an inter-drug effect and an intra-drug effect. The inter-drug effect measures changes in sales that result from prescribing different medicines, while the intra-drug effect measures change in expenditure growth for identical medicines when different package sizes, dosage forms, or potencies are chosen. In the majority of years, both effects were positive, indicating a positive contribution to expenditure growth.

In 1993, the *Health Care Act* introduced a specific budget for medicines. The budget cap caused a substantial decline in both

pharmaceuticals volumes and prices. The first year showing negative growth of the structural component was 1993. The negative inter-drug effect in particular shows that physicians were substituting cheaper for more expensive drugs. Compared with reference prices, the introduction of global budgets has achieved more effective and stronger spending cuts. The reason is obvious: budget caps are stronger regulatory measures than reference prices.

Conclusion

Germany is in a period of transition. To contain health care expenditure, cost control interventions have increased over the last three decades. Germany has implemented such long-term macroeconomic measures as revenue-oriented expenditure policy, contribution rate stability, and global budgeting. The middle-term goal, however, is to reduce the structural deficits of the current system, enhance competition, and bring more market elements into SHI. At present, it is unclear whether Germany is moving for more competition or more regulation in its health care sector.

References

Advisory Council for Concerted Action in Health Care (1994), *Health Care and Health Insurance 2000, Individual Responsibility, Subsidiarity and Solidarity in a Changing Environment*, Expert Opinion Report 1994, Abbreviated Version, Bonn.

Bundesminister für Arbeit und Sozialordnung, *Bundesarbeitsblatt*, (Ministry of Labour and Social Affairs, Labour Bulletins), various issues.

Erbsland, M. and Wille, E. (1994), "Zu den Effekten von Gesundheitsreform und Gesundheitsstrukturgesetz auf den Arzneimittel-markt," in *Die Pharmazeutische Industrie*, 56(10), 847-53; 56(11), 941-48.

Henke, K.-D. (1990), "The Federal Republic of Germany," in Scheffler, R.M. and Rossiter, L.F. (eds), *Advances in Health Economics and Health Services Research, a Research Annual, Comparative Health Systems: The Future of National Health Care Systems and Economic Analysis*, Supplement 1, London, 145-68.

Henke, K.-D. et al. (1994a), "Global Budgeting in Germany: Lessons for the United States," in *Health Affairs*, 13(4), 7-21.

Henke, K.-D. et al. (1994b), "The German Health Care System: Structures and Changes," in *Journal of Clinical Anesthesia*, 6, 252-62.

Hoffmeyer, U. (1994), "The Health Care System in Germany," in Hoffmeyer, U. and McCarthy, T.R. (eds), *Financing Health Care*, Vol. I, Dordrecht, 419-512.

Münnich, F.E. and Sullivan, K. (1994), "The Impact of Recent Legislation Change in Germany," in *PharmacoEconomics*, 6 (Suppl. 1), 22-27.

OECD (1993), *OECD Health Systems, Facts and Trends 1960-1991*, Vol. I, Paris.

OECD (1995), *Health Data*, CREDES, Paris.

Pohlmeier, W. and Ulrich, V. (1994), "An Econometric Model of the Two-Part Decision Process in the Demand for Health," in *Journal of Human Resources*, 30(2), 339-61.

Statistisches Bundesamt (Federal Statistical Office, 1994), *Fachserie 12, Reihe S.2, Ausgaben für Gesundheit 1970-1991*, Stuttgart.

Ulrich, V. and Wille, E. (1996), "Expenditures on Drugs and Health Care Reform: The Case of Germany," in *PharmacoEconomics*, forthcoming.

Verband der privaten Krankerversicherung (Association of Private Health Insurers, 1994), *Die private Kranken-versicherung*, Zahlenbericht 1993/94, Köln.

Reference Pricing for Pharmaceuticals

David Moore

THE USE OF PHARMACEUTICALS IN NEW ZEALAND has been a David and Goliath battle, and reference pricing has been the government's slingshot. Without reference pricing, it is fair to say, the New Zealand health care sector would not be as stable as it is today. Reference pricing is the most powerful policy tool the government has to ensure a free market approach to pharmaceuticals pricing. Reference pricing—as it is working in New Zealand—has had a dramatic impact. So far, the government has saved $30 million and those are $30 million going back into health care elsewhere. New Zealand has been battered by the pharmaceutical wars and, in those wars, reference pricing has been a winning banner.

New Zealand is a country of three and a half million people. It spends about four billion New Zealand dollars on health care annually: the exchange rate is about 90 cents Canadian. The country spends about $NZ672 million a year on pharmaceuticals alone, including taxes and markups but excluding hospital drugs: hospitals pay for their own pharmaceuticals.

New Zealand's health care system has a so-called purchaser-provider split. It has an integrated budget, which means that any money

spent on hospitals takes money away from pharmaceuticals: likewise, if you spend money on pharmaceuticals it takes money away from hospitals. An integrated health budget means that the Regional Health Authorities (RHAs), the health purchasers, have to optimize their overall mix of elective surgery and so on.

Reference pricing: the commonsense ingredient in the health care cocktail

Pharmac is a government-sponsored organization of 15 health professionals, about half of whom are qualified as either pharmacists, nurses, doctors, epidemiologists, or pharmacologists. Also supporting Pharmac is a board of well-known and well-respected doctors, most of whom are general practitioners or clinical pharmacologists. Further support comes from a network of subcommittees, scientific and medical committees that add up to about thirty doctors.

Pharmac is involved in a number of areas in the health care environment. The first is the drug industry, which is one of the most protected and regulated industries in the world. Pharmaceutical markets have a number of special features that work in favour of the vendor and against the buyer. No other industry knows such fragmentation of markets, such barriers to competition, and such regulation. No industry makes better and more profitable use of patents or more actively promotes intellectual property rights than the pharmaceutical industry. No industry fights more aggressively to restrict normal trade flows from one country to another. And it is the taxpayer and the patient who foot the bill for these market distortions.

New Zealand is a small country, vulnerable to and a target for some of the overseas giants who could buy the islands outright with just the money they spend on marketing. It is reference pricing which the government uses to keep the drug barons at bay. Often there is no real price difference between companies and it is difficult for new companies to break into existing pharmaceutical markets.

So there is an elite, powerful, rich little group into whose hands one must play in order to buy pharmaceuticals. With new drugs, there is little if any competition and the prices are substantially higher than those of the older technologies: over time, moreover, these prices do not nec-

essarily decrease as they do in other markets. In some notable instances, there have been later entrants into the market asking for higher prices than the existing players. From an economist's point of view, the market for pharmaceuticals is not clearing.

In New Zealand, the principal of universality does not extend to pharmaceuticals. However, in New Zealand it is the taxpayer who must come up with most of the money for drugs. There is a constant demand for the best possible health care and the so-called best is often tied in with the latest, most popular and most aggressively marketed fad.

The consequences for New Zealand were that it faced a perceived budget explosion when it established the Regional Health Authorities in July of 1993. Pharmaceutical spending was growing by 10 percent to 12 percent annually, and even the drug companies could not argue this fact. They believed the growth rate was 10 percent but the government felt it was closer to 12 percent. At any rate, spending on pharmaceuticals was increasing far faster than the rate of increase in overall health spending. Since there is an integrated health budget, the money for pharmaceuticals had to come from other areas of health care. Reference pricing has helped the government cut through some of the myths in medicine, and it makes sure that people do get the best health care New Zealand can afford. Pharmac is making sure that New Zealanders get the best deal with reference pricing.

Different forms of reference pricing

There are various definitions of reference pricing. The idea of reference pricing as discussed in the United States is to pay whatever other countries are paying for a certain drug. Looking at American drug prices, this approach is understandable. Other countries look very narrowly at reference pricing, using the World Health Organization's definition of interchangeable medicines. In New Zealand, Pharmac goes even farther. Pharmac looks at the clinical effect of a drug and pays the same level of subsidy for all drugs that have the same or a similar therapeutic effect in treating the same or similar conditions.

For example, there may be four similar drugs currently at different levels of subsidy, all marketed to health providers in terms of their individual differences. Pharmac will ask its scientific and medical experts to determine the evidence supporting each of the drugs and will then set

the level of subsidy at the price of the lowest-cost supplier. Unlike the German system, which would determine the level of subsidy based on the average cost of the four drugs, Pharmac determines subsidy from the lowest cost at which there is willingness to supply the drug. Now the suppliers can charge a premium if they really believe their drug is good, and this premium is then passed on to the user. Pharmac's aim is to have one fully subsidized pharmaceutical in each therapeutic subgroup.

The focus of reference pricing is not on pills, though: the focus is on health outcomes. Pharmac looks at a drug's function — not always easy to determine, since crucial bits of information are often missing. It is sometimes very difficult to get explicit information about pharmaceuticals. Of course, even the concept of defining a therapeutic subgroup is contentious. Your reason for not choosing a drug is because of toxicity, side-effect profile or whatever. The idea behind reference pricing is that, hopefully, each therapeutic subgroup will have one fully government-subsidized drug. The New Zealand government is also hopeful that it is putting markets back together, for common sense says: why pay more for the same thing?

Some examples

Reference pricing has had a radical impact in New Zealand. H2 antagonists were the first drugs to come under the scheme. There are 11 brands of H2 antagonists, with no premiums for patients on any one of them. The World Health Organization's essential drug list has, I believe, cimetidine listed only as an ulcer treatment. In mid-1994, H2 antagonists came under price competition from generic antagonists in New Zealand, and the government took "bids" from the various producers of H2 antagonists in order to determine the level of government subsidy.

First, one company offered the government a price reduction of 20 percent, then a further reduction was offered and accepted. Next, the government reduced its investment in H2 antagonists by 28 percent for a period of time. The brand-name companies followed the generic companies down in price. What that tells the government, of course, is that there is a lot more room to go on pharmaceuticals pricing. Considering prices for cimetidine here in Canada, this is certainly instructive.

In New Zealand, more people are now being treated for less money than ever before—a compelling outcome indeed. The budget for H2 an-

tagonists is growing from its lowered base. It is also worth noting that the markets for the two SSRIs, Aropax and Prozac, were combined. This allowed the government to pay for two-thirds of the year's growth in spending on Prozac—a welcome respite.

The New Zealand government had saved about $NZ 27.6 million through reference pricing as of June 30, 1995. The effect of the savings will increase over time. The government is expecting to save about $NZ 42 million in 1996, a similar amount in 1997, and so on. The net present value of all those millions is remarkably high and the anxiety created for the public is remarkably small.

Another effect of reference pricing is not quite so visible. In New Zealand, drug prices are decreasing in real terms. At the moment, its price index is approximately -1 percent in nominal dollars. Prices do not jump up when there is more than one pharmaceutical in a therapeutic subgroup and where the possibility exists to establish a reference price.

The 12-month moving averages indicating the overall effect of Pharmac's activities show that a 10 percent to 12 percent rate of growth in pharmaceutical expenditures expected at the end of last year has been pulled back to 5.6 percent. Pharmac has been able to increase care through the use of pharmaceuticals. It has been able to buy a number of new technologies, provide a fully subsidized proton pump inhibitor. It has a range of other pharmaceuticals under investigation. Pharmac has paid for a 10 percent increase in expenditure on H2 inhibitors, a 10 percent increase in spending on calcium channel blockers, a 30 percent increase in the use of selective serotonin re-uptake inhibitors, and it was able to stay within its budget. This is an achievement of which Pharmac is proud.

Doctors

Doctors also benefit from reference pricing. They have simpler choices. They can choose the best therapy for their patients within an available range. They do not have to worry so much about prices per se, only about prices between different classes of drugs and relative effectiveness for the individual patient.

Overall, with the reforms that have taken place in New Zealand, doctors are striking out into a new age of applied medicine—a new age in the way they run their practices and do business—and reference pric-

ing is helping them achieve their goals. Doctors are moving into contracts and may now hold budgets. They are keen to make savings because they and their practices reap the benefits, as do their patients. If they can give good sound advice which might lead to beneficial changes in lifestyle and improvements in health instead of just filling patients with pharmaceuticals, they now have every encouragement to do so.

Summary

New Zealand is no longer a nation of pill poppers, but a nation striving for quality health care within its means. Doctors, pharmacists, nurses, all medical professionals are able to play their part in this new regime and reap the benefits. Reference pricing helps this vision, this stability. Since Pharmac was set up it has already saved about $NZ 30 million on pharmaceuticals and it is no wonder that some drug companies and their cohorts are upset. Drug prices are falling in real terms. This means that instead of having to cut health care costs as we did in July 1993, we are now using more pharmaceuticals overall while also staying within budget. Before June 1993, pharmaceutical spending was taking New Zealand's health care system into oblivion. This year, Pharmac hopes to save $NZ 42 million, and that is $42 million which it will be putting back somewhere else in the health care system. There will be high-quality health care along with accountability.

Reference Pricing: a Sham and a Shambles

Alister Scott

THE IDEA THAT IT MIGHT BE POSSIBLE to categorize drugs into therapeutic groups, the members of which would be interchangeable in clinical practice, has seductive appeal. In many diseases, a doctor has a choice of drugs from which a selection is made in the case of each particular patient. It is tempting to regard the drugs from which the selection is made as members of a therapeutic group.

As soon as we start to think this way, however, some obvious problems arise. For one thing, a single drug may have several uses: the drug propranolol, for example, a beta adrenergic receptor antagonist, may be used to treat hypertension, cardiac arrhythmias, angina and familial tremor, and in the prophylaxis of migraine, and variceal haemorrhage in patients with portal hypertension. Drugs that may be members of the therapeutic group for one disease, say angina pectoris where calcium channel antagonists and nitrates make up the rest of the group, are not necessarily members of a group for another disease, say migraine. It has

to be accepted, therefore, that any given drug may belong to one or several distinct therapeutic groups.

The next problem is that disease is not uniform either logically or experientially. It is understood that disease may be more or less severe, but it is not so readily recognized that the categorization or naming of disease has a complex logic. A diagnosis, to paraphrase J.S. Bruner's comment on theorizing, is "a way of stating tersely what one already knows without the burden of detail. In this sense it is a canny and economical way of keeping in mind a vast amount while thinking about very little." Although diagnosis often suggests a therapeutic approach, to suggest that a given diagnosis actually entails a particular therapy would usually be wrong.

Duodenal ulcer is an example of an illness for which there is more than one possible therapeutic approach. Duodenal ulcer is defined by its pathological appearance. It may occur spontaneously when the bacterium *Helicobacter pylori* is present in the gastric antrum. In such cases, eradication of the germ is the best therapeutic strategy though not uniformly successful, in which case other drugs or sometimes surgery may be used. A significant number of ulcers are associated with the use of non-steroidal anti-inflammatory drugs. In such cases the best strategy is to stop the drug, if possible, or otherwise reduce gastric acid or else use a cytoprotective agent to achieve a cure. In rare cases, ulcers are due to a gastrin-producing tumour, the so-called Zollinger-Ellison Syndrome, in which case *H. pylori* is present but the ulcer will only heal with effective suppression of gastric acid or removal of the tumour. Because of the heterogeneity of examples of duodenal ulcer, the group of agents that might appropriately be used in its treatment include antibiotics, acid suppressing drugs of more than one class, cytoprotective agents of widely different chemical types, and hormone modulating hormones, while surgery is another option.

Then there is the problem of adverse effects. Even where a group can be defined with reasonable pharmacologic uniformity, there are frequently variations in members of the group with respect to short-term or long-term toxicity. Calcium channel blocking drugs provide an example of this phenomenon. These are drugs used to treat hypertension, and several members of the group are also useful for stabilizing angina. Verapamil is a potent antiarrhythmic drug. Verapamil and diltiazem are used to moderate heart rate in patients with atrial fibrillation. While

the vasodilating properties of nifedipine can cause side effects for some people, they are the reason for its use as an alternative drug for other people, since the dilatation of smooth muscle it produces is often sufficient to give relief from oesophageal spasm.

That even this relatively homogeneous group of drugs cannot be regarded as interchangeable for many uses is apparent from the above. In addition, new data suggest that even when there is a common indication, divergent long-term risks exist among the members of a class. A British study has recently suggested that a similar situation may apply to oral contraceptives with respect to the risk of venous thrombosis.

Apologists for reference pricing in both Canada and New Zealand have used the histamine-2 receptor antagonist group as an example of interchangeable medicines. The example is worth exploring. H2 antagonists are effective in reducing gastric acid and are singularly free of toxicity. Drug interactions with cimetidine are a potential problem, but there is little cause for concern in practice as this can easily be taken into account by the alert prescriber. The main difference between the members of the group is in pharmacokinetics, cimetidine having a relatively short half-life and famotidine a relatively long half-life. The therapeutic ceiling, if doses are properly adjusted, is probably similar between the compounds.

The drugs are especially familiar as ulcer healing drugs but in New Zealand at least, and almost certainly elsewhere, they are widely prescribed for other causes of dyspepsia, notably reflux oesophagitis and so-called "non-ulcer dyspepsia." Prescriptions for these indications vastly outnumber those for gastric and duodenal ulcer healing or prophylaxis. The evidence is that the drugs are effective in healing mild reflux oesophagitis but probably have no effect on non-ulcer dyspepsia. The effective dose for a patient with reflux oesophagitis is not the same as the dose recommended for ulcer healing for all members of the class. In particular, cimetidine, because of its short half-life, has to be given at a dose of 400 mg four times daily to have an effect equivalent to that of 20 mg of famotidine twice daily.

Severe reflux oesophagitis, or oesophagitis complicated by columnar metaplasia (Barrett's oesophagus) is treated best by a proton pump inhibitor. Oesophagitis of moderate severity may be unresponsive to cimetidine but responsive to a longer-acting H2 antagonist. If, in New Zealand, cimetidine were selected as the one available H2 antagonist

because of evidence of equivalence in the treatment of ulcer disease, we would inevitably disadvantage the much larger group with reflux oesophagitis. Alternatively, a larger proportion of this group of patients would be seeking treatment with proton pump inhibitors at more than twice the cost of the longer-acting H2 antagonists.

The idea of therapeutic groups and reference pricing assumes not only that the drugs within a group are sufficiently similar to allow free substitution but also that patients form a uniform population—uniform with one another and uniform with populations studied in therapeutic trials. Mr. Mike Corbeil, Head of the B.C. Pharmacare program, seemed to believe this when he said in his August 25, 1994 letter to doctors:

> Many products within therapeutic classes are equally efficacious and safe when evaluated in rigorous clinical trials.... If all members of a therapeutic category are equally effective, and have similar side-effect profiles, then government . . . must . . . require the most cost-effective product to be the insured drug of choice.

A problem lies in the fact that people enrolled in drug trials differ significantly from the population a doctor sees. The following is the list of exclusions from a trial exploring how the subsequent course of ulcer disease is affected by an initial failure to achieve healing:

> Patients with other gastrointestinal diseases or with renal, hepatic or cardiorespiratory malfunctions were not included in the study. Patients taking analgesics or antiphlogistic drugs were also excluded.[1]

Here is the list of exclusions from a study defining the appropriate antacid dose for ulcer healing:

> Patients with ulcer-related complications such as haemorrhage and perforation, previous gastric surgery, or with any systemic illness were excluded from the study.[2]

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1 P. Pauluzi, G. Ricotta, F. Ripoli et al., "Incompletely and Completely Healed Duodenal Ulcers' Outcome in Maintenance Treatment: a Double Blind Controlled Study," in *Gut*, vol. 26 (1985), pp. 1080-85.

Sometimes the list of exclusions is formidable indeed. Here, abbreviated, is the list of exclusions from a study comparing omeprazole and pantoprazole in the treatment of duodenal ulcer:

> Patients were excluded . . . if they had ulcer complications, more than two ulcers, concurrent gastric or intrapyloric ulcer, reflux oesophagitis . . . pyloric stenosis. . . . Patients with severe diseases (e.g. renal, hepatic cardiovascular or malignant diseases) were also excluded. Patients on glucocorticoids and non-steroidal anti-inflammatory drugs, or [drugs likely to interact with the test drugs] or . . . those prone to allergic drug reactions. Other exclusion criteria included pregnant or lactating women and women of child-bearing age without reliable contraception, patients with a history of alcohol or drug abuse, patients who could not be expected to comply with treatment.[3]

Many if not most of the patients doctors see and must treat would have been excluded from this study.

The healing rate for pantoprazole after one month was 96 percent, incidentally. This is better than can be achieved with cimetidine over three months at 1200 mg per day.[4]

The above indicates unmistakably that the concept of therapeutic groups with interchangeable members is not supportable in pharmacology or therapeutics. Why then has it been adopted? The concept's only possible use is as a bargaining tool with drug manufacturers. To pretend that it encapsulates any element of good medical practice is simply wrong. To pretend that the introduction of reference pricing signals to prescribers a shift from a "patient advocate ethic" to a "justice ethic" is simplistic to the point of dishonesty.[5] It is especially simplistic to refer to

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2 N. Kumar, J.C. Vij, and B.S. Anand, "Controlled Therapeutic Trial to Determine the Optimum Dose of Antacids in Duodenal Ulcer," in *Gut*, vol. 25 (1984), pp. 1199-1202.

3 M. Rehner, H.G. Rohner, and W. Schepp, "Comparison of Pantoprazole versus Omeprazole in the Treatment of Acute Duodenal Ulceration—a Multicentre Study," in *Aliment Pharmacol Ther.*, vol. 9 (1995), pp. 411_16.

4 Many studies could be quoted, e.g. K.D. Bardhan, "Refractory Duodenal Ulcer," in *Gut*, vol. 25 (1984), pp. 711-17.

the rationing of publicly funded medicines as having anything to do with social justice in New Zealand's case, where only the economically disadvantaged cannot buy their way out of the rationing restrictions imposed in the public sector.

The New Zealand experience has been that the introduction of co-payments for pharmaceuticals has influenced drug usage considerably. Co-payments have contained public sector drug expenditure in New Zealand over the past several years far more effectively than the strategies outlined by Pharmac. Table 1 demonstrates the stability of public expenditure on drugs since 1989, when co-payments were first introduced. It also belies Pharmac's claim that "one of the key problems confronting Pharmac in July 1993 was the strong and unsustainable level of growth in pharmaceutical expenditure."[6]

Looking at trends in drug expenditures is an oversimplified way of deciding whether these expenditures are excessive. Any thorough analysis must look not only at dollars spent but also at gains in health status and reductions in hospital stays as pharmaceutical advances are introduced. If these issues are not addressed, the analysis will have little meaning. For example, we spend proportionately more on pharmaceuticals now than was spent in 1940, but who would argue that the level of spending appropriate to an era in which there were no antibiotics, no drugs for hypertension, nothing to effectively treat peptic ulcers—the list goes on and on—would be appropriate for today?

A real concern is developing in New Zealand that new drugs are not being funded because of cost. The cost of new drugs is admittedly often high, but the benefits can be great. There seems to be a tendency to accept that the funding of new medicines is too costly while allowing the sometimes wasteful use of existing drugs. As B.J. Crump and others have commented in a recent article on cost shifting in Britain's National Health Service:

> It may . . . be inappropriate to focus on the cost of a few expensive treatments when a high rate of prescriptions for cheaper drugs may have a bigger overall impact on health care budgets.

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5 S.L. Kletchko, D.W. Moore, and K.L. Jones, *Targeting Medicines: Rationalising Resources in New Zealand*: New Zealand, Pharmac, June 1995.

6 *Pharmac, the First Twenty Months*: New Zealand, Pharmac, 1995.

Table 1: Pharmaceutical Benefits in New Zealand, 1989-1995

	Year to March 1989	Year to March 1990	Year to June 1991	Year to June 1992	Year to June 1993	Year to June 1994	Year to June 1995 (estimate)
Government PBS subsidy[a] ($ million)	549	523	545	556	583	641	673
Subsidy deflated by the CPI (millions of 1995 dollars)[b]	665	592	589	596	616	670	673
Subsidy per head[c]	$196.45	$172.65	$172.32	$172.51	$170.58	$189.16	$187.88
Subsidy per head corrected for % population aged >60[d]	$170.95	$149.79	$149.15	$149.19	$147.45	$163.50	$162.33

Notes:
[a]actual spending
[b]spending in constant 1995 NZ dollars
[c]spending per head of population
[d]spending per head of population corrected for demography.
Source: C.G. McKendry and D. Muthumala, *Health Expenditure Trends in New Zealand: Update to 1994*: New Zealand, Ministry of Health, 1995.

For example, in the West Midlands region during 1993-94 there was increasing concern about the use of expensive treatments [treatments with an annual cost of more than $NZ 5,000] but they consumed only 3.5 percent of the total drug budget and an additional spending of ($25 million) on primary care prescrip-

tions for one gastrointestinal drug was passed without comment.[7]

The funding of health care generally and subsidies for drugs in particular should not conflict with good medical practice, including good prescribing practice. In prescribing antibiotics, for example, a larger dose should be prescribed where higher serum levels are required. The dose of a penicillin that is effective against pneumococcal disease of the lung is much less than the dose required for staphylococcal disease because of the tendency to form avascular abscesses in the latter case. The dose appropriate for pneumococcal disease of the meninges is also high because of the relative barrier to the distribution of the drug posed by the blood brain barrier. In particular cases, because of a patient's age or size or because of physiological peculiarities such as renal failure, unusual doses may be required. The prescriber must be free to make these calculations and decide on the right drug and the right dose for a particular circumstance.

If subsidies are to be designed that will force the use of lower-strength preparations, this can be done safely only in the context of particular and detailed diagnoses. This approach would generate a drug schedule of enormous complexity and demand specification of the diagnosis on every prescription—with all the privacy implications this would involve. After all this, it would still not be dealing with variations in age, weight, and physiology, let alone idiosyncratic reactions and allergies.

The benefits of reference pricing are a mirage, and the scheme should be abandoned. There are much better methods for ensuring high-quality, cost-effective practice; methods which concentrate on the total care of patients, socially, emotionally, and medically.

An example of such a preferred method is found in a study by Bytzer and others in the field of ulcer disease. The study compares prompt diagnosis of dyspepsia by endoscopy with the empirical treat-ment of symptoms.[8] It shows that prompt endoscopy undertaken within seven days of diagnosis and with H2 receptor antagonists

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7 B.J. Crump, R. Panton, M.F. Drummond, M. Marchment, and R.A. Hawkes, "Transferring the Costs of Expensive Treatments From Secondary to Primary Care," *British Medical Journal* 1995; 310: 509-12.

prescribed only for those patients in whom peptic ulcer or oesophagitis was discovered:

- saves money and
- provides greater patient satisfaction.

Compared with the common "therapeutic trial" approach, the savings were:

- a 40 percent saving in the prescription of acid-reducing drugs,
- a 50 percent reduction in dyspepsia-related sick days (as well as a reduction in non-dyspepsia-related sickness), and
- a 58 percent reduction in GP visits (more than balancing the increased cost of immediate endoscopy and other specialist visits).

This is the way to manage drug costs: searching empirically to discover how diseases can best be managed and reviewing all the steps required in the management of disease. The study clearly shows the tradeoffs that occur between drug and investigational budgets and between health funds, social welfare funds, and personal spending. Such conclusions reflect the real world of life and medicine. They stand in sharp contrast to the introspective, emasculated theorizing of the bureaucrats now directing the demise of so many health care systems around the world.

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8 P. Bytzer, J.M. Hansen, and O.B. Schaffalitzky de Muckadell, "Empirical H2-Blocker Therapy or Prompt Endoscopy in Management of Dyspepsia," in *Lancet*, vol. 343 (1994), pp. 811-16.

The Great Debate About Reference Pricing of Pharmaceuticals

David Moore and Alister Scott
***moderated by* Michael Walker**

Michael Walker: The first rebuttal will be given by David Moore. After the speakers have given their rebuttals, then we will have your questions and comments from the floor.

David Moore: Some people seem to think health care spending is a bottomless pit. How much use would Dr. Scott be to his patients if health care in New Zealand went bankrupt? He seems to be saying, "Give me a blank cheque to spend money."

If you strip away the clouds of argument around the essential polemic, it reads: doctors know best, doctors are the patients' advocates, and every patient is different. But if there is one thing I have come to understand, it is that medicine makes economics look like a precise science.

Dr. Scott has left you thinking that there is a lot of difference between all these various H2 antagonists. A booklet from the Sullivan Re-

search Centre at St. Joseph's Hospital in Hamilton, Ontario, written by an internationally renowned group of doctors, says: "Under most circumstances, all H2 antagonists are clinically similar but they differ greatly in price. When H2 antagonists are compared for safety, only subtle differences are found to exist." The booklet goes on to recite a number of myths. For instance, "Myth: cimetidine must be given more than once a day. Fact: all H2 antagonists can be given as a single daily dose in the evening." We need to look to the evidence. We use evidence—medical and scientific evidence—to back up the use of reference pricing as an economic instrument.

Reference pricing is the common sense which cuts through all of the hype and delivers on its promise. Reference pricing has enabled a small country like New Zealand, with a very restricted health budget and just 3.5 million people, to have a stable, high quality health care system and still allow for growth.

MW: Thank you for your rebuttal. Alister Scott, you now have time for your rebuttal.

Alister Scott: I have listed here the therapeutic options in reflux esophagitis just to make the point that reference pricing will not actually slow the escalation in costs. If you look at the cost per tablet and recognize that H2 receptor antagonists for reflux esophagitis have to be given in multiple doses and can be combined with motility-reducing drugs, you may wind up using drugs which are in different therapeutic categories to achieve a particular purpose, a purpose which can actually be achieved more simply and more cheaply by a drug which is not listed within a particular therapeutic group.

The Associate Minister of Health in New Zealand, Mr. Morris Williamson, is the person who mainly takes responsibility for pharmaceutical benefits. He said in a news release: "If a new medicine is better for patients, or more cost-effective, then it will be subsidized." This is a political statement: no ifs, no buts, no maybes. He went on: "There is no way that public money should be spent to buy or subsidize drugs which offer no effective improvement over existing medicines." This tells you that there is to be no competition either. Finally, he stated that he does "not believe drugs should be subsidized which are slightly more effec-

tive while there are others as good." If you can make sense of that, then you can probably make sense of reference pricing.

MW: If I understand what Mr. Moore is saying, the New Zealand government aims to save $NZ 42 million a year with reference-based pricing. That works out to about $NZ 11 per person per annum. Are you telling us that $11 per person per annum is going to save health care in New Zealand?

DM: $NZ 42 million is roughly 5 percent of our pharmaceutical spending—5 to 7 percent. It is important to note that this is not a private-public sector debate. The health management organizations who have come to us in New Zealand with ideas have indicated that you can save between 10 percent to 20 percent by the use of economic instruments without cutting across patient access. With reference pricing's 5 percent, we have practically achieved this goal.

MW: It is admirable how you have pushed down the cost of health care in pharmaceuticals. That is good, but it seems to me that this is only possible for New Zealand, given that you are such a small market. But you could not really recommend reference pricing as a solution for larger economies because, in the end, if prices were pushed down to the bare minimum, you would leave the pharmaceutical companies without enough money to really carry on their research and the flow of drugs would reduce the market. I can see you are getting some benefits, but other people are paying for it.

DM: Every country has to look to its own mix of health services and decide where it wants to go. We have been practising reference pricing in New Zealand since the 1980s: it is nothing new to New Zealand. Whether it is good for Canada I have no idea, nor could I comment.

But do not get the idea that we have low drug prices in New Zealand. In fact, we have in certain instances some of the highest drug prices in the OECD. We quite often buy new technologies very early and then are obliged to wait for the second, third, fourth, fifth, sixth entrant to bring the price down. So I think we certainly do make our contribution to pharmaceutical company profits. Besides, we are not paying for research. We are not paying for tomorrow's research, let alone yester-

day's research. Most of the money in pharmaceuticals in New Zealand goes into marketing, sales teams, glossy brochures, flying doctors to attractive facilities for ski weekends.

MW: That certainly may be true, but I remember a few years ago when we were talking about the inutility of advertising and why should we spend so much money on advertising. We now know from a considerable amount of experience that if you only have one kind of automobile it is of inferior quality, and nobody wants to drive it. Advertising is part of the economic process. While you may not think it is essential, we have this experience of what happens in economies where there is nobody competing, when there is no contention for the market. And contention happens through advertising and the variety of ways in which that is done.

DM: We have 6 or 7 ACE inhibitors in New Zealand. We are unlikely to see a generic ACE inhibitor before the year 2000, and we have quite high ACE inhibitor prices. I do not think there is any fear of pharmaceutical companies going broke on ACE inhibitors.

We have a list of 2,500 drugs. We purchase new drugs every year at quite a rate. In fact, I was looking at comparative Canadian figures for new registrations and acceptance of applications. In some instances, we have run out of money in New Zealand but we still approve 70 percent of the drug applications that come through our door.

MW: Dr. Scott, are doctors prohibited from prescribing certain therapies or is your complaint basically that because some of the drugs are subsidized, patients might prefer to have the lower-cost therapies where you might prefer some other course of treatment?

AS: Doctors are free to offer any advice. Doctors will offer the best advice for their patients, but can their patients take the best advice? If the best advice involves a treatment which is not readily accessible to them, the doctor's advice is really missing the point. It is the patient who is disadvantaged.

The patients are disadvantaged if they have to make copayments that are difficult in their economic circumstances, and patients are disadvantaged within the public system if they cannot buy their way out of

waiting lists. Our median waiting times are measured in months: 10 months, 15 months, 18 months.

MW: Mr. Moore, is there a restriction on the health care of seniors with these subsidized drugs? Are their reactions monitored? What happens if patients need a different drug?

DM: At the individual level, there are always exceptions. We pick up these exceptions through what is called an "exceptions policy," where case-study evidence is provided to the Regional Health Authority and the person may then receive a different drug via this process. So there is always some sort of give in the system to deal with individual patient needs.

MW: Can a person in New Zealand choose to buy any drug he wants? Is it just that the government will not pay for it?

DM: Yes.

MW: And the government is implicitly endorsing a particular drug and treatment? And there is a kind of tension between the doctor and the government as to who is right about it? Is that essentially what it comes down to? So it is not a matter of paying, it is a matter of whom do you trust—your doctor or the government?

DM: The government, of course, works with doctors. If we did not have doctors on our side, it would be very difficult to implement the policy. Patients can buy their own medicines. We have seen some of them advertised on television directly to patients, which is a process that we as health purchasers feel entirely comfortable with.

MW: With reference-based pricing, did New Zealand lose R&D jobs in pharmaceuticals?

AS: There is no primary pharmaceutical research in New Zealand except with respect to a very narrow range of cancer drugs. Otherwise there is no drug development going on in New Zealand. New Zealand

doctors do play quite a large part in the evaluation of existing drugs, though.

MW: It is generally acknowledged that increased drug use is responsible for escalating drug costs. What has New Zealand done to address this important cost driver?

DM: The main reform has been doctor budget holding where quite a number of doctors are involved with budget holding schemes. If there are any remaining funds at year end, the doctor ploughs that money back into providing free consultations, bus trips to local health care organizations...some doctors have bought bone density scans, and so on. So, while there have been some supply-side reforms, the reforms have tended to focus on the demand side.

MW: Did New Zealand measure the impact of reference-based pricing on other budget envelopes? For example, doctors' specialty referrals, hospitalization, etc.? In other words, did New Zealand measure the net effects on total health care costs?

DM: In New Zealand, we do not have patient registers, so it is very difficult to measure these effects. We try to work as best we can within an integrated health budget to get the best possible health care with the money we have.

AS: It is one of the tragedies of the New Zealand reform that very little research has been done to see what the impact has been. Even important data like waiting list data have not been collected and published by the Ministry of Health. It has been left to private and voluntary organizations to document what has been happening in the health sector in the two years since reform. The information they have is that the number of people on waiting lists has increased by 18 percent in the last two years and waiting times have increased by almost as much as well.

The available evidence (which is very poor evidence) about the movement of patients into other parts of the health system is that acute medical care, which is offered by the hospitals, is being increasingly demanded. No one quite knows why this is, but there is a very strong suspicion that it is because primary care has become less adequate. And one

of the issues within primary care is the availability of the appropriate drugs at the times patients need them.

MW: If I go to a doctor, I still have to pay for myself?

AS: Yes, if you visit a primary care doctor you have to pay a substantial amount of the consultation fee. If your income is over $NZ 33,000, you pay the entire consultation fee. If you are indigent, you pay around 40 percent to 50 percent of the fee, and if you are a child you pay slightly less. Beyond this are the barriers posed by the pharmaceutical copayments or, in some instances, premiums. It is a very complicated system.

MW: Are the hospitals pay as you go?

AS: No, the public hospitals are almost fully funded. You may have to pay a small amount if you are an out-patient and you have a relatively high income—not that $NZ33,000 per year is a particularly high income. So in the public hospital you do not pay. You are admitted immediately if it is an emergency, if you have an acute condition. If you do not have an acute condition you go on a waiting list. What has been happening in New Zealand hospitals is that a larger and larger portion of their work is acute care, much of which we at the hospitals believe should have been handled at an earlier stage in primary care. As a result, elective care is becoming increasingly squeezed, and the waiting lists are increasing.

MW: If it is true that the savings on the pharmaceutical side are $NZ 11 per head and it costs $NZ 30 to go see a general practitioner—in other words, if one-third of the people have to go back for one extra visit because a drug is not working—that wipes out any savings from the move to reference pricing. It would not take very many of these visits—which are being paid for by the patient—not only to wipe out your savings, but in fact to be more costly than the situation was before you started out. But you are not going to capture these effects because you are only looking at your budget and not at the patient's budget. Is this the case?

DM: No, this is not the case. We look at a list of seven different criteria, one of which is direct cost to the users. There have been savings from the reference pricing of H2 antagonists. Because there is enough competition in the market, all of the drug companies met the new level of subsidy and so there was no increase in patient cost. Again with Prozac, there was no additional patient cost. All of these were free gains to health care which indeed have been ploughed back into the system.

Part II: The Health Care System in Canada

Improving Health Care for Canadians

William McArthur, Cynthia Ramsay, and Michael Walker

SECTION I

From 1867 to 1984—a brief historical perspective

The BNA Act of 1867 (and the *Constitution Act* of 1982) gave the federal government responsibility for national health concerns such as quarantine, marine hospitals, and health services for aboriginals and the armed forces.[1] The provinces were given control over local health matters such as hospitals, asylums, and charities in and for the province. Since health

1 This section draws on numerous documents. Important among these are: *The Royal Commission on Health Services*, vols 1 and 2, Ottawa: Queens Printer, 1964 and 1965; A. Crichton, D. Hsu, and S. Tsang, *Canada's Health Care System*, Ottawa: CHA Press, 1994; Michael Walker, "Anatomy of a Conundrum: Canadian Health Care in the 1980s," in *Policies and Prescriptions*, Australia: The Centre for Independent Studies, 1986, pp. 23-43.

care was identified with hospitals, it was considered to be a provincial responsibility.

In the 19th and early 20th centuries, Canadians paid doctors, hospitals, pharmacists, and other health care providers out of pocket when they received a treatment or service; user fees were the method of payment. The government funded public health services only. For those people who could not afford to pay for their care, there were three types of social safety net: philanthropy, social assistance, and mutual aid. In larger cities, voluntary organizations proliferated, giving aid to specific groups of low-income people.

Despite the availability of alternative forms of aid, municipalities assumed most of the responsibility for looking after the poor. By 1914, they also monitored infection control, set up sanitary services, and provided some public nursing. Many offered part-time public health work to doctors. Because of the benevolent nature of their work, many people thought that these doctors should be guaranteed work as personal practitioners for the rest of their time, and, in 1916, the Municipal Doctors' Scheme was introduced in Sarnia, Saskatchewan; doctors were paid from taxes to provide clinical services to residents. The scheme was soon introduced in other provinces as well: in rural areas, mining towns, and heavily industrialized towns. About the same time, municipalities began seeking to join together to become hospital funding authorities so that they could set up hospitals to attract doctors (whose incomes would be guaranteed by the Municipal Doctors' Scheme).

During the Depression in the 1930s, there was general financial hardship, and the medical profession was not exempt. Organized medicine responded to the situation by pressuring both the federal and provincial levels of government to provide some type of first-dollar health insurance for low income persons and the unemployed. The Depression prompted the growth of medically sponsored prepayment plans and non-profit hospital insurance sponsored by provincial hospital associations.

Universal health insurance was first proposed in 1919 by Mackenzie King as part of the Liberal party campaign platform. It was recommended by organized labour on a regular basis thereafter. The government of British Columbia actually passed an *Act to Provide for a Provincial System of Health Insurance* in 1936 but it was rejected by the

medical profession and, in the end, it was never implemented. In Ontario, the entrepreneurial spirit was stronger than the spirit for government intervention. Doctors in Ontario were forming prepayment schemes, customarily offering first-dollar coverage and providing direct payment from the plan to the practitioner. In Windsor, doctors formed the Essex County Medical Society and began a non-profit medical services prepayment program for hospital care that was adopted by Toronto doctors (the Blue Cross). During the 1940s, as economic growth in Canada continued, more people contributed to these types of plans for both hospital insurance and medical care. In 1943, privately operated hospital insurance began in B.C., and by the early 1950s most Canadians had some form of hospital insurance, whether publicly provided, non-profit or commercial.

In 1945, there was a federal-provincial conference (the Dominion Provincial Conference on Reconstruction) to consider programs of social reform. The conference produced a draft health care bill for the provinces, modelled partly on the U.K. National Health System which was influenced by Britain's main reformer of the time, Lord Beveridge, who advocated that the state provide social security programs for its citizens from cradle to grave. Patients were to register with family physicians in health regions. These family physicians would be responsible for their patient "lists" and would be paid on a capitation basis administered under the direction of a commission representing both consumers and the professions.

The plan was not enacted because it was seen by the governments of Ontario and Quebec as a federal encroachment on the provincial authority granted them in the BNA Act, and many provinces favoured free market insurance. Instead of a full health insurance plan, the federal government made grants available to the provinces for planning and hospital construction through the Hospital Construction Grants Program (HCGP) of 1948. Under this legislation, the federal government completely funded the building of hospitals virtually anywhere in Canada. It is not surprising that over the next 12 years the number of hospital beds in Canada increased at double the rate of the expansion in population, and thereby created a bed surplus, the need for which had not been established.

By 1950, Saskatchewan (1947), British Columbia (1948), and Alberta (1950), had enacted universal hospital insurance plans. Other provinces

followed suit. As a result of the HCGP, the number of hospital beds in Canada increased, costs increased, and the provinces soon asked the federal government to legislate the nation-wide universal hospital insurance it had offered them back in 1945. Instead, in 1957, the *Hospital Insurance and Diagnostic Services Act* (HIDS) was passed. Prior to 1957, Canada's health prepayment system was a composite of public and private plans: provincial medical and hospital coverage for low income individuals, universal hospital insurance provided by a number of provinces, private medical and hospital insurance on a non-profit basis sponsored by provider associations, and a limited amount by for-profit private insurers. By 1961, however, all of the provinces had adopted universal hospital insurance because the federal government was paying 50 percent of the average provincial costs.

The main problem with HIDS was that services were insured and eligible for cost-sharing only if they were provided in hospitals; there were no incentives to use less expensive sites (i.e., home care). Also, there were no organizational framework impositions on hospitals—there was no accountability for the funds required. If a hospital did not spend its entire allotted annual budget, the province would reclaim the unspent funds. However, if a hospital needed additional funding, the province would provide it. This created disincentives to run a hospital efficiently. The number of in-patient beds increased by a further 34 percent from 1960 to 1970, while the Canadian population increased by only 19 percent.

In 1964, the Hall Commission made its report, recommending that the federal government cost-share a universal medical insurance model and that medical services delivery should be reorganized. The *Medical Care Act* of 1966 (implemented in 1968) did not incorporate the reorganization recommendation. However, it did provide federal-provincial cost-sharing for services provided by physicians (only). To qualify for funding, a province's program had to be:

- *universal*—it had to cover all residents of a province,
- *portable*—it had to cover residents of one province requiring medical services in another province,
- *comprehensive*—it had to cover all medically necessary services, and
- *publicly administered*—a non-profit program.

Saskatchewan and British Columbia qualified for funding immediately. B.C. had initiated the B.C. Medical Plan in 1965. Alberta and Ontario were slow to join because there was strong lobbying by private insurance interests, and Quebec endured a specialists' strike. By 1971 though, all provinces and territories had joined the plan.

Hospital costs continued to grow, in part because the federal government had no control over total provincial expenditures, and in part because the provinces had little incentive to contain costs. As a result, the cost-sharing agreement was replaced in 1977 by Bill C-37, the *Federal-Provincial Fiscal Arrangements and Established Programs Financing Act* (EPF). The EPF reduced the direct federal contribution to health care and tied any increases in federal payments to GNP growth. To compensate, federal income and corporate taxes were decreased to create "tax room" for the provinces. The conversion from a federal-provincial cost-sharing agreement to one based on block funding had little if anything to do with any desire by either level of government to improve medical or hospital care delivery. The EPF allowed the federal government to limit its health care expenditures and it gave the provinces greater control over how the money for education and health was to be spent.

The Canada Health Act

In 1984, in spite of much opposition from both organized medicine and from provincial governments, the federal government passed the *Canada Health Act* (CHA) which reiterated the requirements of the 1966 *Medical Care Act* and added another: accessibility. Federal payments to the provinces would be reduced, on a dollar-for-dollar basis, by the amount of user charges by hospitals and extra billing by physicians. Direct federal prohibition of these fees was impossible because, constitutionally, health care is a provincial responsibility.

As table 1 indicates, there has been a steady decline of federal financial support for health care since the late 1970s. In 1995, the federal government announced that it would cut federal transfers to the provinces further. As federal funding decreases, these funding arrangements will become less and less binding, and provinces will find themselves with more freedom to reform their health care systems.

Table 1: Provincial Funding as a Percentage of Total Federal and Provincial Funding of Health Care

Year	NF	PEI	NS	NB	PQ	ON	MB	SK	AB	BC	Cda
1970	31	31	32	46	72	56	46	36	44	58	56
1975	44	38	34	39	75	57	44	40	49	62	58
1980	42	37	40	46	69	63	47	53	64	71	63
1985	42	40	52	47	67	73	60	65	78	71	69
1990	59	56	63	63	73	83	68	73	82	81	78

Source: Isabella Horry and Michael Walker, *Government Spending Facts 2*, Vancouver: The Fraser Institute, 1994.

Much of the recent debate about health care has focused on the sanctity of the CHA and its principles, rather than whether or not adherence to these principles actually creates a healthy population or permits health care delivery systems to adapt. The federal government and some provincial governments are defending the act as an essential pillar of the future health care edifice. Others, including Premier Klein of Alberta, have expressed concern that the CHA is now an impediment to the kinds of changes that the provinces must make to respond to both the fiscal and the health needs of their citizens.

The ideological divide, of course, is the Alberta premier's idea that there may be an increased role for private clinics and other private health providers in the health care system of the future. Echoing the long-expressed opinion of The Fraser Institute, critics of the CHA note that the act is a kind of Great Canadian Myth honoured largely in the breach. Here we explore the sense in which such an assessment might be accurate, and why the *Canada Health Act* ought to be abandoned in favour of a modern, relevant alternative.

Universality

The principle of universality "requires" that 100 percent of the residents of a province be entitled to insured services. In spite of the fact that low income residents are exempted from the modest premium which must be paid in B.C., it is estimated by the B.C. Ministry of Health that only 97 percent of the residents of the province are actually covered by the Medical Services Plan, the provincial insurer. Therefore, contrary to the "requirement" that every British Columbian be insured, over 100,000 people are not publicly insured in B.C. A testimony to this situation can be found in the emergency departments of some downtown Vancouver hospitals, where about 10 percent of the British Columbians coming in for emergency care have no medical coverage.[2] In provinces that charge insurance premiums, the poor, the mentally challenged, and a significant number of healthy young adults who reject the thought of illness or accident have no coverage. Universal medical insurance is not a reality in Canada.

However, this does not mean that people are denied care. An uninsured person arriving at a hospital or in a doctor's waiting room with an urgent condition is treated. The universality provisions of the act are unimportant in that they are not being met, and there are few individual consequences as a result.

Accessibility

The existence of premiums neither hinders nor guarantees a person's access to medical care. There are data showing that access to service in Canada is not equal. For example, much of the queue jumping in British Columbia is for non-medical reasons. Politicians, health professionals, and the influential often obtain care more rapidly than most other citizens.[3] As well, any wealthy Canadian has the option of receiving more expedient treatment in the U.S. or in another province with shorter hospital waiting times. Contrary to the belief that within

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2 W. McArthur, Personal communication with Dr. J.M. Etherington, Head, Emergency Department, St. Paul's Hospital, Vancouver, B.C.

3 D.H.A. Amoko, R.E. Modrow, and J.K.H. Tan, "Surgical Waiting Lists II: Current Practices and Future Directions Using the Province of British Columbia as a Test Study," *Healthcare Management FORUM*, vol 5, no. 4, 1992.

Canada there is equal access to health care services, a Fraser Institute study has shown that waiting times for surgical procedures vary greatly across the country, with wealthier provinces tending to have shorter hospital waiting lists.[4]

An Ontario cancer treatment study has shown that waiting times for cancer treatment in Canada are substantially longer than in the U.S. and longer than the time radiation oncologists consider to be the medically acceptable maximum.[5]

While unequal access is a fact of the Canadian health care system, controlling costs through the use of waiting lists, i.e., through rationing, is not accepted by the public as a satisfactory cost containment measure. This was revealed in British Columbia when the government, in response to pressure from vociferous patients waiting for treatment, allocated more than $25 million towards cutting waiting lists for surgery and to reduce waits for publicly funded magnetic resonance imaging (MRI) machines.[6]

The latter development reflected the fact that there are two private MRI clinics in Vancouver charging $595 to $750 a test. They are open 6 days a week and guarantee test results within 48 hours. They are evidently fulfilling demand for diagnostic testing which is not being met by the public system.

Portability

The Canadian who gets sick in Florida or California rapidly discovers that effective portability ceases at the Canadian border. Quebecers who find themselves requiring medical services in another Canadian province must pay out of pocket for those services. Upon returning home, they will be reimbursed only for the amount these services would have

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4 "Waiting Your Turn: Hospital Waiting Lists in Canada," *Fraser Forum Critical Issues Bulletin*, various editions.

5 W.J. Mackillop, "Waiting for Radiotherapy in Canada and the U.S.," presented at the 36th Annual American Society for Therapeutic Radiology in San Francisco, October 3, 1994.

6 Office of the Premier of British Columbia, "$25 Million to Reduce Cancer Treatment and Surgery Waitlists," News Release, April 4, 1996.

cost if performed in Quebec. This occurs because there is no reciprocal billing agreement between Quebec and the other nine provinces.

Comprehensive

The list of services covered by the CHA is not comprehensive by any means. Hospital insurance only covers services performed in a hospital, and medical care insurance covers services performed by a restricted set of primary providers; they both only cover services designated as medically necessary and there is no consensus on what constitutes medically necessary services. Since health is a provincial responsibility, different provincial insurers cover different procedures.

Although B.C. ostensibly would like to "preserve Medicare," earlier this year it was considering de-insuring non-essential services. For example, the removal of warts may no longer be covered by the Medical Services Plan. This procedure is no longer covered in Alberta, Saskatchewan, Manitoba, or New Brunswick. Across the nation, coverage varies widely in the areas of cosmetic surgery, reproductive services, and general health maintenance. For example, reversals of tubal ligations and vasectomies are always covered in Ontario, Quebec, New Brunswick, and the Yukon; they are sometimes covered in Nova Scotia, Newfoundland, and the Northwest Territories, while patients in B.C., Alberta, Saskatchewan, Manitoba, and P.E.I. must pay for these procedures. Another example is electrolysis, which is covered only in B.C. and in three other provinces or territories.[7]

Some people argue that de-insuring services would not save money, while others claim that de-insuring would make it harder for the government to control the quality of services, and thus leaving procedures to the private sector could cause the public sector more expense in the end. Health economist Robert G. Evans from the University of British Columbia gives the following example to support these claims. Even if *in vitro* fertilization is not covered publicly, "a couple's sickly quadruplets will end up, at public expense, in the hospital."[8] All of this will cost the public system more money in the end, presumably.

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7 *Vancouver Sun*, March 23, 1995, pp. B1 and B12.

8 *Ibid*, p. B12.

Evans's comment betrays the implicit controversy about medical necessity that underlies the debate about the boundaries of the public health care system. It also shows how shallow are the arguments against private sector participation in the delivery of health care services since there are all sorts of activities that *might* increase the number of medically necessary procedures—from skiing accidents to excessive consumption of alcohol, fats, and some vitamins. This does not mean that the public sector ought to be the exclusive operator of ski hills, bars, restaurants, or health food stores!

The problem is that, as has recently been determined in Oregon, while it is possible to rank medical interventions according to their efficacy and necessity, the ultimate question of how far down the list the public sector will go is not a medical question but a fiscal one. In the end, all questions about medical care are questions about economics. It is the denial of this central fact which is the Achilles heel of the *Canada Health Act* and the main reason it is proving to be an impediment to the smooth and effective adaptation of the health care sector in Canada.

Publicly Administered

This provision of the CHA, reflecting the British *Beveridge Report* which inaugurated socialized medicine in the U.K., is a purely ideological manifesto. There is nothing about the principles of universality, accessibility, portability, and comprehensiveness that require health care to be publicly administered. Indeed, it is increasingly believed by some analysts that the publicly administered principle is incompatible with the others and that it is the single biggest impediment to achieving them. Nevertheless, it is the central belief of those who support the status quo.

The main argument in favour of government administration of the health care system is that it will minimize the cost of administration which would otherwise be involved. A multiplicity of insurers would entail duplication of billing and administrative functions, as occurs in the United States. Indeed, studies have shown that great administrative savings can be achieved if duplication is eliminated. What is not often appreciated is that there are also costs involved when there is only one supplier—something which has been recognized by economists and others with respect to the markets for all other goods and services. In fact, in most democratic countries, regulatory agencies exist to prevent monopolies from occurring. The reason monopoly is feared is the dete-

rioration which typically occurs in the markets it visits—including higher prices, lower quality of service, lagged innovation, and loss of consumer satisfaction.

The same problems typify the markets for health care. For example, government is the monopoly employer of health care personnel. When labour negotiations break down in a monopoly system, there are no other sources of care available, and the patients pay the consequences. Strikes, such as the 17-day B.C. nurses' strike in 1989, effectively shut down most of a province's health care system.[9] As a result, treatments are delayed and patients suffer unnecessarily. This type of cost is difficult if not impossible to measure and is never reported by the proponents of monopoly health care.

Summary

The post-World War II history of health care in Canada is one characterized by a constitutionally constrained federal government exercising its fiscal powers, with taxpayers' money, to make itself a major player in the health care system. Initially, federal funds were used to build hospitals, the need for which had not been proven. Universal insurance for hospital care ensued—insurance for care which in many cases could and should have been provided in less expensive and more effective environments than hospitals. Having paid for the construction of the hospitals and for the care provided in them, it remained only for the federal government to pay doctors to work there, and this it accomplished with the *Medical Care Act*. The *Canada Health Act* merely reaffirmed the leading role the federal government had cast for itself as the main provider and funder of health care in Canada.

Canadian health care and the OECD

Canada is a member of both the Group of Seven (G7) and the Organization for Economic Cooperation and Development (OECD). It shares many commonalities with the other countries in these groups. While there are many ways of examining and comparing the health of similar

9 Michael Walker, *Wall Street Journal*, October 18, 1991, p. A15.

populations, a few generally accepted measures help to place Canada within the context of its OECD partners.[10] By placing Canada in an international context, one can see how myths have come to define the Canadian "health care crisis." Working from these myths, the authors will now show why recent attempts at health care reform in Canada may be misdirected.

***Myth:* Health Expenditures are Directly Related to Health Status**

The Japanese have the longest life expectancy, at 82.2 years for females and 76.1 years for males (see figure 1). These figures are much lower for Mexico, where the average life expectancy of females is 74.4 years and for males is 68.4 years. In most OECD countries, however, females can expect to live 79 to 81 years and males 72 to 75. Canada is no exception: life expectancy for females is 81.2 years and for males 74.9 years. Perhaps surprisingly, life expectancy is not directly related to amount of money spent on health care. The percentage of gross domestic product (GDP) spent by OECD countries on health care varies considerably (see table 2).[11] For example, Denmark spends 6.7 percent of its GDP on health care while the U.S. spends 14.1 percent; yet life expectancy data are quite similar for both countries. Japan, at 7.3 percent, has one of the lower expenditures on health as a percentage of GDP but has notably longer life expectancies.

A more detailed examination of life expectancy information for Canada reveals some interesting trends. Both males and females can expect to live, on average, about five years longer than they did 20 years ago, but the progressive increase in life expectancy observed over the last 50 years appears to have halted, and the OECD reports that the number of years Canadians can expect to live in good health actually declined by 2.3 years for females (see figure 2) and 0.4 years for males between 1978 and 1991. At least part of this decline appears to be statistical

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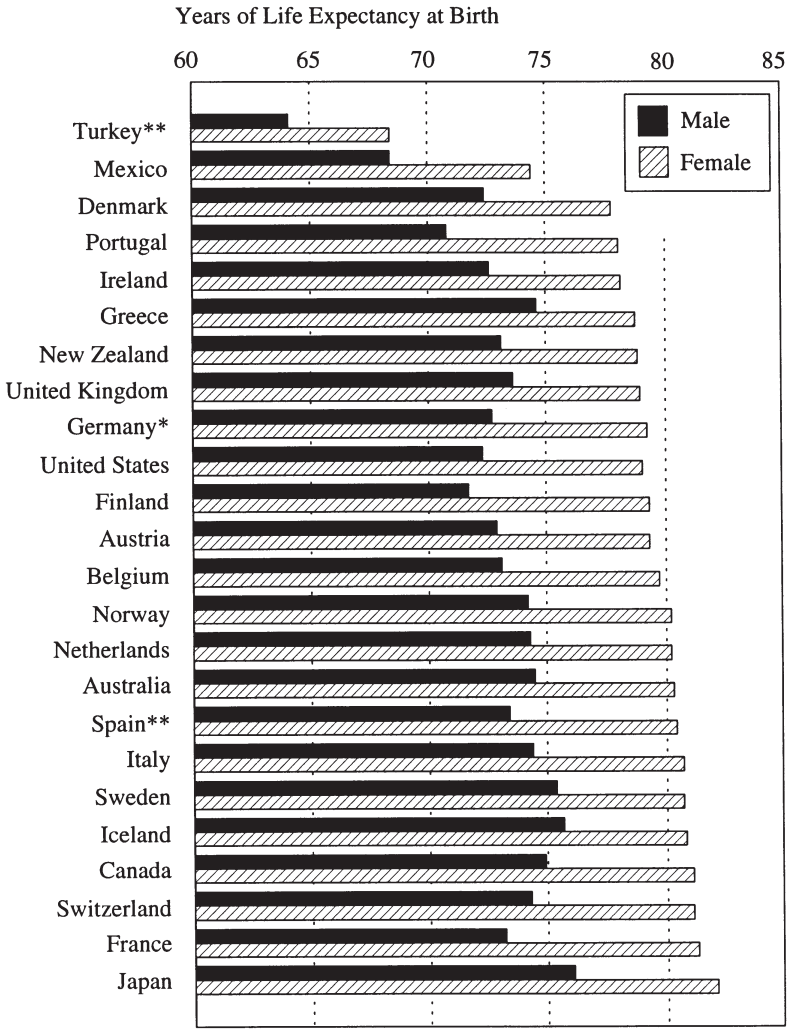
10 Much of the information here is drawn from OECD data released in May 1995, which provide statistics to the end of 1994. Comparative information is sometimes incomplete. Thus, it is sometimes necessary to use data from different years. The most recent available data have been used throughout.

11 Figures for total expenditure on health as a percentage of GDP are 1993 OECD data.

Figure 1: OECD Life Expectancy at Birth (1992)



Source: OECD Health Data, Electronic Version #3.6, released May 1995.

Table 2: Total and Public Expenditure on Health Care Expressed as a Percentage of GDP (1993)

Country	Total exp. on health as a % of GDP	Public exp. on health as a % of GDP	Country	Total exp. on health as a % of GDP	Public exp. on health as a % of GDP
Australia	8.5	5.8	Norway	8.2	7.6
Belgium	8.3	7.3	New Zealand	7.7	5.9
Canada	10.2	7.4	Austria	9.3	6.1
Denmark	6.7	5.5	Portugal	7.3	4.1
Finland	8.8	7.0	Spain	7.3	5.7
France	9.8	7.3	Sweden	7.5	6.2
Germany	8.6	6.0	Switzerland	9.9	6.8
Greece	5.7	4.3	Turkey	2.7	2.2*
Iceland	8.3	6.9	United Kingdom	7.1	5.9
Ireland	6.7	5.1	United States	14.1	6.2
Italy	8.5	6.2			
Japan	7.3	5.2			
Mexico	4.9**	2.9			
Netherlands	8.7	6.8			

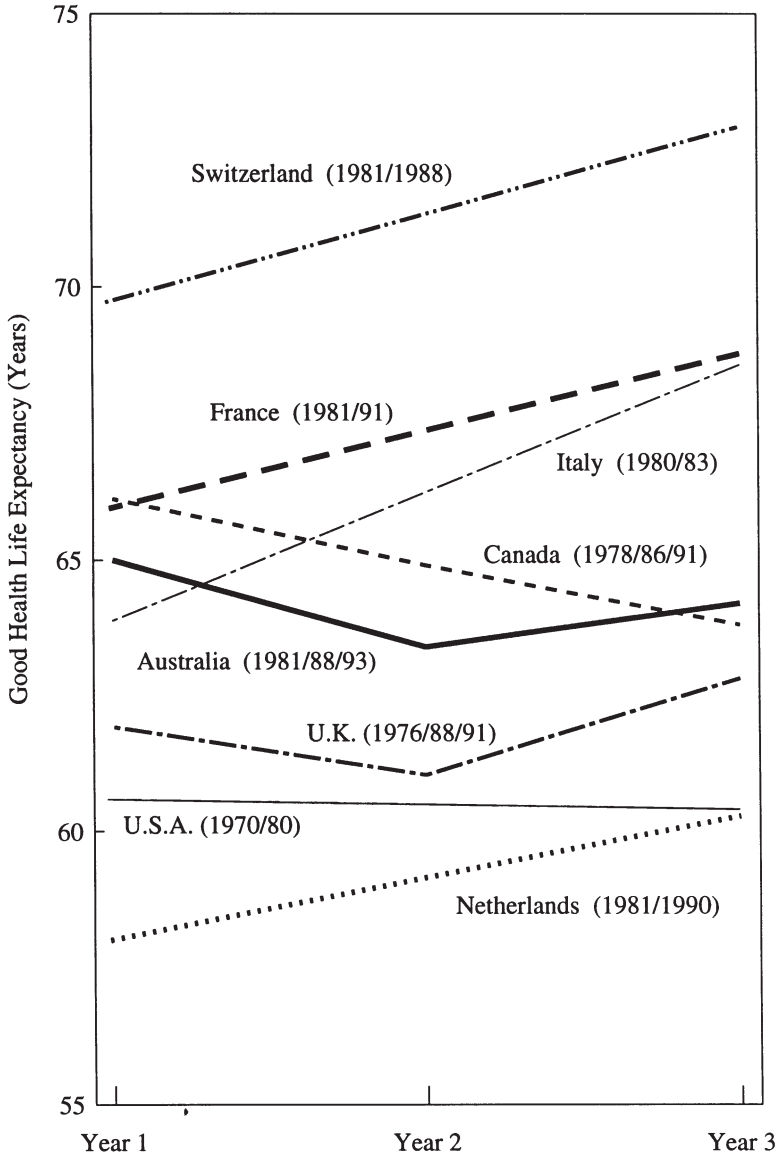
* = 1991; ** = 1992
Source: OECD Health Data, Electronic Version #3.6, released May 1995.

artifact, since data collection criteria changed between 1978 and 1986. However, the same standards applied in 1986 and 1991 and the data show that overall life expectancy at birth for Canadians declined in that time.[12]

The reason for this change is not obvious. However, there is a consistency between this development and the recognition in recent surveys that there is an increasing amount of rationing in the health care

12 Statistics Canada, *Health Reports 1995*, vol. 7, no. 1, p. 56. Preliminary reports indicate that this downward trend was not maintained in 1994. See Statistics Canada, *The Daily*, May 24, 1996.

Figure 2: Female Good Health Life Expectancy From Reporting OECD Countries



Source: OECD Health Data, Electronic Version #3.6, released May 1995.

system.[13] It has long been known that when rationing emerges in a health care system, those most likely to feel the impact are the elderly.[14] The reason is that in a classic triage system, since those who are older benefit less (i.e. for fewer years) than those who are younger, older patients tend to be placed at the end of the queue.

Myth: A Publicly Funded and Controlled Health System is the Most Efficient and Effective Way to Ensure Quality Health Care

In terms of total health purchasing, the U.S. and Canada both spend in excess of 10 percent of GDP (see table 2). Other countries with reputations for excellent care, however—including Japan, New Zealand, and the U.K.—all spend less than 8 percent of their GDP on health care. A review of public expenditures on health care reveals a slightly different picture. Big spenders in this category include Canada, France, Belgium, and Norway, for which more than 7.0 percent of GDP represents taxpayer financing of health care. Canada's public expenditure on health care exceeds that of the U.K., Australia, and New Zealand by 1.5 percent of GDP or more, and the U.S. by 1.2 percent of GDP. These four countries, all with substantially different health care systems, provide a comparable level of care to Canada, and spend a substantially lower percentage of tax dollars to achieve it.[15]

Only the public sectors of Iceland, Canada, New Zealand, and Ireland spend more than 4 percent of GDP on in-patient care.[16] Canada's

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13 "Waiting Your Turn, Hospital Waiting Lists in Canada," *Fraser Forum Critical Issues Bulletin*, various editions.

14 E.A. Binney and C.L. Estes, "The Retreat of the State and Its Transfer of Responsibility," *International Journal of Health Sciences*, vol. 18, 1988, pp. 83-96; A.L. McKinnon, "`We've Got the Best Cared For Seniors in the Country': Impacts of Health Care Cuts and Reforms on Older Albertans," *Canadian Association on Gerontology Meeting*, Vancouver, B.C., Oct. 28, 1995; O. Agbayewa, "Suicides Among Elderly Linked to Societal Factors," *Medical Post*, vol. 7, no. 26, Oct. 10, 1995.

15 OECD data for 1992.

16 Treatment is classified as "in-patient" when the recipient is resident or remains overnight in a hospital or other facility, as opposed to "ambulatory care" where the patient goes to a facility or office for treatment.

4.3 percent of GDP spent on in-patient care is high when compared with that of countries such as Australia (2.9%), Germany (2.7%), the U.K. (2.7%), and the U.S. (3.6%).[17] These countries are among the technological leaders in the world, providing quality care in the in-patient setting, and they do so at a lower public cost than Canada. And Canada's public expenditure exceeds that of most of the OECD countries in other areas of health care as well. For example, Canada's spending on ambulatory care is triple that of New Zealand, Norway, or Ireland, without demonstrable differences in the quality of care being provided.[18]

***Myth:* There are too Many Physicians in Canada and not Enough Other Health Care Professionals**

Canada, with 5.5 percent of total employment composed of health care personnel, employs a larger percentage of health care workers than the U.K., Italy, or Spain. However, Canada is not a large employer of health care personnel when compared to Australia, France, Norway, Sweden, Switzerland, the U.S., and other countries (table 3).

Canada has more physicians as a percentage of its population (0.22%) than the U.K. (0.15%) or Japan (0.17%), about the same percentage as New Zealand and the U.S., but less than Germany (0.32%), Norway (0.32%), and Switzerland (0.3%).[19] It appears that in the developed world, medical considerations such as life expectancy, and cost considerations such as public expenditure on health care, are not directly related to the numbers of practising physicians or other health care personnel in any particular jurisdiction.

Nursing employment figures provide some of the most striking contrasts in the data reviewed. Canada reports that 1.12 percent of its population are employed as certified nurses, a figure exceeded only by Norway, Iceland, Finland, and Switzerland. The other G7 countries, however, report nurses as constituting less than 0.8 percent of their populations.[20] Furthermore, as table 3 shows, Canada joins Ireland, Ja-

17 OECD data for 1992.

18 OECD data for 1990.

19 OECD data for 1992.

20 OECD data for 1988 to 1993.

pan, and New Zealand in having nurses constitute more than 40 percent of the total health care workforce. Other health care professionals whose percentages vary widely among OECD countries include dentists and pharmacists. Practising dentists range from 0.7 percent of health employment in Mexico to 8.2 percent in Greece. Most of the OECD countries are in the 1.0 percent to 3.0 percent range, and Canada lies in the middle at 2.2 percent. Pharmacists range from 0.7 percent of health employment in the Netherlands, to 10.5 percent in Portugal. Germany, Australia, Iceland, the U.K., the U.S., and Canada all report that practising pharmacists make up between 2.0 and 3.0 percent of health employment.

***Myth:* Canadians Overuse Their Health Care System**

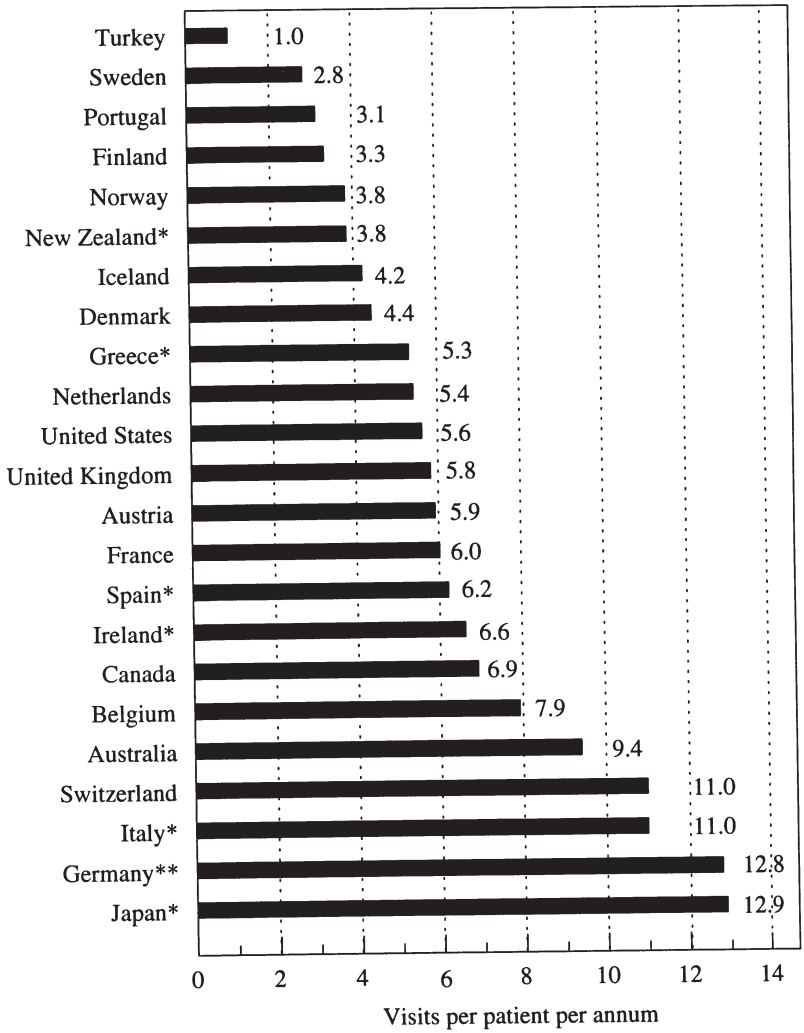
Information on primary care use is incomplete; there is little internationally comparable information regarding the use of diagnostic radiology, laboratory, and immunization services. However, significant information is available for physician use. Patient contacts with a physician range from a low of 1 contact per person each year in Turkey to a high of 12.8 visits per person a year in Germany. As figure 3 shows, Canada, with a rate of 6.9 contacts per person each year, has a considerably lower rate of use than Australia (9.4), Germany (12.8), Japan (12.9), and Switzerland (11.0), but a higher rate than the U.S. (5.6) and the U.K. (5.8). New Zealand reports only 3.8 contacts per annum, but this does not account for patients seen and paid for through the accident compensation commission, and it includes an estimate for those who pay their doctor's bill privately. Nevertheless, this figure raises the question of whether the sizable user fee of $30 to $35 paid by non subsidized patients to general practitioners in New Zealand is a disincentive for people to visit their doctors—a matter that requires further evaluation. Despite the information from New Zealand, however, it is apparent that Canadians come in contact with physicians much less frequently than Australians, Germans, Italians, and Japanese—at about the same rate as the French and Irish, and slightly more often than the British and Americans. Arguments that Canadians abuse their health care system by visiting their doctors too often, and that they must be encouraged to use the system "properly," are simply not supported by the data.

Table 3: OECD Medical Manpower (1989-92)
Numbers are for personnel actively employed

Country	Health Sector Emp. as % of Total Employment	All Physicians as % of Health Emp.	Consultants as % of all MDs	Dentists as % of Health Emp.	Pharmacists as % of Health Emp.	Nurses as % of Health Emp.
Australia	7.1	7.1	34.4	1.2	2.0	26.9
Belgium	6.0	15.6	40.5	3.1	5.6	—
Canada	5.5	9.0	41.2	2.2	2.6	46.7
Denmark	4.7	12.1	5.9*	2.3	0.8	29.1
Finland	7.4	7.4	55.8	2.7	4.2	31.4
France	**7.4	**9.5	48.7	**2.3	**3.1	**19.1
Germany	—	✧12.2	53.9	✧2.7	✧2.3	✧20.9
Greece	*3.3	*28.1	**55.7	*8.2	*6.1	**29.0
Iceland	6.8	8.6	—	*2.7	*2.6	*39.4
Ireland	5.3	10.1	—	2.3	1.8	42.4
Italy	4.4	9.4	—	**3.0	**5.3	25.8
Japan	*2.4	*12.8	—	*4.5	*5.7	*47.0
Mexico	*1.5	12.3	43.9	0.7	—	21.2
Netherlands	6.4	*11.3	*29.2	*2.4	0.7	—
Norway	✧9.1	—	—	—	✧1.0	—
New Zealand	4.4	11.2	30.8	2.2	3.9	45.5
Austria	—	—	53.2	—	—	—
Portugal	*2.9	25.4	33.8	1.5	10.5	25.3
Spain	3.6	32.8	—	2.4	8.1	34.5
Sweden	9.9	5.6	62.2	2.0	1.2	18.3
Switzerland	9.9	5.9	33.0	0.9	—	—
Turkey	0.9	30.4	47.1	6.1	9.1	27.1
U.K.	4.7	7.1	—	1.7	2.7	—
U.S.	6.8	*7.9	✧50.9	1.9	2.3	22.5

Data are for 1991 unless otherwise indicated.
✧ = 1989; * = 1990; ** = 1992; — = no figure reported for 1989-1992.
Source: OECD Health Data, Electronic Version #3.6, released May 1995.

Figure 3: Physician Contacts per Person, per Annum



* = prior to 1990.
* = 1992.
Note: There is no data for Mexico.

Source: OECD Health Data, Electronic Version #3.6, released May 1995.

***Myth:* If Hospital Funding is Cut or Left to the Private Sector, Canadians Will Suffer; Some May Even Die**

The average length of stay (ALOS) in acute care hospitals in OECD countries varies from a low of 4.2 days in Turkey to a high of 12.4 days in Germany. Canada (8.6 days) has a longer length of stay in acute care hospitals than France (6.5), Sweden (5.5), the U.K. (5.1), the U.S. (7.1), and Australia (5.0).[21] In terms of efficiency, Canada has a bed occupancy rate of 78.6 percent, while Denmark, Belgium, Ireland, and Germany all have rates in excess of 80 percent. Canada does, however, fare better than the U.S., which has a bed occupancy rate of 66.2 percent, and the U.K., which has an occupancy rate of 76.2 (1986 data). OECD bed occupancy figures are not reported for New Zealand.[22]

The preceding comparison of hospital use statistics is important because hospitals account for approximately 38 percent of expenditures on health care in Canada. Since staffing hospitals accounts for approximately 75 to 80 percent of their costs, an international comparison of hospital staffing ratios is also interesting. Here again, there is enormous variation between countries. Japan has a staff-to-bed ratio of 0.8, while Mexico exceeds all other countries with a ratio of 6.1 persons per bed. The U.S. has the second-highest ratio of 3.6 persons per bed, while Canada reports 2.8 staff per bed.[23] The Japanese have the longest life expectancy, yet they are among the lowest public money spenders on health care, and provide hospital care with a staff-to-bed ratio just over one-third that of Canada.

The number of acute care beds per 1,000 population provides another insight into hospital expenditures (see figure 4). Canada, with 3.9 beds per 1,000 population, has slightly more than half the number of acute care beds per 1,000 population as Germany and New Zealand, which both have over 7 beds per 1,000 people. The U.K. (2.2), the U.S. (3.5), and Norway (3.6) provide hospital services with significantly fewer acute care beds per 1,000 population than Canada. These data,

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21 OECD data for 1991 to 1993.

22 OECD data for 1990 to 1993 unless otherwise indicated.

23 OECD data for 1990 to 1994.

like others, change with time, and British Columbia presently has under 2.5 beds per 1,000 people.

Canada, along with the U.K., Finland, and Turkey, are the only OECD countries that report private hospital beds as less than 5 percent of the total number of beds. In most countries, private hospitals play a significant role in the provision of care: Belgium reports that 61.8 percent of beds are private; Germany, 47.8 percent; France, 36 percent; the U.S., 81.6 percent; Australia, 39.1 percent; and New Zealand, 35.5 percent.[24] It must be emphasized that private ownership of hospitals does not imply that only patients with private insurance are treated in these facilities, but it does mean that these facilities are managed and run as businesses, with proper accounting procedures (accrual) and concern for efficiency and profits.

Conclusion

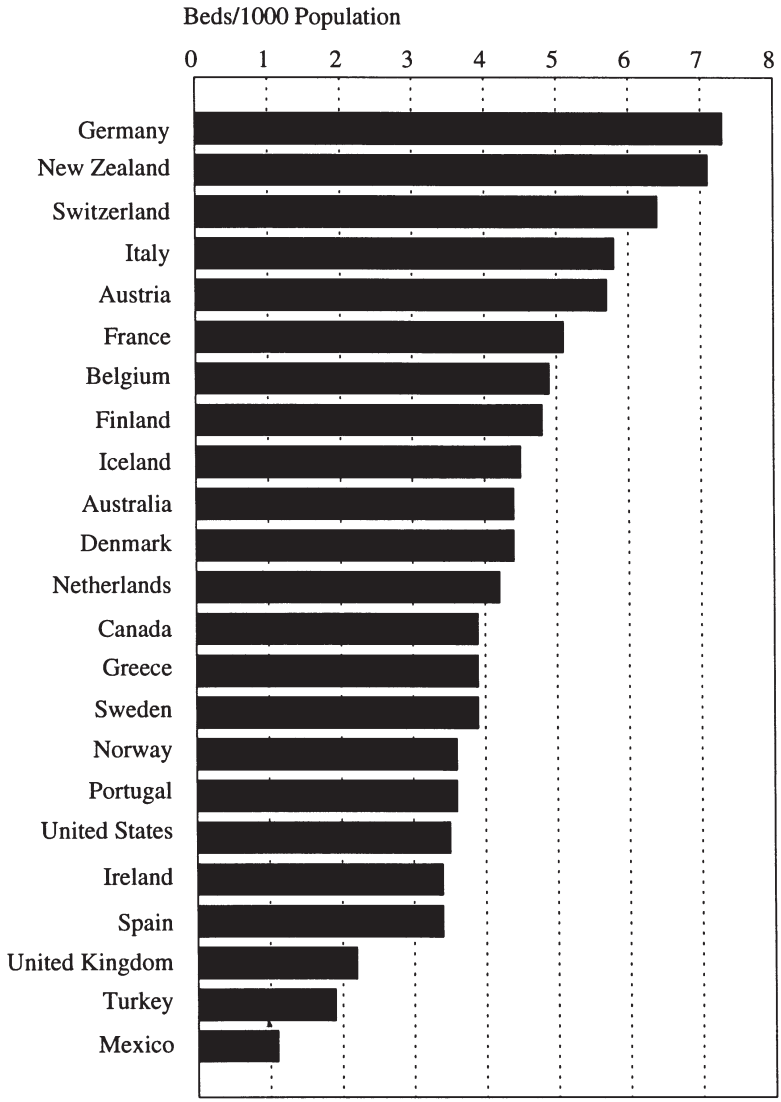
The direction of recent health care reform in Canada shows that the policy makers have bought into the myths rather than into what the data show. The myths have come to define the problems that the provinces are attempting to resolve. Their solutions will not be effective because the problems are ill-defined. Reducing expenditures on health care, closing hospitals, cutting the number of hospital beds, restricting doctors' billing numbers, and prohibiting private clinics are unproven "shoot from the hip" attempts at reform. The OECD data indicate that such measures will not necessarily improve Canada's health care system. On the other hand, some changes, such as increased privatization, do not create a threat to health care delivery as is often claimed and more often believed.

Primary care in Canada

Primary care services are those to which users have direct access without referral from another provider. Table 4 and figure 5 provide the 1992 figures for the numbers of professional and technical personnel actively employed in their fields and give some idea of the diversity of people and skills that go to making up the health care field. These figures repre-

24 OECD data for 1989 to 1993.

Figure 4: Acute Care Beds per 1,000 Population (1991)



Mexico is for 1986; Japan—no reports.

Source: OECD Health Data, Electronic Version #3.6, released May 1995.

sent total active health care employment and are not broken down between employment in primary care and employment in other areas. Many people in the categories listed work almost exclusively in direct contact with the public, and therefore are primary care workers. These include chiropractors, dentists, opticians, optometrists, pharmacists, and public health inspectors. Others, such as most nurses, laboratory and radiation technologists, and respiratory therapists work in hospitals or other secondary care facilities and come into contact with patients by referral from other health workers. They, therefore, are part of the secondary or tertiary care environment. Still others who assist primary care providers see patients by referral but are nevertheless part of the primary care environment; dental assistants and dental hygienists fall into this category.

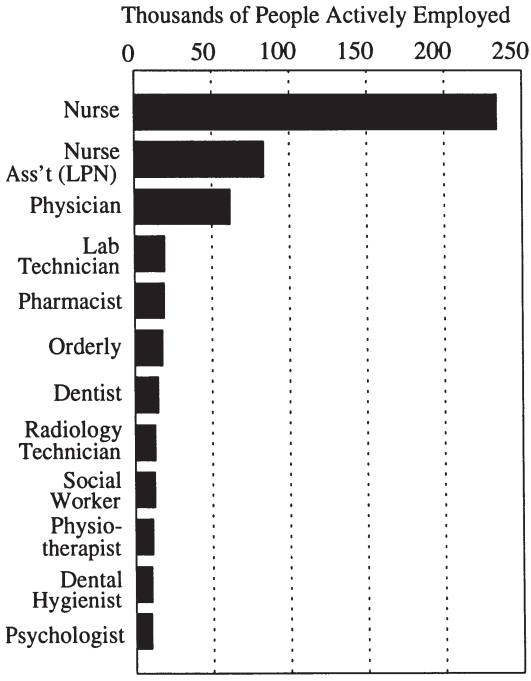
Other health care workers may seldom see patients but are still important providers of health care. Biomedical engineers and health service executives are representative of this category. Veterinarians treat animal disease and in so doing play an important health care

Table 4: Professional and Technical Employment (Canada 1992)

Professional/Technical Category	Active Personnel
Nurse	234,128
Nurse Assistant (LPN)	83,749
Physician	61,649
Lab Tech	19,367
Pharmacist	18,969
Orderly	17,763
Dentist	14,897
Radiology Tech	12,890
Social Worker	12,571
Physiotherapist	11,363
Dental Hygienist	10,529
Psychologist	10,118
Dietician	6,397
Licensed Veterinarian	6,369
Optician or Optometrist	7,086
Respiratory Therapist	3,848
Chiropractor	3,748
Audiologist/ Speech Pathologist	3,747
Health Record Administrator	3,457
Health Service Executive	2,824
Dental Assistant	2,091
Public Health Inspector	1,607

This chart does not include a further 7 categories of personnel, each of which employs less than 1,000 people. Source: Statistics Canada, *Health Professionals and Population per Professional,* 1992, table 32.1.

Figure 5: Canadian Health Occupations Employing more than



Source: Statistics Canada, *Health Professionals and Population per Professional,* 1992, table 32.1.

role by preventing and controlling the spread of disease through animal vectors. Rabies (hydrophobia) and hydatids (echinococcus granulosus) are examples of potentially fatal human illnesses for which veterinarians provide primary control.

Physicians are almost equally divided between generalists who specialize in providing primary care, and consultants whose practices are confined to discrete and carefully circumscribed areas of medicine or surgery. The role of the consultants is to provide advice or technical expertise to help the primary care physicians fulfil their responsibility for the co-ordination and management of overall patient care. In 1992, approximately 30,000 Canadian physicians provided primary care and approximately the same number were consultants who saw patients on referrals from primary care physicians.

Patients who elect to pay their own bills, as opposed to having them paid by the provincial insurance scheme, can, in theory, proceed directly to a consultant physician at their own expense. However, most consultants in Canada will not see a patient without a referral from a primary care physician, regardless of who is paying the bill. This is be-

cause the decision as to what consultant can most appropriately assess and treat a particular disorder is in itself a complex decision, one often beyond the ken of the best-informed lay person. For example, the investigation of headache is often performed by otolaryngologists, ophthalmologists, general internists, neurologists, rheumatologists, oncologists, and neurosurgeons. However, selecting the particular field of expertise and the particular individual with the most appropriate knowledge and training to assess a case is an exquisitely individual matter, and one of substantial importance since the selection of the appropriate consultant can have a profound effect on the outcome for the patient. This type of decision making is the domain of the specialist in general medicine, the family practitioner.

Primary care in Canada is organized in a variety of different ways. Most providers, including physicians, dentists, opticians, optometrists, chiropractors, veterinarians and many physiotherapists, establish independent practices, either solo or in some form of association with one or more of their peers. As in most countries, these individuals or groups of individuals are generally paid on a fee-for-service basis. In some circumstances, communities or provincial bodies have established clinics that incorporate a variety of different health care workers operating under one roof. Payment modalities are variable in these circumstances, but are often based on hourly or sessional rates. In some industrial settings, company clinics have been set up to provide on-site primary care to employees. The nature and extent of care varies greatly according to the circumstances; Stelco and Dofasco in Hamilton, and the "Big Three" automakers in Ontario offer examples of different types of primary care provided by industrial employers. Care providers in these circumstances are normally salaried. In many remote northern communities, initial primary care is provided by skilled registered nurses who have extra training in diagnosis and treatment, and who are salaried.

Issues in primary care

The notion exists in some quarters that the root problems in the Canadian health care system stem from two sources. First, the superabundance of approximately 30,000 primary care physicians who see too many patients too often for the purpose of increasing their individual incomes, and second, pharmaceutical companies making enormous

profits from the illness and misery of the sick and disabled. Neither of these concepts withstands scrutiny.

Earlier we revealed that Canadians come in contact with physicians less often than Australians, Germans, Italians, and Japanese, about as often as the French and Irish, and slightly more often than the British and Americans. Yet Australia, Germany, Italy, Japan and the U.K. all spend proportionally less on health care than Canada, while the U.S. spends more. These and other data reported above belie the suggestion that the primary care system in Canada needs to be dismantled and rebuilt. There are ways in which it can be improved, however, and these will be the focus of a later portion of this document. But efforts to enhance the present system usually tend to focus on the way primary care providers are remunerated, and this deserves a brief discussion at this point.

Payment modalities

As noted above, the mechanism for payment of primary providers varies considerably according to profession, place, local custom, and a variety of intangible factors, and has been the subject of extensive discussion and debate for many years. Several different systems exist and each comes with benefits and drawbacks.

Fee-for-service

Under this arrangement, the practitioner is paid a specific fee for each individual service rendered, and the fee is generally the same regardless of the complexity of, or time spent on each case. Fees are set by the practitioner, by the applicable professional organization, by the insurer, or by negotiation between the parties. Proponents of fee-for-service note that it promotes efficiency in service and provides an incentive for handling a large number of patients. Critics claim that there is a strong financial incentive toward a high volume, low density practice which is best described as treating a large number of patients with little or no illness. It is claimed that there is a strong financial disincentive to care for patients with complicated and time consuming complaints. Opticians, optometrists, dentists, chiropractors, veterinarians, physicians, and many physiotherapists tend to be paid on a fee-for-service basis.

Salary

Some practitioners work on contractual arrangements which may range from time-limited hourly contracts known as sessional fees to permanent annual salaried positions with agreed upon sickness, holiday, and pension benefits. Salaries may be supplemented by performance bonuses, and in permanent positions performance is usually rewarded with promotion. Proponents of salaried doctors point out that salaried arrangements permit professional providers to concentrate on the quality of service while liberating them from the pressure to treat large numbers of relatively healthy individuals in order to maintain a satisfactory income. Critics claim that salaried provision promotes inefficiency, laziness, and reduced productivity because of lack of incentives to increase work effort or quality. Health executives, nurses, laboratory and x-ray technicians, academic physicians, and many pharmacists are paid on a salaried basis.

Capitation

A capitation system is one in which a provider is paid according to the number of patients on his or her roster. A primary care physician might provide care for 1,500 to 2,000 patients and be paid a set amount for each patient from which to provide all of the patient's primary medical care. A practical variation of this approach is known as "weighted capitation." Here, the funding provided for each patient is weighted according to his or her age with a higher per capita payment for infants and the elderly, both of whom require more attention than the age groups in between. Table 5 reveals the average provincial health care expenditure for 1994 broken down by category of expenditure and age. Weighted capitation balances, to a degree, the disparity in costs of care at various ages. This arrangement discourages practitioners from taking only healthy young adults as patients and, in theory, promotes improved access for those who need more care. Other factors such as disability and chronic disease can be factored into the equation if desirable. Proponents of this approach claim that it eliminates the incentive to overservice, which is said to be inherent in fee-for-service payments, while its opponents claim that capitation provides an incentive to underservice and not provide necessary care.

Table 5: Per Capita Provincial Government Health Expenditures by Category of Expenditure and Age (Canada 1994)

Category	($ per capita, by age group)				
	Total	**0-14**	**15-44**	**45-64**	**65+**
Hospitals	794	163	331	717	3,857
Other Institutions	166	22	54	74	1,015
Physicians	343	201	282	410	716
Other Professionals	23	17	16	24	61
Drugs	93	10	23	62	572
Other Expenditures	222	100	208	159	597
Total	1,642	514	914	1,446	6,818

Source: Health Canada, Policy and Consultation Branch, *National Health Expenditures in Canada Summary Report 1975-1994,* January 1996, p. 22.

Capitation is not used extensively in Canada at this time, but it is seen by many physicians as a way of enabling them to concentrate their energies on patient care,[25] and also as a mechanism for reducing the presently increasing bureaucratic government intervention in medical practice. The College of Family Physicians of Canada and some provincial medical associations have been promoting forms of capitation in their proposals for amending the methods of primary provider remuneration.[26] On the other hand, government, through the Deputy Minis-

25 W. McArthur, personal communications. This is a frequent topic of conversation among family practitioners today, with many expressing interest in moving to capitated remuneration.

26 "A Discussion Document on Primary Health Care Reform in Canada," The College of Family Physicians of Canada, Sept. 19, 1995.

ters of Health Committee, has been promoting capitation as a means of overcoming perceived deficiencies in fee-for-service financing.[27]

One aspect of capitation that is seldom mentioned is that it brings with it rostering of the patients served. That is, every patient treated under a capitation scheme must be on the roster of a particular primary care physician and except in special circumstances, such as absence from the home community, must receive all their primary care from that doctor. Unless this proviso is included, it would be difficult to see any advantages in a capitation scheme. However, there is considerable doubt that Canadians, who seem to value their ability to "doctor shop," are ready to embrace what would probably be seen as a degree of regimentation not previously encountered in health care in Canada.

Summary

Each payment modality certainly brings with it specific benefits and disadvantages as well as incentives for certain kinds of behaviour by practitioners and their patients. To date, no one system has been universally satisfactory in any jurisdiction. In Canada, there appears to be a growing belief that capitation, or weighted capitation, may solve many of the health care dilemmas facing Canada. This presupposes that physician payments constitute a significant problem for health care in Canada, a suggestion that appears to have little or no factual support. Also, we must remember that the British have paid their primary care physicians on a capitation basis for nearly 50 years, and this has not been a panacea for the problems associated with delivery of health care there.

The reality is that altering the mode of payment to primary providers almost certainly will change the behaviour of those providers, but the results may be rather different from those anticipated, and not all beneficial. For example, as noted in part I by Margit Gennser, Swedish doctors are salaried and have little incentive to be productive. Consequently, they commonly see 12 or fewer patients per day and Swedes have an extraordinarily low physician contact rate of 2.8 visits per year (see figure 3). Any change in payment schemes will fail that sees provid-

27 "A Model For The Reorganization of Primary Care and the Introduction of Population Based Funding," The Advisory Committee on Health Services, B.C. Ministry of Health, July 18, 1995.

ers dragooned into a situation of which they neither approve, nor help to create. To be successful, reforms must create incentives to change.

Another and more attractive alternative to changing payment modalities is to change the way primary care is funded. In order to do this, funding must be directed to benefit individual patient care rather than make the individual patient fit into a preconceived bureaucratic concept of what the patient's needs are. This concept is discussed in greater detail later.

Pharmaceutical costs

An important aspect of primary care is the administration of drug therapy. In recent months, there has been considerable publicity regarding the cost of pharmaceuticals. In British Columbia, a program of reference-based pricing has been introduced in an attempt to reduce the cost to the taxpayer of publicly funded prescription medicines. Other provinces are considering similar plans.

The reference-based pricing policy in British Columbia states: "In consultation with an expert committee, therapeutic guidelines will be established and the best overall drug product(s) to treat a specific medical condition will be identified. Pharmacare will reimburse other drugs in the same therapeutic category based on the price of this reference product."[28] On the surface, this plan is beguilingly attractive. Patients whose pharmaceuticals are subsidized will be able to obtain, for just the dispensing fee, the drug selected by a government-appointed committee. The drug selected will be therapeutically equivalent to others in the category and it will be the least expensive. If the physician believes another drug is required, he/she has only to fill in the prescribed form and fax it off to the bureaucracy knowing that the likelihood that it will be approved is 95 percent. If the doctor's application is not successful, the patient still has the option of paying the extra cost above that for the government-approved drug and thereby obtaining it as a privately paid but subsidized item. The B.C. Ministry of Health estimates that this will result in savings in drug costs of about $30 million annually.[29]

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28 B.C. Ministry of Health, *Pharmacare Bulletin*, Aug. 25, 1995.

This and similar plans assume, first, that there is a problem to be solved, and second, that this type of approach is the way to solve it. These assumptions require a closer look.

Those who claim that there is a problem point to the fact that drug costs have increased more than other health expenditures over the last 20 years. In 1980, Canadians spent 14.7 percent of their total health care budget on all physician services, and a further 8.4 percent on pharmaceuticals. By 1994, these figures had become 14.2 percent for all physicians and 12.7 percent for pharmaceuticals dispensed outside hospitals.[30] However, the pharmaceuticals figure does not take into account the approximately $800 million in drugs used in hospitals and paid for in hospital budgets.[31] This $800 million represents more than 1 percent of total health care spending; thus, in 1994, Canadians spent almost as much on pharmaceuticals as for all physician services.

Superficially, it would seem that government, the monopoly provider and purchaser of health care in Canada, should be concerned about the escalation of costs related to pharmaceuticals. When examined more closely, however, a different picture emerges. Of all pharmaceutical spending outside hospitals, the public sector component has increased from 2.7 percent of total health care costs in 1980 to 5.6 percent in 1994. However, pharmaceutical purchasing by Canadian taxpayers, which in 1994 amounted to $100.14 per capita, falls well below the OECD average, and seems small when compared with the routine expenses of day-to-day living.[32]

Another important fact is that pharmaceuticals have brought an enormous increase in the capability to fight and control disease. In many cases they have replaced much more expensive interventions. Thirty years ago, one of the most common procedures performed in Ca-

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29 B.C. Ministry of Health, "Pharmacare Initiatives Saving Money, Improving Services," News Release, November 30, 1995.

30 Policy and Consultation Branch, Health Canada, *National Health Expenditures 1975-1994*, January 1996.

31 Statistics Canada, *Hospital Statistics: Preliminary Annual Report 1992-93*, cat. 83-241 annual.

32 *Ibid*.

nadian hospitals was a Vagotomy and Pyloroplasty, an intra-abdominal surgical procedure designed to relieve the symptoms of peptic ulcer disease. As a result of a number of drugs that have come on the market this procedure is seldom performed today, and the consequence is a substantial reduction in costs combined with considerable reduction in patient suffering and disability. There are many examples of how new drugs have reduced costs, but these seem to be ignored by those who choose to focus only on the cost of the drugs, without examining the total picture.

When examined from the viewpoint of the benefits and savings invoked by the introduction of newer drugs, the incremental increase in taxpayer cost from 2.7 percent of health care to 5.6 percent seems small. It appears that those who focus on drug costs as a problem in Canadian health care have picked a very shaky cause on which to focus their efforts.

Moreover, when the full impact of cost containment on drugs is examined closely, a more disturbing picture appears. William Looney has pointed out that "there is growing clinical and documentary evidence demonstrating that reforms to cut government exposure to rising drug costs have an unanticipated adverse impact on the national health services, in the form of additional specialist referrals and hospitalizations; denial of needed therapies, particularly for the elderly and other vulnerable groups; deterioration in the overall quality of medical treatment; increased bureaucratization; and higher costs system wide."[33] Looney's work is substantiated by other studies, including those of Soumerai et al., who examined the results in New Hampshire and New Jersey when a cap was placed on medications available to Medicaid patients in New Hampshire.[34] When the cap was instituted in that state, there was a sub-

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33 William Looney, *Drug Budgets: The Hidden Costs of Control. The Impact of European Drug Payment Reform on Access, Quality and Innovation*, Centre for the New Europe, June 1995.

34 S.B. Soumerai, D. Ross-Degnan, J. Avorn, T.J. McLaughlin, and I. Choodnovskiy, "Effects of Medicaid Drug-Payment Limits on Admissions to Hospitals and Nursing Homes," *New England Journal of Medicine*, 1991, vol. 325, pp. 1,072-77; and "On Squeezing Balloons: Cost Control Fails Again," Editorial, *New England Journal of Medicine*, 1991, vol. 325, pp. 1,099-100.

stantial increase in admissions to nursing homes and a lesser but still measurable increase in hospitalization. These figures reversed themselves when the cap was lifted. Furthermore, conservative calculations revealed that the extra costs created by the cap exceeded any savings by a significant amount.

There are other solidly based examples of how programs such as reference-based pricing actually increase the cost of health care substantially. In a recent 13,000-patient health maintenance organization (HMO) study, seemingly benign measures such as restricting formularies to generic drugs were shown to create even more expensive health problems.[35] The proponents of such programs usually report the savings realized in drug costs alone, and seldom if ever report the other costs incurred. Studies conducted in Arkansas, California, Texas, and Germany have demonstrated that the hidden costs of reference-based pricing programs greatly exceed any savings.[36] There is no reason to believe that the experience in Canada would be any different. Programs such as those presently functioning in B.C. will likely increase overall costs and also cause a deterioration in the quality of care available to patients, particularly the most vulnerable—the frail, the elderly, and low-income patients.

The focus on containing drug costs has occurred in spite of the lack of evidence supporting the need for such a measure. Furthermore, the literature indicates that a narrowly focused drug cost containment policy will not be successful, but will, in all likelihood, increase the cost to the taxpayer, while resulting in a deterioration in available care. We will return later to the issue of pharmaceuticals and how they ought to be managed in a comprehensive reform of the health care system.

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35 Susan Horn, Ph.D., P.D. Sharkey, Ph.D., D.M. Tracy, Ph.D., C.E. Horn, B. James and F. Goodwin, M.D., "Intended and Unintended Consequences of HMO Cost Containment Strategies: Results from the Managed Care Outcomes Project," *American Journal of Man. Care*, Vol. II, No. 3, March 1996, pp. 253-64.

36 Dr. R. Robinson, "Economic Models for Evaluating Health Care Costs," Presentation at The Fraser Institute, March 12, 1996.

The hospital sector

Acute care hospitals consume 38 percent of health care resources, cost $27 billion annually, and represent the single greatest health care expense.[37] In any consideration of health care reform it is natural to focus in some detail on this aspect of spending. But first, how does the system work now?

Control and management of acute care hospitals vary from province to province, but in general, voluntary, non-profit boards of directors are responsible for supervising, directing, and controlling the senior management of these facilities. However, in British Columbia and most other provinces, the boards can operate only within fiscal and administrative regulations set by government. They can neither build, renovate, nor operate without government approval. They cannot even sell their property unless the government agrees. If a board is seen to step out of line, it can be replaced by the Minister of Health. With variations in approach, this type of control over hospitals is exercised by provincial governments across Canada, and for this reason most Canadian acute care hospitals are considered by OECD analysts to be public sector bodies.

Performance measures

Hospital services are measured in various ways. These include such factors as appropriateness, effectiveness, and efficiency. An appropriate service is one that, on the best scientific evidence, will improve the health status of the recipient the most and where the benefits exceed the risks by a wide enough margin to make the service worth providing. An effective service is one that improves the health status of the recipient. An efficient service is one that is delivered in the most cost-efficient place at a time when the effectiveness of the intervention will be optimal.[38] Other important concepts are those of utilization, utilization re-

37 The Health Services Utilization Group for the Conference of Federal/Provincial/Territorial Deputy Ministers of Health, "When Less is Better: Using Canada's Hospitals Efficiently," June 1994; J.N. Lavis and G.M. Anderson, "Inappropriate Hospital Use in Canada: Definition, Measurement, Determinants and Policy Implications," Queen's University of Ottawa Economic Projects, 93-08.

view, and utilization management. Utilization is the use of services or resources, utilization review is the assessment of the appropriateness and efficiency of hospital care through review of medical records, and utilization management is the deliberate action by payers or hospital administrators to increase the efficiency and effectiveness with which services are provided.[39]

The most recent OECD comparative data date back to 1991. Though slightly out of date, they appear to point to specific deficiencies in the Canadian hospital system. Some of these data, illustrated in table 6, reveal that the majority of OECD countries provide high quality acute care with a much lower average length of patient stay (ALOS) than do Canadian hospitals. The number of beds per capita in Canada is higher than in countries such as the U.K., Ireland, and the U.S., while the number of bed-days per capita is more than 50 percent higher in Canada than in the U.K., Australia, Sweden, and the United States. Staff-to-bed ratios show that the number of Canadians required to support each bed is more than 50 percent higher than in Australia, Ireland, and Switzerland, more than 150 percent higher than in France, and 250 percent higher than in Japan. The number of registered nurses per bed in Canada is more than 50 percent higher than in Germany and approximately double the numbers for France and Japan. These data suggest that significant improvements in efficiency, effectiveness, and utilization are required in the Canadian hospital sector.

A review of the problems related to the hospital sector in Canada was conducted by the Health Services Utilization Working Group in its working paper for the 1994 Conference of Deputy Ministers of Health.[40] This report largely confirms and expands on the OECD data comparing the situation in Canada with other countries. There is detailed documentation to show that from 48 percent to 65 percent of acute care patient days are being provided to patients who are not acutely ill. Half or

38 *Ibid*.

39 S.M. Payne, "Identifying And Managing Inappropriate Hospital Utilization: A Policy Synthesis," *Health Serv. Res. 1987*, 22(5), pp. 709-769.

40 The Health Services Utilization Group for the Conference of Federal/Provincial/Territorial Deputy Ministers of Health, "When Less is Better: Using Canada's Hospitals Efficiently," June 1994.

Table 6: Average Length of Stay, Beds per Capita, Hospital Staff per Bed, Nurses per Bed (OECD 1991)

	ALOS Days	Beds/1,000 Pop.	Staff per Bed	Nurses per Bed
Australia	5.00	4.40	1.90	1.35
Belgium	8.50	4.90	1.46	0.82
Canada	8.60	3.90	*2.80	*0.82
Denmark	6.50	4.40	3.02	0.89
Finland	7.00	4.80	2.00	0.65
France	6.70	5.10	1.11	0.40
Germany	13.10	7.30	**1.31	0.51
Greece	—	3.90	1.37	0.70
Iceland	6.00	4.50	—	—
Ireland	6.80	3.40	1.75	1.29
Italy	**11.20	5.80	1.61	0.69
Japan	—	—	0.80	*0.42
Mexico	—	**1.10	5.98	2.09
Netherlands	10.9	4.2	2.19	**0.87
Norway	7.40	3.60	**2.78	**0.87
New Zealand	—	7.10	**2.00	*1.20
Austria	10.00	5.70	0.76	0.59
Portugal	8.30	3.60	2.00	0.53
Spain	9.30	3.40	2.20	0.58
Sweden	6.20	3.90	**1.85	—
Switzerland	13.00	6.40	1.95	1.01
Turkey	4.40	1.90	1.00	*0.33
U.K.	5.40	2.20	3.27	1.63
U.S.	7.20	3.50	3.50	1.46

*1990 data; **pre-1990 data; —data not available.
Source: OECD Health Data, Electronic Version #3.6, released May 1995.

more of the services—and therefore the costs—provided in acute care hospitals were either non-essential or could have been provided more efficiently elsewhere. The report documents examples of inappropriate service, ineffective service, inefficient service, and inappropriate use. The following is a paraphrased version of some of its findings:

> Both Canadian and international studies of hospitalization reveal large proportions of non acute and, therefore, inappropriate admissions and use of patient days in hospitals.
>
> There are large variations in the ways in which hospitals are used; individual physician patterns and practices were the key determinants of over use.
>
> Simply reducing acute care capacity did not eliminate inappropriate service or the risks associated with prolonged stays. It is necessary to introduce utilization review to address these topics.
>
> There are very good, well validated, low cost assessment tools for carrying out utilization review, several of which have been used successfully in Canada.
>
> There are wide variations in medical practice in Canada and the most effective way of dealing with this is the development of clinical practice guidelines.
>
> There are many proven ways of reducing in-patient hospital costs. These include pre-admission clinics, day surgery, same day admitting policies, length of stay targets, discharge planning, and other utilization management initiatives. Short stay units, day care, and "do not admit to hospital" orders that respect individual and family choice, are other commonly used measures for reducing hospital costs.
>
> Diagnostic services such as labs and imaging need to be managed better. Studies have shown a great deal of overcapacity with unrealized potential for centralization and coordination to improve both quality and efficiency in the use of equipment.
>
> The inappropriate use of emergency departments has resulted in less than ideal service for genuine emergencies and inefficiency in the use of expensive resources.
>
> Current fee-for-service physician payment systems appear to result in the provision of more services. Canadian and Ameri-

can studies report a reduction in in-patient use of from 20 percent to 40 percent on the part of physicians paid by other means.

Studies of waiting lists typically reveal failures in prioritization and management rather than insufficient capacity in the system.

Doctors who use the hospitals are responsible for generating most of the costs, but they are not employees and have few incentives to economize, nor do they incur any financial risk or consequences from their patient management decisions. Including physicians in policy formulation, management processes, information systems development, and as genuine management team members eligible for financial rewards and penalties with their contributions is highly desirable.

Rigid job categorization and inflexible education programs supported by the unions provide a substantial barrier to change and improvement. Health care workers of the future will have to be adaptable to changing circumstances. This will require changes in the way health care unions operate.

Public debate and discussion of the issues concerned in health care is essential. At the moment, the knowledge of individual members of the public is restricted to the personal experience of themselves or their family. While important, single-encounter information provides very little insight into the overall aspects of this large and complex system.

Many of the observations and findings brought forward by the Working Group support and corroborate studies conducted at The Fraser Institute and elsewhere which appear to indicate that hospitals in Canada, as in many other countries, are inefficient, overused, and fall short of management standards acceptable in the private sector. However, it would be unfair and wrong to blame only the hospitals and those who run them for this incentive-based overuse. These deficiencies appear to be due, in part, to unnecessary government regulation and control. For example, some of the problems are an ongoing consequence of the 1950s hospital construction program, followed by *The Hospital and Diagnostic Services Act* which effectively enticed people into hospital for treatment, much of which could have been done as well or better elsewhere, and at lower cost. The hospitals can hardly be held accountable

for the thousands of frail but otherwise healthy elderly patients who occupy acute care beds because, in many cases, no other placement potential exists. This situation is exacerbated by the perverse incentives of the present system. While intuitively it appears that expenditures could be reduced by reducing the time each patient stays in hospital, the reality is that admitting and discharging patients quickly is labour intensive and therefore costly. This gives hospitals a financial incentive to slow turnaround, thereby increasing length of stay and reducing efficiency and productivity. However, if appropriate incentives for efficiency existed, there is little doubt that the hospitals would be more creative in finding appropriate placement for such patients.

Hospital budgeting

A key factor in the huge expense of hospital operation has to do with the way these insitutions are funded. The report from the Working Group on Hospital Utilization makes 20 recommendations, but it does not go far enough. The missing link is that there is little incentive for hospitals to implement these measures. The pivotal point in addressing this issue is the mechanism by which hospitals are financed.

In most countries, privately owned and operated hospitals provide a significant proportion of care, and have to compete with similar facilities to retain the privilege of serving their clientele. These private hospitals may receive funds from individual patients or their insurers (U.S.), the government (U.K.), or both (New Zealand). Since these facilities operate within a competitive market they have an incentive to institute internal measures to improve efficiency, effectiveness, and proper use, and in these circumstances the role of government is restricted to ensuring that taxpayers' money is targeted toward designated areas of need.

In Canada, 28 percent of all health care funding comes from the private sector.[41] However, very little of this private sector money goes toward hospital costs. This is an area in which Canada lags behind most OECD countries; competitive, privately owned and operated hospitals must be encouraged to compete for the opportunity to offer service to patients from both the private and public sectors. This is an essential in-

41 OECD Health Data, Electronic Version #3.6, released May 1995.

gredient for beginning to bring the benefits of market-driven incentives to secondary care in Canada.

In some countries, government payments to hospitals are based on the population being served. Each hospital has a population catchment area, and only people from that area are entitled to treatment. Portability is achieved by arranging for patient billing to be transferred from catchment area to catchment area. In another model, hospitals are remunerated on the basis of each patient treated. For example, in the U.S., the individual patient is often regarded as the primary payer, and either the patient or his insurer is billed item by item for services rendered. This account is then given to the insurer, which may be a health maintenance organization (HMO), the government (Medicaid, Medicare), a private company, or the individual patient, who may be responsible for paying all or some part of it. Experience shows that this type of itemized accounting produces higher administrative costs than a monopoly system. Of course, that does not mean that the overall cost in quality-adjusted terms of a system relying on individual billing will be higher than a monopoly, government administered system. For the provision of most goods and services, we rely on the market system to provide competition among suppliers; this influences the package of quality, availability, and price that is offered to the consumer. The extra cost of separate billing in these markets is to some degree offset by the overall efficiencies which result from competition.

In most parts of Canada, hospital funding is not based on the population served, nor is it dependent on the number of services provided; instead, it is generally calculated on the basis of the previous year's funding by a system known as "global budgeting" which does not take into account usual market factors such as the number, type, and quality of service provided. There is a negotiation around whether the previous year's budget should be increased, decreased, or maintained—hence the name "global" budgeting. Usually, there is no discussion about the number of services of each type to be provided, nor is quality of care discussed. Indeed, some claim that quality of care is not measurable.

Individuals working in the health care field recount a multiplicity of examples that reflect the types of deficiencies that come with global budgeting. Consider, for example, the situation in a British Columbia community hospital where two surgeons performed identical procedures. One, as a matter of routine, admitted his patients to hospital for

five days, while the other surgeon performed all his procedures on an out-patient basis. The cost of hospitalization in a community hospital varies greatly, depending on location, size, and case load, but in general runs between $600 to $750 per patient per day.[42] Thus, in the situation described, there was an extraordinary variation in cost to the system depending on which surgeon performed the operation, but for some time, there was no examination into whether one surgeon was keeping his patients in the hospital too long, or whether the other surgeon was releasing his patients too early (which would result in patient suffering and further costs to the system at a later date). Eventually the matter was resolved, but if the hospital had been competing with other hospitals for funds, this fiscal anomaly would likely not have been permitted in the first place.

Global budgeting does not create any meaningful incentive for a hospital to be efficient. If a budget is not spent in one year the hospital will receive less the next, and is thereby punished for saving. If something is sold for a profit, the amount of the profit is deducted from the next year's budget—once again punishment for fiscal prudence.

Labour in the hospital sector—the case of British Columbia

Another critical factor in understanding the cost of running hospitals relates to the labour sector. The latest available Canadian figures are for 1992-93 and reveal a total of 165,747 public hospital beds employing 395,000 people at a cost of $17.8 billion.[43] By 1995, this is estimated to have increased to approximately $21 billion. This figure represents over 73 percent of total hospital expenditures, a percentage that is much higher in some hospitals and in some locations. For example, the Vancouver Hospital has a budget of $400 million and employs 9,000 people who receive 80 percent of the total budget or, on average, over $35,500 in salary and benefits per person per annum.[44] This amount does not in-

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42 Statistics Canada, *Hospital Statistics: Preliminary Annual Report*, 1992-93, table 16, pp. 32-3.

43 Statistics Canada, *Hospital Statistics: Preliminary Annual Report*, 1992-93.

clude the money paid to physicians who are, for the most part, paid on a fee-for-service basis by the Medical Services Commission.

The Seaton Commission on health care in B.C. indicated that hospital workers are paid more than their counterparts outside the hospital sector and that their wages have outpaced general wage levels since 1969. The commission drew the following conclusions from these facts:

> Such trends do not, of course, tell us whether nurses' or other hospital workers' wages are too high or too low. . . . It might . . . be argued that wages in hospitals compare favourably with those in similar occupations elsewhere. But perhaps they are also underpaid.[45]

Many jobs in hospitals are similar to jobs performed in other sectors of the economy. The largest overlap of comparable workers is between the hospital and hotel sectors. Both sectors need food service personnel, laundry service, housekeeping service, maintenance, and clerks. Many jobs, of course, cannot be compared directly, such as those in the hospital sector that require specific medical knowledge: this group includes people such as nurses, technicians, and lab assistants. Excluding these medically specialized workers from the comparison leaves 18 clearly comparable occupations. The effect of existing wage differentials between comparable workers is shown in table 7, using the Royal Columbian Hospital in B.C. as an example. Even though only 18 occupations are compared, if the Royal Columbian Hospital were to pay these workers wages comparable to those of their private sector counterparts, it would save over $2.6 million a year.

This comparison, however, includes only 372 of 766 (medically) non-technical workers at the Royal Columbian Hospital. Given an average wage differential for the 372 workers compared of $3.94 an hour, it is possible to extrapolate the potential savings which could be realized if all the non-technical hospital workers were paid on par with the hotel workers. Adding the amount for these remaining workers to that calculated for the 18 clearly comparable occupations, total savings for the

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44 L. Bartz, Director, Communications and Public Affairs, Vancouver Hospital, in the *Vancouver Sun*, July 15, 1995.

45 *Closer to Home: The Report of the B.C. Royal Commission on Health Care and Costs* (1991) pp. B-93.

Royal Columbian Hospital would be $5.4 million a year, equivalent to about 4 percent of its total annual budget. Other B.C. hospitals could similarly save 4 percent or more of their annual budgets. Extrapolation gives us a general sense of the savings to be achieved province-wide. If British Columbia could save 4 percent of its total annual spending on acute care hospitals in the province, the savings would be approximately $115 million a year.[46]

Most critics of the health care system focus on capping doctors' billings and restricting entrants into medical school as cost containment measures. The cost of the many other workers in the health care sector usually goes unmentioned. This has incorrectly placed much of the blame for increasing health costs on the shoulders of physicians who, as a group, receive a lower percentage of the health budget than they did 20 years ago.

Summary

In the hospital sector in Canada, the ultimate consumer is the patient, but the patient has little or no say in what types of services are purchased. The government is the only major health insurer, the only major purchaser of health services, and government is also the only supplier of almost all hospital services. This creates a conflict of interest which would be unacceptable to Canadians in almost any other sector of the service industry.

It is apparent also that the largest single cost for hospitals is the cost of labour, and from the evidence presented it seems clear that the wages being paid to hospital workers are not competitive with those in the private sector. This factor, when combined with the OECD data which reveal that staff-to-bed ratios are higher in Canada than in many other prosperous countries, makes it clear that hospital employment and wages are a major target area for efficiency gains.

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46 Calculations based on expenditures on hospital services in B.C. for 1995/96 of $2.88 billion. B.C. Ministry of Health, "B.C. Hospitals Get Funding Increase as Clark Redirects Savings to Protect Health Care," News Release, April 9, 1996.

Table 7: Hospital Employees Union (HEU) and Local 40 (Greater Vancouver Hotel Union)—Wage Comparisons

Worker Type	Hospital Hourly Wages ($)	Average Hotel Hourly Wages ($)	Number of Employees at Royal Columbian Hospital	Potential Hourly Savings ($)
Housekeeping Aide	15.93	12.46	85	294.59
Cleaner	15.93	12.51	58	198.46
Laundry Aide	16.67	12.40	22	93.90
Purchasing Clerk	20.53	13.73	2	13.60
Storekeeper	17.46	12.83	2	9.27
Stores Attendant II	16.26	13.00	19	61.94
Food Service Worker I	15.69	12.30	86	291.91
Food Service Worker II (Dishwasher)	15.99	12.23	15	56.36
Cook I	16.88	13.10	6	22.67
Cook II	17.4	14.04	5	16.79
Maintenance Worker	18.04	13.89	10	41.54
Groundskeeper	19.21	13.71	1	5.51
Electrician	24.58	15.08	16	152.08
Plumber	23.88	15.21	6	52.02
Painter	21.83	13.37	3	25.38
Switchboard Clerk	16.31	12.38	12	47.22
Admitting Clerk	16.31	12.85	24	83.07
Hourly Savings				$1,466.31
Monthly Savings				$219,359.39
Annual Savings				$2,632,312.66
Annual Savings: All Other Non-Technical Workers				$2,786,796.67
Total Annual Savings for Royal Columbian Hosp.				$5,419,109.33

Sources: HEABC/HEU final wage rates, effective April 1, 1995. Collective agreement between the Greater Vancouver Hotel Employers' Association and Local 40, effective November 1, 1991 (wages effective until November 1, 1995). Wage rates given are for employees who had worked in the hospital/hotel for at least 12 months.

Case study—misguided directions for British Columbia[47]

As noted earlier, many of the changes which have taken place in the health care sector in Canada, including the introduction of universal health insurance, have taken place for political rather than medical reasons. Inefficiencies have been built into the system. These inefficiencies are manifesting themselves in many ways, such as progressively longer waiting lists, increased costs, limited technology, and limited R&D in Canada. Many provinces have turned to regionalization and increased decentralization of services as solutions to the problems of access and cost. In B.C., the response to these escalating problems was to set up the Seaton Commission on Health Care in 1991, which delivered the document, *New Directions, Closer to Home* recommending, among other things, the regionalization of services.

New Directions, the document, resulted in New Directions, the reform strategy; its purpose was to change how health is defined, to change how health services are provided, to promote better health for all British Columbians, to spend limited health dollars in a more sensible and efficient way, and to give communities and regions more control over the planning and delivery of health services (closer to home). Doctors and hospitals were to represent the core of health services, but New Directions was to emphasize such previously neglected health areas as home care and community health services.

New Directions has admirable objectives for a community-based health care system. It aspires to ensure that people get the right service at the right time from the most appropriate provider. For example, community health centres are intended to be responsive to the specific needs of the community and allow for more "client-centred" care. As well, links with other health and social services are intended to support the continuity of comprehensive care. Greater public involvement at the community level is supposed to allow for the identification of health priorities and the allocation of available resources in a way that best meets local needs. Effective and efficient use of resources is meant to be

47 Unless otherwise indicated, the information for this case study is derived from Ministry of Health documents prepared to inform the public about *New Directions for a Healthy British Columbia*, 1993.

achieved through improved administrative savings and by tying health expenditures to health outcomes.

New Directions fails in that it neglects to include one important mechanism for ensuring that "people get the right services at the right time from the most appropriate provider": the market. The market would communicate the wants of patients to care providers. The market would allow for competition between providers. Competition would ensure that providers respond appropriately and adopt the most efficient and effective methods of delivering health care. Competition would also facilitate technological advancement, not only in medical devices and procedures, but in the way in which medicine itself is practised. Until market mechanisms are put in place and the incentive structure of the medical system is overhauled, any reform is bound to fall short of its intent. Advantages such as the reduction in hospital waiting lists noted in the U.K. and the significant increase in surgical throughput observed in New Zealand illustrate the benefits of introducing market incentives to health care.

The organization of New Directions

Community Health Councils (CHCs) and Regional Health Boards (RHBs) have been created to aid in planning, managing, and delivering services at the community level. The government hopes that regionalization will reduce duplication of services and administrative costs. Twenty RHBs and 85 CHCs have been created, and the roles of these bodies vary across the province, depending on the sizes of the communities, the health services they provide, and the wishes of local residents.

CHCs have replaced the separate boards of governance that existed in each community. Their composition is as follows: one third elected by the public, one third appointed by the Health Minister, and one third appointed from other elected bodies (e.g. school boards, municipal councils, etc.). At the moment, the public representatives are people who were nominated from community steering committees. Elections for these positions are expected to begin taking place in the fall of 1996.

CHCs are accountable to both their RHB, and the communities they serve. Each CHC participates in the decision-making process through representation on an RHB. Council responsibilities are still being

phased in, but ultimately, the CHCs will participate in the planning, co-ordination, and control of community health services such as acute care, mental health, and continuing care. Over time, they will be responsible for allocating the funding for most community health services; they will be permitted to enter into contracts with public and private health providers to deliver some services. They are intended to ensure that their community has access to core services which meet provincial standards.

RHBs are composed of CHC representatives and Minister of Health appointees. They are accountable to the community, to populations not represented by a CHC, and to the Minister of Health. Initially, their role is to plan and co-ordinate regional health services and determine, with the aid of the CHCs, which services will be provided regionally and which will be provided at the community level. Eventually, RHBs will receive and allocate to the CHCs a global budget and, with the Ministry and the municipalities, will plan capital projects. A large part of their mandate will be to protect the health interests of the taxpaying public who fund the system.

The Ministry of Health is still the centre of power in the system. It is accountable to the legislature for the health system in B.C. It provides all the funding, defines the range of essential services, and sets standards and policies for the equitable provision of these services. The Ministry will allocate resources to RHBs in accordance with a funding formula for health programs based on such factors as age, gender, and health status of the population. It will conduct research and evaluate health services. It will be responsible for planning, funding, and monitoring tertiary care services, and it will continue to provide and co-ordinate services that are provincial in nature, such as the B.C. Centre for Disease Control. It will also continue to directly administer the Medical Services Plan, the Alternate Payments Plan, and Pharmacare.

How New Directions has not worked

New Directions was supposed to save money for the province and thus the taxpayers. It was also intended to improve the availability and quality of health services received by British Columbians. "Overall institutional cost reductions have not been realized, however, and there are no indications that accessibility to care in B.C. has been improved as few

new community programs have yet materialized."[48] The failure to renegotiate health workers' union contracts, and the government decision to merely shift labour around rather than to examine which types of labour would be most effective in a regionalized system have constrained the ability to contain health costs and improve service. CHCs are unable to ensure that their communities' needs are met as their role has already been changed by the Ministry of Health. Rather than allowing them to possess any real decision-making power, the Ministry has relegated the CHCs to an advisory role. This mistake parallels a similar situation in New Zealand which appears to be impeding progress there also.

Hospitals

In 1995, 123 acute-care hospitals in B.C. received an increase in funds of over $90 million, a 3 to 4 percent increase in the budgets of over half of the hospitals. During the 1995/96 fiscal year, allocations to hospitals will rise to $2.88 billion, a 2.5 percent increase in funding. Over the past 4 years, $1.25 billion of new provincial funding has been committed to hospital services.[49] The government has spent a total of $150 million since 1991 building new nursing homes and renovating older ones.[50] In 1995-96, mental health and continuing care facilities will receive funding increases of 4.5 percent and 8 percent respectively.[51] The total health budget will have risen to $6.5 billion by 1995/96, an increase from $6.25 billion spent by the Ministry of Health in 1994-95, and up from the $6.0 billion it spent in 1993-94.[52] Health care spending appears to be flourish-

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48 Murray Martin, President and CEO, Vancouver Hospital, speaking at Medical Grand Rounds in December 1995.

49 B.C. Ministry of Health, "B.C. Hospitals Receive Budget Allocations for 1995/96," News Release, May 31, 1995; and "B.C. Hospitals Get Funding Increase as Clark Redirects Savings to Protect Health Care," News Release, April 19, 1996.

50 *Vancouver Sun*, May 30, 1995, p. B4.

51 *Better Health Care News: An Update From the B.C. Ministry of Health*, Spring 1995, p. 3.

52 Public Institutions Division, Statistics Canada, *Provincial and Territorial Expenditure, Financial Management System*, January 15, 1996.

ing in B.C. with the occasional exception, such as the closing of the Shaughnessy site of University Hospital. Its programs and staff, however, have not been cut; they have been absorbed by the Vancouver Hospital at its two sites, and by community hospitals in the area.

Doctors, nurses, and government

B.C. health providers are discontented. Most vocal in recent months have been the physicians who feel that they are being completely excluded from the government's decision-making process. Dr. Victor Dirnfeld, past president of the B.C. Medical Association (BCMA), has said that "doctors have witnessed other instances when the Ministry [of Health] has promised to consult with them, and then imposed policies with little notice—such as the introduction of reference-based prescription drugs."[53]

Doctor and nurses are sparring too. With the move to regionalization, nurses, as represented by the Registered Nurses Association of B.C., have been advocating community health centres controlled by nurses rather than doctors. They have also suggested that nurses should be the first point of contact for patients, given the emphasis being put on containing the costs of the health care system. They contend that doctors are "clinging tightly to fee-for-service . . . [you] have to wonder whose interest they are looking after," while the BCMA contends that the nurses' union is proposing a role for nurses for which they are not trained.[54]

Closer to home

The Ministry has claimed that it is downsizing. What it is actually doing is transferring—it has transferred approximately 3,200 jobs from the Ministry to the CHCs and RHBs. The government is extending its influence over health care rather than relinquishing any power to the regions and communities. The Ministry still "holds the purse strings"; it has defined the core services that communities must deliver and it has negotiated the collective labour agreements to which the regions are bound to

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53 *Vancouver Sun* , October 6, 1995, p. B1.

54 *Globe and Mail*, September 28, 1995, pp. A1-2.

adhere. Regionalization is inheriting the problems of uncoordinated planning and financing that afflicted the "old" health system.

The transfer of problems to the regions rather than their resolution is further demonstrated by a report released recently by the B.C. Women's Hospital indicating that women are not being well served by the health system:

> The system is too rigid and too tightly bound to the medical model. . . . It doesn't emphasize prevention. It isn't geared to meeting the diverse needs of women from different ethnic backgrounds. It is not accessible enough.[55]

With its stated goals being "to serve all people equally well, while becoming more responsible and flexible to our changing needs,"[56] New Directions is a failure. Its implementation began years ago and its supposed benefits have yet to be seen. Costs have not been contained; service has not been improved. Perhaps these concerns contributed to the Ministry's recent decision to "put all regionalization activity temporarily on hold."[57]

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55 R. Wigod, *Vancouver Sun*, August 16, 1995, p. A1.

56 B.C. Ministry of Health, *New Directions News*, September 1994.

57 B.C. Ministry of Health, "New Minister Outlines Priorities for Health," News Release, June 21, 1996.

SECTION II

Remedies for health care in Canada

Possibly the greatest practical weakness of the Canadian health care system is that it is virtually devoid of the normal competitive forces that guide and shape most other economic activities in Canada. Countless examples from Canada and around the world demonstrate that when government bureaucracy, central planning, and protectionism replace competition, the result is always the development of expensive, unresponsive systems that fail because of increasingly debilitating bureaucratic, administrative, and consequent fiscal overburden. Examples range from the "cradle to grave" health and social welfare systems in New Zealand to the remarkable story of how government subsidies and intervention destroyed the once lucrative peanut market in the U.S.[58]

The question for Canada and Canadians is not if there is a need to introduce competition and the changed incentives that it would bring to the health care system, but rather *how* this introduction can be managed. It goes without saying that it must be done within the context of ensuring quality care for all citizens, and that it is unacceptable to Canadians that any citizen should be deprived of quality care because appropriate and effective services are not available, as is more and more the case with the present system, or because of genuine inability to pay. Fortunately, the introduction of competition into the health care sector will not only reverse the current deterioration in services and care available to our citizens, but will also ensure that the present faulty system becomes more efficient and effective with a consequent improvement in the quality and type of service available to all.

The proposals put forward in this section are neither radical nor particularly new. They have been used in one form or another in several countries which preceded Canada by years in the introduction of socialized health care and consequently faced sooner than Canada has the economic crisis that this type of system helps to create. Happily for Canadians, much of the experimentation that goes with system change has

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58 J. Bovard, "This Farm Program is Just Plain Nuts," *Wall Street Journal* , August 30, 1995, p. A14.

been completed in these other jurisdictions. It follows that Canadians can benefit from their experience and do not have to repeat their mistakes. The information which follows is, in the authors' opinion, the most practical way to proceed in coping with the health care dilemma facing Canada and Canadians. The information presented does not pretend to be a detailed road map of exactly how and where to proceed, but rather a bird's-eye view of how the health care landscape should be modified to begin creating a responsive, cost effective, and sustainable system.

Focus for improvement

The focus of our suggested revisions is the creation of incentives that will influence the behaviour of the participants in the system, particularly the health care providers. What follows is a proposal that the present, centrally controlled and centrally regulated system be modified and improved by:

- introducing positive incentives for fiscal responsibility in primary and secondary care;
- introducing competition between the providers of both primary and secondary care;
- separating the purchasers, providers, and regulators of health care;
- emphasizing the importance of individual patient choice and decision making;
- enhancing the patient advocacy role of primary care providers
- ensuring that treatment decisions are made by competent providers and their patients;
- ensuring that no Canadians are deprived of appropriate care because of financial hardship; and
- encouraging the health care sector to become an engine of industrial productivity.

The Canada Health Act

In an earlier portion of this document we noted that for nearly a century health care policy in this country was driven by political expediency as opposed to health care needs, and that the basic principles of the *Canada*

Health Act are ideological rather than practical. Furthermore, they keep the provinces from taking measures that would likely solve the problems they are facing. In particular, some of the solutions to the emergent problems of health care that have been adopted in both the U.K. and New Zealand are incompatible with the *Canada Health Act*.

Inevitably, the influence of the federal government will wane as fiscal incapacity increasingly inhibits the federal ambition to control health care. The role of the federal government in health care reform should be to repeal the *Canada Health Act* and restore to the provinces their constitutional duty to provide for the health of their citizens. Although immediate repeal of the act is unlikely, there is still much the provinces can do to modify and improve care within the present system. We describe these measures in the balance of this document.

Private versus public

The words "private," "private sector," "privatization," and "public" mean different things to different people in different contexts. When applied to facilities, they reflect ownership. For example, in terms of long term care in Canada, there are both "private" and "public" facilities, meaning that the ownership and management of the facility is exercised either by the state or by a private group or individual. However, ownership and management give no indication of the clientele served. Whether people are paying privately from their own pockets or are subsidized in whole or in part by the state is a matter quite unrelated to ownership.

In most countries, the hospital sector is balanced between publicly and privately owned and operated facilities. Both compete for the opportunity to provide service to publicly *and* privately financed patients. In Canada, the operation, funding, and management of acute care hospitals are controlled by government, which exerts *de facto* ownership over nearly all acute care facilities in the country. The degree of control varies from province to province, but in British Columbia, for example, a hospital board cannot sell property or even undertake minor renovations without approval from Victoria. This situation needs to be changed so that competition, incentives, and market forces replace government as the controller of operational decision making.

Patients, like facilities, can be divided into private and public sector, and in Canada almost all people fall into both sectors, depending on time and place. The vast majority of Canadians are private sector patients when they visit the dentist, who is an important provider of professional health care. However, when the private sector patient who saw the dentist in the morning visits the family doctor in the afternoon, it is likely that he will do so as a public sector patient whose expenses are paid in full by his state-run insurance. When patients go to the pharmacy to pick up medication, depending on their age and social circumstances they will either pay for the medicine out of pocket, in which case they would be private patients, or if they are elderly or in need the state may pay, in which case they are public sector patients. Thus, virtually all Canadians are both private and public patients from time to time and, as noted earlier, OECD figures reveal that approximately 28 percent of all Canadian health care expenses are presently paid by citizens in their private capacity.

The role of the private sector

The private sector must be permitted and encouraged to play a bigger and more effective role across the broad spectrum of health care. There is no more justification for preventing private sector entrepreneurs from offering medical services than there would be for preventing the private sector from marketing the most critical health product of all—food. Why should Canadians not have choices regarding the time, place, and nature of their medical care when the suggestion of similar restrictions for food would be met with universal outrage? It is difficult to conceive why people should be denied choice in medical services when the only governmental challenge is to make sure that no Canadian is deprived of appropriate medical care because of true financial need. Instead of an acquiescence with the present, gradually eroding system, the emphasis should be on letting the marketplace compete with the public sector for the opportunity to provide care, while at the same time targeting taxpayers' dollars to those in true need of assistance.

Several steps need to be taken in this respect. First, all restrictions should be lifted that prevent Canadians from obtaining comprehensive health insurance from private insurers. Making this change would separate individuals into two distinct groups: those who choose to remain

as subscribers to the publicly run health insurance program and those who choose to belong to a private program. The default will always be the public program, which will automatically provide care for everyone who does not select private coverage. The Germans impose a means test for those wishing to opt for private coverage; only those with assets and income above a pre-determined level are eligible for private insurance. This serves to protect the less affluent from signing up for insurance which they cannot afford, and which would, in most cases, be provided through the public sector.

This would not mean, at least initially, any basic change in the health care insurance arrangements of most Canadians. They would continue to participate in wholly government-sponsored and -run health care arrangements. Changes would occur gradually, and only for those who wished to make a change. Nevertheless, the experience of countries such as Germany and the U.K. indicates that there would in fact be change and that 10 percent or more of the population would opt to have private rather than public health care coverage. Evidence from the German experience also suggests that the opting out provisions would actually improve the position of those who stayed in the public system.

Second, many hospitals should be privatized. This topic is dealt with in more detail later, but it must be emphasized that Canada lags far behind most other industrialized countries in encouraging various types of public and private hospitals to compete with one another for the opportunity to serve patients. It is important to understand that in these hybrid arrangements private hospitals do not treat only private patients, and public hospitals do not treat only publicly insured patients. Instead, all compete for the opportunity to treat all patients. Observers from the U.K. report that the introduction of this approach over the past few years has had a revolutionary and beneficial impact on hospital care for public patients in that country.[59] This was confirmed by Stephen Pollard, former chief of policy development for the British Labour Party think tank, who notes elsewhere in this volume that:

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59 Personal communications, W. McArthur with various practising physicians in England and Scotland.

> There is a myth that any form of health provision from outside the NHS [National Health Service] is by definition "tainted" with capitalism or private profit. In fact, nothing could be farther from the truth. Today's non-NHS health care providers in the U.K. include a wide range of charitable and religious providers who, rather than actively undermining public health, help to promote it. Independent suppliers of health and community services not only provide useful measures of quality against which state provision can be checked, but often encourage new and innovative care models.[60]

We concur with Pollard's view and note that his opinion is widely supported by politicians of all political stripes in Europe and Australasia.

Separating purchasers from providers

The purchasers of health care must be separated from the providers of that care. There is a serious conflict of interest in health care in Canada because the state is purchaser, provider, and regulator of virtually all medical services in the country. This conflict has been resolved in New Zealand by the creation of an independent public purchaser, a body that is responsible *only* for purchasing all medical services for their clientele, the members of the public who are insured under a government funded health insurance scheme. We need to follow New Zealand's lead. Such an agency would create a situation where competition will have a powerful beneficial impact on cost containment and quality of care.

In order to achieve this, it will be necessary to set up Regional Purchasing Agencies (RPAs) to act on behalf of their clients—all publicly insured people living in their regions. These bodies will have as their sole responsibility the procurement of health care. They have no role in the provision of those services except that like any other purchasers, they have a responsibility to monitor and review the services delivered by the provider. RPAs should be provided with small and tightly controlled budgets to perform their duties, and rigorous fiscal constraints should apply to the number and size of their administrative support staff. Incentives which reward efficiency and discourage bureaucratic

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60 Page 8 of this volume.

growth are essential if undesirable administrative proliferation is to be avoided. In the New Zealand scenario, support staff numbers have been severely restricted in each agency; there would be no reason to do otherwise in Canada. What follows is a description of the general function of the RPAs.[61]

Needs assessment

Each RPA has an ongoing responsibility to assess the health care needs of the population in its region. To achieve this, data are collected from providers on current and past performance, morbidity and mortality statistics are studied, and whatever studies are deemed appropriate to determine any particular special health care needs in the region are conducted. Public consultation is important since it permits the agency's clients to have a voice in purchasing decisions, and should be achieved by holding public meetings, receiving written briefs from individuals and groups, and by any other means the agency finds useful. This is comparable to the manner in which public companies hold annual general meetings to report on the activities of the previous year and hear from shareholders.

Contract development

Having defined the health needs of the people in the region, the agency then prepares detailed Requests for Proposal (RFPs) which are then turned over to the hospitals and any other potential contractual providers for evaluation. The providers then prepare detailed bids for the various contracts which are returned to the RPA and the process of negotiating, drawing up, and awarding the individual contracts then proceeds. This process is exactly parallel with service contracting procedures in the private sector, and results in vigorous competitive bidding.

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61 Much of the description of the role, responsibility, and function of the RPAs in New Zealand has been taken from the literature published by the New Zealand health authorities. Some sections are almost verbatim; others have been modified to bring them into line with the circumstances in Canada. See *Policy Guidelines For Regional Health Authorities 1995/96*, New Zealand Ministry of Health, Spring 1995.

Contract monitoring

The RPA has a considerable responsibility for monitoring the provision of the contracted services. However, it is important to note that the agency's interest is in outcome measures only. Statistics such as mortality, complication rate, and customer satisfaction would be of interest to the RPA, but other factors often considered in hospitals, such as length of stay, cost per patient, cost per diagnosis, and similar measures would be of little interest to the RPA. The contracts with providers would establish firm and recognized ways of measuring outcomes. The inputs to the process would be the concern of individual providers, who would have an incentive to keep their costs comparatively low since they would be bidding, at arm's length from other providers, to acquire the contracts being let by the RPAs.

In New Zealand, the government has established six principles which the RPAs must follow. The agency must apply these principles in purchase decisions, and clarify the tradeoffs made.

The six principles are:

- equity
- effectiveness
- efficiency
- safety
- acceptability, and
- risk management

These principles provide simple, practical, and meaningful guidelines for the purchasing authorities in New Zealand. These are the guidelines that govern public sector purchasing of health care whether from public or private suppliers. Private insurers and providers operate completely independently of the RPAs but have to compete with the public sector for clients and the opportunity to market their services.

The principles are based on several years of experience with this type of funding and provide a useful starting point for provincial health authorities in Canada. Undoubtedly, modifications will be required, and it is predictable that what is satisfactory in one province may not be in another. For example, Prince Edward Island would probably not wish to place heavy emphasis on aboriginal health issues, whereas British Columbia would. Similarly, health issues related to heavy industry would be of importance in southern Ontario but less relevant to Sas-

katchewan. This type of flexibility is difficult to achieve in the present, centrally planned system in which local input seems to be regarded as little more than obstruction of federal and provincial bureaucrats.

One universally desirable benefit from the creation of the RPAs is that they replace much of the function of provincial health ministries, thereby opening the way for considerable downsizing in staff requirements at the provincial level.

Another important factor is the matter of selection and appointment of the RPA board of directors. This raises a philosophical dilemma. In a democratic society, the natural predilection is to select people through the electoral process. However, the unfortunate example of many municipal elections reveals a public apathy towards the process, and it is clear that in an election where only 10 to 30 percent of the eligible population votes, there is a undesirable potential for special interest groups to gain control of the system to the detriment of the public at large. On the other hand, there can be few Canadians remaining who would support a patronage appointment system. Across the country, politicians of all political hues have traditionally used patronage appointments to pay off political debts, with the result that in many circumstances, individuals without appropriate qualifications have been put in control of important public functions.

Neither local elections nor patronage provide a satisfactory method of selecting individuals for these important positions. An alternative is to create a body made up, in part, of people with proven professional skills, and in part of individuals designated by local municipal bodies. With respect to the professional appointees, carefully defined job descriptions for membership on an RPA must be developed and these positions should be opened up to a provincially administered competitive process of the type prevalent in the private sector job market. The actual selection process should be conducted by an independent, three- to five-person panel of respected and qualified citizens appointed for the sole purpose of selecting people for professional positions on the boards of RPAs.

The authors propose a six-member RPA with the following general job descriptions:

- Chairman of the RPA—to be elected by the board members annually among themselves,

- Economist/Certified Financial Advisor—a person with a postgraduate degree and at least 5 years' experience as a practising professional economist/CFA, with knowledge and experience in health economics,
- Epidemiologist—a professional undergraduate degree in one of the health sciences (nursing, medicine, pharmacy, nuclear medicine, et cetera) plus a minimum of a Master's degree in epidemiology and at least 5 years' professional experience as a practising epidemiologist,
- Administrator—a person with a postgraduate degree in Business Administration and a minimum of 5 years' experience in a senior administrative capacity in the private sector,
- Three members designated by local municipal bodies at their discretion.

Appointment should be by Order in Council for three years, with the provision that no one may serve more than two consecutive terms on an agency.

Primary care solutions

Introducing competition to the primary care sector is an important aspect of getting tax spending on health care under control. There are several aspects to this: one is the degree to which less expensive, predictable costs should be paid by taxpayers. This document noted earlier that Canadian taxpayers support primary care more than most countries. This is an aberration, not only in the international context, but also in the Canadian context of dealing with other health related issues such as dental care, where private provision and payment are the norm.

A digression on insurance

Another aspect is that insurance, which is what the various health care payment schemes are, is not well suited to absorbing routine, generally predictable expenses. Just as Canadians do not buy insurance for the purchase of food or routine periodic automobile maintenance, it is difficult to understand why insurance is involved for the relatively small ex-

penditure normally incurred by visiting primary care health providers. The total average annual cost per person for primary care in Canada is approximately $860, of which about $480 is paid for from the public purse.[62] In British Columbia, the primary care physician component of this amounts to approximately $175 per annum.[63] It would be less expensive for taxpayers to pay for their own primary care expenses themselves than do it through the present bureaucratic, government-controlled system. To the extent that recurrent primary care expenses are paid via "insurance," the insurance amounts to a pre-payment scheme—one where the government takes a sizeable handling fee.

Canadians want and must be given the assurance that they are protected from financially crippling medical costs, and they also properly demand that no Canadian be deprived of appropriate quality care because of financial inability to pay. Catastrophic medical costs are, in the final analysis, a shared community risk. Happily, since they afflict a relatively small fraction of the population, protection from the impact of catastrophic illness is not hugely expensive when considered as a pooled expense financed by a catastrophic insurance premium. All residents who can afford to do so must be required to get such insurance because of the general Canadian agreement that nobody ever be denied treatment. If all will be treated, then all who can afford to do so must participate in the cost of the system. However, individuals should have the choice of obtaining catastrophic insurance through either a private insurance scheme, or the public sector program, which of necessity would be the default program.

Reforming primary care

Having observed that Canada spends more than other countries on primary care, and having ensured that nobody would be denied care as a result of reforms, the question is, how should we reform our primary

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62 Calculated from the fact that in 1993, 30 percent of all health expenditures were on primary care but only 20 percent or $14.4 billion were paid from taxes.

63 Calculated at the average rate of 7 office visits per annum at $25 per visit.

care sector? How can it be made more cost effective? Once again, as in the case of the system reforms discussed earlier, the answer can be found in the experience of other countries.

The following portion of this document examines two proposals for bringing efficiency to the provision of primary care. The mechanisms described could exist side by side in some jurisdictions, while others may wish to incorporate only one or even a portion of one into their particular environments. Both systems have been tested and proven in other countries and both systems are gathering support and momentum where they have been instituted. The first, budget holding as it is called in New Zealand (the U.K. term is fundholding), is highly suited to a situation where the state continues to be a major stakeholder in the provision of health care funding. The second, a plan for creating Medical Premium Accounts (MPAs), is adaptable to both private and public care, and puts considerable decision making in the hands of the patient.

Budget holding

Budget holding is a system which enables the public purchaser, the RPA, to allocate taxpayers' dollars to budgets managed by primary care physicians for the provision of medical care to their patients. Funds allocated to budget holding are used exclusively for the provision of patient services; none of the money provided is used for direct physician remuneration, which is handled separately through one of the established payment modalities. The amount allocated to each budget holder is determined according to the age, and in the case of severe chronic illness, the health status of patients registered in the budget holding practice. Savings are not returned to government, but must be applied to enhance patient care in accordance with specific regulations. For example, a practice with a substantial number of frail elderly patients may choose to hire a registered nurse to make more frequent house calls on housebound patients. Such a move could increase the frequency of patient assessment, improve the quality of care, increase patient satisfaction, and permit physicians to more appropriately reserve their skills for sicker patients and more complicated cases. Coincidentally, it would increase the number of patients the physician could manage. To the extent that remuneration depended on number of patients per physician, there

would be an incentive for physicians in a budget holding practice to become more efficient.

On the other hand, since patients would be free to change physicians if the service they received was not satisfactory, the budget holder would have to keep the level of service up and indeed improve it in the face of competition from other budget holders. In general, patients would see very little change in their circumstances in the short term. They would continue to select their doctors, and the service level would not change much. Eventually, however, patients would experience shorter waiting times to see specialists, for diagnostic testing, and those surgical procedures for which the budget holder was responsible.

Budget holding is based, first, on the straightforward belief that patients, in consultation with their physicians, are generally in the best position to make decisions about the services that suit their individual needs, and second, on the principle that competition creates better service provision than monopolies underpinned by governments and restrictive regulations.

Patient-consumer advocacy

In an ideal world, the consumer alone would make decisions about his or her individual health care needs and act accordingly. The reality is, however, that many health care choices are far more complicated than even the best-informed lay person can comprehend or assess. For example, only a qualified specialist may be able to provide an informed opinion on whether a $48.55[64] X-ray, a $151 ultrasound, a $600[65] computerized tomography scan, or an $800[66] magnetic resonance image is most appropriate for the diagnosis of a particular condition. Decisions of this nature are common in medicine. Identification of options is often the responsibility of physicians who are specialists in a particular

64 British Columbia Medical Association, *Guide to Fees*, April 1, 1995. This is the BCMA total fee for both the technical and professional component of an examination of the abdomen.

65 Costs vary considerably. This is a conservative estimate for the technical and professional component in the examination of the abdomen.

66 See previous footnote.

field, but the interpretation and explanation of these complicated options to patients is usually the responsibility of the primary care physician who has a unique role as the patient's advisor.

This means that the primary care physician and the patient, acting together, are in a unique position to make treatment decisions. These decisions have an impact on budget allocation for individual patient care, and in a budget holding scenario the primary care physician must balance the needs of each individual patient with the needs of other patients in the practice.

This may seem to be significantly different from current practice, where each individual appears to be dealt with separately. However, at the moment in most Canadian jurisdictions and certainly in British Columbia, physicians' choices for their patients are second guessed by health care bureaucrats in, say, Victoria. These overseers are charged with the task of ensuring that unnecessary tests are not administered and that unnecessary procedures are not ordered. However, they make their decisions on the basis of statistical norms and other system-wide characteristics. They do not know the particular patients and are not in a position to make the sorts of trade-offs and sensitive diagnostic inferences that a budget holding physician can.

In both the current system and the budget holding system, resources must be allocated. The difference is that in the budget holding case, decisions are made with greater knowledge of individual patients' needs.

Budget holding characteristics

Budget holding can be established in many different forms and tailored to meet local needs. Services that can be covered by this type of funding arrangement include X-ray and laboratory services, Pharmacare drugs, home care nursing, physiotherapy, rehabilitation services, many outpatient surgical procedures, podiatry, audiology assessment, substance abuse clinics, community mental health nursing, occupational therapy, speech therapy, neonatal care, and dietetic services.

One positive attribute of budget holding is that it introduces a desirable degree of flexibility into the present inflexible, centrally planned system. This flexibility permits patients and providers to participate in the planning process at the local level, and thus create a locally respon-

sive system which will enhance consumer satisfaction and, with responsible professional input, improve the appropriateness and quality of care. For example, in a small rural community, likely there would be only one X-ray facility and one laboratory. The consequence would be that competition cannot exist for these services, but there could still be considerable savings from the provision of state-subsidized pharmaceuticals. Consequently, physicians practising in the area might opt to participate in budget holding for this item alone. At the end of the first year, the savings achieved would be applied to an identified area of patient need, and a service such as a part time home care physiotherapist might be considered.

Alternatively, a practice operating in an urban area would have an opportunity to let a wide variety of providers bid for contracts to provide care. In this way, a budget holding urban practice might well contract for most of the wide range of medical services noted above. When a little experience has been garnered, it seems likely that some larger clinics operating in urban areas would want to enter into "total budget holding" in which they assume responsibility for a budget covering all health care for the patients on their roster. This type of budget holding has been operating on a trial basis in the U.K. for more than a year, and while only preliminary results are available they are encouraging in that "the projects are already bringing about real changes in service delivery as well as cost savings."[67]

Budget holding enables physicians to negotiate contractual relationships with such other health providers as laboratories, X-ray clinics, individual providers, and hospitals. Competition is real and effective. Institutional and individual providers have to compete in both cost and service for the opportunity to sell their product. It is hard to exaggerate the positive effect this would have on quality of care and the more prudent allocation of financial resources. In such a system, the main incentive for the provider is to improve the quality of care and thus the satisfaction of each patient.

Budget holding by itself provides no direct financial rewards to physicians, since expenditures may be made only for the enhancement of patient care, and then only when the savings have been achieved and

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67 *Fundholding*, vol. 3, no. 21, December 7, 1994, p. 22.

approved by external audit. Physician financial remuneration comes exclusively from fees paid under the particular payment modality in place at any particular time. In such a system, physicians stand to reap a small but appropriate benefit in that as they get better organized and more efficient the total practice roster may be increased, but in this circumstance the patients' demands for top quality service would effectively militate against patient rosters becoming excessively large. One area of minor controversy in Britain has been that physicians responding to patient demand have at times used funds to expand or improve practice facilities.

Improvements such as a play area for toddlers or upgraded computing equipment for practice management have been carried out in some cases. An argument can be made that this increases the capital assets of the practice and thereby in due course financially benefits the physicians. After investigation and review, however, the British have chosen to leave this marginal benefit untouched. It would be a simple matter to address it through the tax system, but since the incentives for physicians to participate in budget holding are principally professional and the financial benefits are very limited, it would be prudent to follow the British example and leave the possibility of limited capital gain as a small but tangible financial incentive to improvement.

Advantages and disadvantages

No discussion of budget holding would be complete without an examination of its advantages and disadvantages. The first and possibly most important advantage is that budget holding creates a limited competitive market in which the consumers, acting together with their physician advisors, directly influence decision making about the purchase from providers of such services as X-rays, laboratory work, and pharmaceuticals. This healthy competition among providers will effect a reduction in costs and an improvement in service. Second, budget holding engages primary care physicians in the management of the system, a feature which has been lacking in recent years in Canada. Third, budget holding will make physicians aware of costs and consequences in a way hitherto believed impossible. The present regulatory approach to cost control has done little to improve physician awareness of costs, but budget holding puts the primary care physician directly in the line

of fire on cost control because the budget holder is responsible for managing those costs. Finally, if benefits of the type seen in New Zealand and Great Britain are realized, there will be measurable benefits such as increases in productivity as measured by patient throughput and improvements in the quality of care.

Budget holding is not without disadvantages which must be recognized and, where possible, minimized. The first and most obvious disadvantage is that such a program does not come without cost. Establishing and maintaining budget holding involves substantial costs in administration, training, and evaluation. Physicians, by virtue of their experience as employers and financial managers, have considerable small business experience. However, it is quite a step from this to successful budgeting, contract development, and contract management. As in Britain, it will be necessary to set up training courses for a budget manager in each practice or group of practices. Experience indicates this may be somewhat easier than some might suggest. Advocates of budget holding maintain, and the evidence seems persuasive, that connecting primary care givers with the financial consequences of their actions and thus unleashing a hitherto untapped resource of innovation and entrepreneurial spirit greatly outweighs the obvious upfront costs.

Another possible criticism is that budget holding would create a two-tier system, in which practices in the program could negotiate faster access for their patients at better rates than those outside the system. This is a valid criticism. However, it is also true that as competitive forces come into play, patients will choose to attend practices where they receive the best care at the best price. If this puts less effective practices out of business, whether they be budget holding practices or not, it is a benefit to the system overall. The purpose of adopting budget holding is to introduce competition, and inevitably competition will identify winners and losers.

An invalid criticism of budget holding is that some budget holders will be successful by offering non-essential "frill" services to attract patients. Such a tactic, if used to excess, would cause the budget holder to lose the confidence of the RPA by which it is funded. The RPA's responsibility includes monitoring the providers with whom it contracts for the delivery of services. Budget holders' practices would, therefore, be checked on a periodic basis to ensure that the correct amount of the right kind of testing was being carried out and that recognized patterns of

practice were being followed. In other words, budget holders would be subject to competitive pressure from their clients and from the RPAs.

There is a suggestion that budget holding forces physicians to ration health care at the bedside. This is a valid observation, but the question must be asked: would the average Canadian feel more comfortable having the physician at the bedside make decisions about what care is affordable and appropriate, or having that decision made by a remote bureaucrat, likely with no medical training, based on general demographic and morbidity statistics? Since resources in the public health care system are limited, these are realistically our options, and it appears that most Canadians would prefer to have the physician at the bedside examine and decide after appropriate consultation with the patient.

A theoretical criticism of budget holding is that it leads to some patients being short changed in favour of others deemed more worthy, for whatever reason. Smith *et al*. outline several variations on this theme, and while they note that this type of behaviour could occur, there is little evidence to support the existence of such a problem. The British were concerned about this possibility and investigated it. They found very few complaints, and not one incidence. While this is reassuring, it is clearly one of many areas that would require monitoring.

As Stephen Pollard has pointed out in the preceding section, budget holding will be retained by the Labour Party if it forms the next government. One reason is that it has been saving money for the government. But surely, an equally important reason is its popularity with the general public.

Overseas experience

The U.K.

A system of provider fund holding was pioneered in the U.K. starting in 1990, and by the end of 1994 had expanded to cover 34 percent of all patients. This mechanism, known in the U.K. as general practice fund holding (GPFH), was introduced by an innovative group in Britain's National Health Service (NHS) through a pilot program in which a limited number of family practitioners were allocated NHS budgets and given the responsibility for purchasing health services for their patients. The program, which began as something of an afterthought, proved to

be a means of reintroducing competition and the entrepreneurial spirit to health care in Britain.

In England, "GPFH allows volunteer general practices of 7,000 patients or more to hold a budget with which to purchase:

a) a proportion of hospital and community health services (HCHS) for their patients;
b) all drugs that they prescribe or dispense for their patients, and
c) the services of the staff that they employ to help deliver their service, e.g., practice manager, practice nurses and receptionists."[68]

It is important to note that GPFH covers only about 20 percent of health expenditures in fund holding practices. Items such as general medical admissions to hospital, accident and emergency cases, obstetrics, renal dialysis, chemotherapy, and fracture clinics remain under the control of the appropriate regional authority at this time. However, GPFH does cover a selected list of about 300 surgical procedures, out patient mental health, community nursing, radiology, laboratory services, physiotherapy, occupational therapy, podiatry, speech therapy, and dietetics.[69] In Wales, Scotland, and Northern Ireland, the sizes of practices permitted to participate in GPFH are smaller than in England, and in Scotland there is no minimum size for participants in the community option.

Gerald Malone, the British Minister of Health in December 1994, made it clear that GPFH had become so successful that the government had decided to expand it; there are now a number of total fund holding practices which have been running on a pilot basis since April 1994. In a press release dated December 2, 1994, Mr. Malone is quoted as saying, "I believe it [GPFH] represents value for money, and will help drive forward the dramatic improvements in care that fund holding is bringing to patients."[70] There are no firm data yet from the pilot total fund holding practices but the available evidence suggests that "the projects are

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68 R. Smith et al., *A Practical Guide to Fund Holding*, Oxford: Blackwell Science Ltd, 1994, p. 4.

69 *Ibid*.

70 Ministry of Health press release, Richmond House, 79 Whitehall, London, England, December 2, 1994.

already bringing about real changes in service delivery as well as cost savings."[71]

There are many ways to measure the success or failure of health outcomes, but one measure that cannot be overlooked is consumer satisfaction. The remarkable results from a recent survey from Oxfordshire are summarized in table 8. The figures give some idea why many patients and health care providers perceive practical benefits from fund holding. While the information in table 8 reflects the benefits observed in just the first year, it seems reasonable to expect that these benefits will be magnified as experience with this venture grows.

New Zealand

New Zealand, like the U.K., preceded Canada by many years in the introduction of state-controlled health care. But in 1984, in the run-up to the general election, the country faced a liquidity crisis and was forced to deal with the consequences of years of extravagant overspending. (Contrary to popular belief, the International Monetary Fund played no role in the resolution of the crisis.) Faced with the imminent possibility of being unable to refinance government loans, the New Zealand government was obliged to take urgent measures, and one of the first targets of fiscal responsibility was the much-vaunted New Zealand health care system.

Like Canadians, New Zealanders had long thought of themselves as world leaders in the provision of health care, and they were very proud of their "cradle to grave" system which dated back to the post-depression Labour government of the late 1930s. Since 1984, the thrust in health care has been to implement many of the initiatives outlined in this paper, and budget holding has become an important part of introducing fiscal responsibility to New Zealand's financial arrangements.

Substantial reforms to New Zealand health care were introduced on July 1, 1993. The results, while preliminary, will interest Canadians. The changes in the system can be divided into three major categories. First, in the secondary care sector, purchasers and providers were separated by the creation of 4 regional bodies which were given sole responsibility

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71 *Fund Holding*, "Total Fund Holding Projects Make Their Mark," December 7, 1994.

Table 8: Achievements Listed by an Oxford Region Practice in the First Year of Fund Holding (FH)

Service	Wait Before FH	Wait After FH
Rheumatology Clinic	14 weeks	6-8 weeks
Orthopedic Assessment	18 weeks	8 weeks
Total Hip Replacement	18 months	9 months
Cataract Surgery	18 months	7 months
Dermatology Assessment	14 weeks	4 weeks
Gynecology Surgery	18 months	9 months
General Surgery	12 months	3 months
Chiropody (Podiatry)	9 months	3 weeks
Dietetic Assessment	3 months	3 weeks
Speech Therapy	6 months	6 weeks

Source: R. Smith *et al.*, *A Practical Guide to Fund Holding*, Blackwell Science Ltd., 1994, p. 95.

for determining the needs of the population in their area, developing contractual relationships with the hospitals and some other providers for the provision of service, and monitoring the extent and quality of service provided. Second, hospitals were grouped into geographically aligned crown corporations known as Crown Health Enterprises (CHEs) which then negotiated contracts with the regional bodies. Third, substantial changes were made in primary care by introducing budget holding as a mechanism for financing primary services.

The literature from New Zealand places some emphasis on the introduction of competition to the system. However, a political decision was made to pay more attention to introducing reform with a minimum of confrontation and to redirect financing to areas where special needs had been identified, for example, programs designed to improve Maori and child health. New Zealand decided to place the long-term goal of establishing a sustainable system ahead of the goal of rapidly creating

the benefits of a true competitive free market system. Needless to say, supporters and opponents of the changes have vastly different views of the outcomes, and each group produces an array of figures supporting their particular position. From a Canadian viewpoint, there is much to learn from the New Zealand experience, both in terms of what should and should not be done.

New Zealand and Canadian health care are similar in many ways. One particular similarity is that in both countries primary care physicians are remunerated on a fee-for-service basis as opposed to the capitation model employed in the U.K. However, primary care practitioners in New Zealand recover from 50 to 80 percent of their fees directly from the patient, and recoveries of this nature have been part of the system since it was introduced in 1938. Another major difference from the Canadian system, and one that conveys a substantial advantage to New Zealanders, is that they have always had a private component. Private hospitals and clinics have never ceased to be a key part of health care there. Since competition and enterprise have been discouraged in Canadian health care for many years, it is likely that the transition to a sustainable system will be more difficult here.

The information from New Zealand is sparser than from the U.K. because the system is newer. However, budget holding is expanding rapidly, and by mid-1995, 40 percent of general practitioners had moved voluntarily to budget holding for both pharmaceuticals and laboratory test expenditures, a further 15 percent were budget holding for pharma-ceuticals only, and 8 percent were being paid on a capitation basis.[72] It is interesting that this has occurred in spite of expressed scepticism and concern by both the New Zealand Medical Association and the New Zealand General Practitioners' Association. This situation provides an important example for Canada because health planners were able to use incentives and innovation to persuade individual practitioners of the benefits of moving to the new system in spite of the opposition of organized medicine. This emphasis on incentives and choice has worked in a way that draconian confrontation never could.

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72 Personal Communication, to W. McArthur from L. Hawkins, Chief Advisor, Strategic Planning, Ministry of Health, Wellington, March 25, 1996.

The results in New Zealand have not been uniformly beneficial. For example, examination of the first year of RPA activity there shows that overall surgical throughput increased 3.9 percent in the first year of operation, followed by a further increase of 1.6 percent in the second year. However, between June 1993 and June 1995, the number of people on the overall surgical waiting lists increased 20 percent. The numbers of people waiting for cardiovascular surgery, general surgery, gynaecology, ophthalmology, and orthopaedic surgery all increased, but those for otolaryngology, neurosurgery, and paediatric surgery decreased.[73] A closer examination reveals that procedures designated as "higher priority" have shown a dramatic increase in throughput while lower-priority procedures have shown a decrease. New Zealanders acknowledge that the waiting list information is misleading, at least in part because of deficiencies in the way the lists are created. There have been no standard clinical criteria for putting a patient on a list, and names can appear on more than one list and remain on the list after patients have moved, gone to the private sector, or died of an unrelated condition. Efforts are currently being made to improve the way waiting lists are created and introduce a method for prioritizing those requiring care.

The medical (as opposed to surgical) results of hospital care appear to have been almost universally beneficial under the new arrangements. In 1993/94, patient discharges increased 3.8 percent, day patient discharges increased 7.2 percent, and average length of stay dropped from 7.5 days in 1990/91 to 4.53 days in 1994/95. These are solid indicators of enhanced productivity.

From a fiscal management viewpoint, the results produced in 1993/94 exceeded expectations. The regional purchasers, with an income of NZ$3,857.7 million, spent NZ$3,826.6 million, creating a small surplus of NZ$31 million. On the other hand, recent information indicates that the Crown Health Enterprises (CHEs), which are in fact the hospitals, are having to deal with a massive rundown of their capital assets that has occurred over the last 20 to 30 years, and as a consequence are presently operating at a deficit.

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73 *Purchasing for Your Health: Report of The Performance Monitoring and Review Unit, 1994-1995*, New Zealand Ministry of Health, p. 77.

When New Zealand introduced its RPAs, the legislation included provision for the creation of a vigorous private sector component to compete for the opportunity of providing a broad spectrum of health care. This part of the legislation has not been implemented in full, and so the system continues to operate in large measure as a government monopoly. In fact, critics of the New Zealand changes claim that the overall effect has been to replace one central ministry with four regional sub-ministries which continue to act in the same manner as the previous central body. Whether or not this is fair comment, it seems that the full benefits of reform will not be realized until the private sector creates real competition for the public sector. This is well recognized in New Zealand, but those involved in developing the system note that the changes introduced to date are substantial and beneficial, and argue that proceeding too rapidly would risk upheaval that could jeopardize the long term evolution toward a truly competitive and balanced private-public system of health care.

Canadians have much to learn from the New Zealand experience; most important is that major innovations in a complex system such as health care require careful planning and monitoring. Shotgun approaches of the type seen recently in some Canadian provinces, where the wisp of an idea is converted overnight into legislative and bureaucratic edict, are doomed to failure even when the idea is good.

Provider remuneration

It was noted earlier that budget holding does not require primary care providers to be remunerated in any particular fashion. In different countries, existing budget holders are paid in a variety of different ways. In the U.K., most primary care physicians work under a capitated system. In New Zealand, they generally receive fee-for-service payments, and in both countries some are salaried. These different payment modalities are possible because the providers who manage the patient care funds do not receive their own remuneration from these funds. Indeed, providers in Britain and New Zealand are prohibited from benefitting financially from the budget, though indirect and appropriate benefits of the type described earlier are both permitted and encouraged in both jurisdictions.

The foregoing should not be taken to signify that provider remuneration and budget holding are necessarily unrelated. In different times and different places, one or more or a mixture of remuneration systems may be desirable. There is at least a theoretical argument that a capitated system aligns more easily with budget holding than salary or fee-for-service. As noted earlier, for capitation to be effective it is necessary that patients be on the roster of a specific primary provider and receive all their primary care from that practice; it is not clear that such a system would be acceptable to the majority of Canadians.

The matter of provider remuneration has been extensively studied and reported on. In the opinion of these authors, it would be folly to attempt to dictate a uniform policy for Canada or any province. Rather, it would be better to develop pilot projects which enable provincial and local authorities to make evidence-based decisions about the benefits and deficiencies of any particular form of remuneration.

Budget holding summary

On balance, it appears that budget holding has much to offer Canadians who choose to retain the state as their primary health insurer. Regional Purchasing Agencies would have the authority to enter into contracts with medical clinics and groups of providers for the provision of basic medical services.

Physician groups would be funded for the expenditures to be made during the year on behalf of their patients, based on past experience with costs incurred by the health care system as a whole for people with the age and sex characteristics of the groups' patients. The physicians themselves would enter into separate discussions with the RPA on remuneration; some groups might opt for fee-for-service, some to be paid per patient, and some to be salaried. Since the RPA would have many arrangements, it would be able to assess the cost and effectiveness of the different kinds of arrangements and negotiate accordingly.

Future possibilities

This section has constantly focused on the incentives, both positive and negative, that are created by current institutions in the health care sector. Our goal is to identify and create incentives that will improve efficiency, productivity, and thereby the quality of care for all Canadians.

The introduction of budget holding within RPAs will dramatically change the incentives for health care providers. However, until the federal legislation is changed, the central source of all funding for the health care system will continue to be taxation, and the amount of funding will be subject to the ebbs and flows of political decision making. For many, perhaps most of the population, this would be entirely acceptable. However, an increasing number of Canadians are dissatisfied with the service they are receiving, and some are seeking care outside their province of residence or outside the country. Evidently they are willing and able to spend more money on their care than the government is prepared to provide through Medicare.

The obvious answer is to permit these people to make alternative arrangements for their own care—including the option of buying insurance from a private provider. The private provider would then become the RPA-equivalent for those opting for private coverage. A person choosing to insure privately would be able to transfer to the private insurance company an amount equivalent to the sum which the RPA would otherwise have received from the government for his or her care. (This would parallel the types of arrangements presently possible in countries like Germany, Britain, and New Zealand.)

Medical premium accounts[74]

An alternative to provider budget holding is to allot health care funds directly to the consumer. During the national debate on health care in the U.S., an idea for returning purchasing power to the patient was developed by the National Centre for Policy Analysis (NCPA) in the form of a medical savings account (MSA). The general idea of an MSA is that an employer deposits a fixed amount of money from the total dollars he has already been spending for employee health insurance (say, half of the total) into an employee's MSA. The company then uses the remain-

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74 The information about Medical Premium Accounts is adopted from *Medical Savings Accounts* published by the Evergreen Freedom Foundation in Washington in 1995, and from John C. Goodman and Gerald C. Musgrave, *Patient Power*, Washington, D.C.: The Cato Institute, 1992. As well, this concept has been developed in various policy briefs published by the National Centre for Policy Analysis in Dallas.

der of the funds to buy a higher-deductible, catastrophic medical insurance policy which is less expensive than a low-deductible policy. (The deductible in health care insurance is comparable to the deductible that Canadians encounter in automobile collision and comprehensive insurance.)

When faced with medical expenses, employees first use the money in their MSA which can be used only for health-related expenses. Now while employees are permitted to use these funds to pay for any health-related service, only expenditures on services covered by the company plan count towards their deductible. So, for example, suppose the deductible is $2,000 per year. A person might elect to spend $500 from his MSA on massage therapy or nutrition counselling. If these services were not covered by the insurance plan, the person would have used up some MSA funds but would still face the full $2,000 deductible if a need arose for other health-related services during the year.

At the end of the year, any funds remaining in a person's MSA may be withdrawn, left to accumulate in a separate account for future medical expenses, or rolled over into a retirement savings plan. The most important aspect of an MSA is that the money belongs to the employee; that employee is responsible for these funds and can reap the benefits of using the medical system more prudently. In addition, since much of the cost of insurance lies in claims processing, the account portion of the MSA reduces administration costs as smaller claims do not have to be processed.

Companies in the U.S. that have adopted the MSA framework (the details of each plan can vary) have demonstrated that MSA-type health insurance saves them money. The employees of these companies have benefited as well: they have more control over the type of care they receive, and they are rewarded for prudent use of the health care system because they retain any money remaining in their MSA at year end.

Public sector delivery

The authors propose that the MSA concept be adapted to the Canadian context under the name Medical Premium Account (MPA). The MPA concept would create a more efficient and a more effective method of providing publicly funded universal insurance. An MPA would be truly portable, as the funds belong to the individual. It would be truly

comprehensive, as the funds could be used to purchase any health services the individual desired, thus offering greater consumer choice. It would inform the consumer and the supplier of the true costs of health care and it would provide them both with incentives to use the system appropriately. As well, an MPA would ensure that the health provider was the agent of the patient, not the agent of the state or a specific institution. The doctor-patient relationship which has been eroded over the years by government regulations and cost cutting measures would be restored.

How MPAs work

The MPA is divided into two parts: an individual's account and the cost of the higher deductible. Every citizen is endowed with a medical premium account from the government. The citizen then must use a significant portion of the account to acquire private insurance to cover catastrophic illness. If he or she fails to do so, a portion of the sum is directed to the area RPA for the purchase of catastrophic insurance. The government would finance MPAs in the same way that it funds the RPAs—from general tax revenues. Under this scenario, hospitals would be privatized, clinics would be privately run, and health care providers would bill patients directly, rather than the government.

Table 9 depicts how the funds would be allotted to an MPA for single individuals, for a family of four, and for an older couple living in British Columbia. The money allotted to an MPA is that which remains after the actuarially determined cost of catastrophic insurance is deducted from total health expenditures per capita on each demographic group. The example in table 9 shows the calculations for a $1,000 per year deductible, assuming that initially the government still spends the same total amount on health care per capita.

The money in the MPA goes towards paying for all health services and routine medical bills, including pharmaceuticals, that cost less than the deductible. Any medical service, including those not covered by the individual's or family's insurance plan, can be paid from this account—for example, massage therapy or herbal remedies. However, only covered services count towards the deductible. The provision of government-funded catastrophic insurance ensures that no Canadian who

Table 9: Medical Premium Account—$1,000 Deductible
Funds available for Medical Premium Accounts
(B.C., Direct Savings Desired by Government = Zero)

	Single Male Aged 25	Single Female Aged 25	Family (Male & Female Aged 35 and 2 children)	Couple (Male & Female Aged 55)
Total Expenditure on Health Care per Capita	$649	$1,268	$3,091	$2,777
Cost of Catastrophic Insurance	-$298	-$633	-$1,825	-$1,537
Funds Available for an MPA	$351	$635	$1,265	$1,240

Note: Total expenditure data for B.C. are from 1991, B.C. Stats. The cost of catastrophic insurance is estimated using various documents from the National Center for Policy Analysis in Dallas, Texas.

suffers a heart attack or a major illness is bankrupted by the cost of medical treatment.

Consider, in table 9, the case of a single female aged 25 in British Columbia. In 1991, the B.C. government spent about $1,268 to provide her with health care. If an MPA system were implemented, approximately $633 of that amount would go towards paying for her catastrophic insurance, so that she would be left with $635 in her MPA from which to pay for all routine medical expenses. If she spends all of the funds in her MPA, she is responsible for paying out of pocket the next $365, which is about what she would pay in premiums in B.C. or Alberta. In contrast with the present insurance system, however, with an MPA she does not have to pay any premiums or fees for medical care from the account portion of the MPA until she actually receives the care. Once the $1,000 deductible is reached, the government-provided catastrophic insurance begins.

With an MPA system, patients have an incentive to "shop around" for services, as they keep any money remaining in their MPA at the end of the year. Health care providers have to compete for clientele and therefore they have an incentive to reduce their operating costs without reducing service quality; they will also have to become more patient-oriented and more knowledgeable about the benefits to be derived from alternative forms of health care.

There is no need for public policies directed at increasing the amount or type of care available to identifiable groups because everyone, irrespective of gender or minority status will have, as a Canadian, funds with which to purchase health care services. Patient demand will dictate the services offered by health care providers, and providers who do not supply the amount and type of health care demanded by their patients will go out of business.

Public and private insurance co-exist in this scenario. The public and private plans would cover core services as defined in consultation with professional groups and with the public, not simply from following the status quo. A person who chooses to opt out of the public insurance scheme—the local RPA—takes her MPA with her, along with a portion (perhaps 50 to 75 percent) of the high deductible insurance cost paid by the government. She would then have to enrol with a private insurer, selecting an insurance package that corresponds closely to her specific requirements—such as one that includes acupuncture, general practitioner visits, or visits to a chiropractor. As with the public plan, only expenditures on the health services covered by her insurance plan count towards her deductible, but she may use the MPA to pay for any health-related expenses during a year.

As mentioned above, in such a system, private insurers have to cover the defined set of core services but are permitted to offer "extras" for additional premiums. They should be required to accept any eligible individual who wishes to transfer from the public system but not those transferring from other private insurers, to avoid the dumping of more costly clients onto other insurers. There needs to be some public discussion about whether or not to incorporate the German model of permitting only those above a certain income or asset level to transfer to private insurance. This restraint would protect the less well-off from signing up for plans they cannot afford, but may be too restrictive for Canadians.

For people who are uncomfortable with the idea of any remaining MPA funds being redeemable as cash by the individual at year end, alternatives exist, as has already been mentioned. It could be required that any remaining funds be rolled into a retirement savings plan and locked in until the individual reaches a designated age. Another option would be a requirement that any surplus MPA funds remain in an individual's MPA account to cover future medical procedures which are not covered by public insurance—for example, cosmetic surgery, or the more expensive health care that is necessary as people get older. The tax system could also be used to ensure that the "funds" are spent on health care—i.e. every Canadian, irrespective of income, could be given a set number of tax credits reserved for health care.

Some will argue against the MPA concept on the basis that people may act irresponsibly with respect to their health simply to retain the extra funds. However, such theoretical concerns are not supported by experience with MSAs in the U.S., where it has been shown that people do act responsibly and that they do get necessary health care in an MSA scheme.[75] There are numerous social welfare programs in Canada that give money directly to recipients, and although abuse of these programs does occur there are feasible methods of reducing fraud to a manageable level. Individuals purchase home insurance and car insurance, they balance cheque books, they hold credit cards, and they cope with many complicated transactions on a daily basis. The introduction of an MPA would be a huge change in the Canadian mode of thinking about how health care is funded and there would have to be a period of adjustment, of course. Individuals can and do adapt, however, and once they experience the choices granted to them by an MPA they will be hesitant to turn back.

Pharmaceuticals

Earlier, we addressed pharmaceutical costs and noted that there is little evidence that the cost of drugs to taxpayers constitutes a significant problem. Furthermore, the evidence suggests that attempts at cost constraint such as the present reference-based pricing program in B.C. are

75 *Medical Savings Accounts*, Washington, D.C.: Evergreen Freedom Foundation, 1995.

not only tackling a non-existent problem but, even if a problem did exist, are doomed to failure. The literature suggests that instead of reducing health care costs significantly, the real effect will be a substantial increase in overall costs.

This leaves the question of how taxpayer-purchased pharmaceuticals for the elderly and the poor should best be managed. In the opinion of the authors, this is an area that should be resolved by either the budget holding or MPA arrangements. No one is more suited to make the most appropriate decisions about the selection of pharmaceuticals than the physician acting in concert with the patient. The patient wants the best possible results and the physician is in the best position to make the decision about how to achieve those results.

In the budget holding and MPA scenarios, both the patient and the physician would rather accept 6-cent erythromycin tablets instead of $2.25 ciprofloxacin tablets if the health outcome is satisfactory. The patient wants his or her bronchitis or earache resolved and the physician wishes to treat the patient satisfactorily. In either scenario, both the patient and the physician wish to be fiscally prudent. The budget holding provider would like to conserve the drug budget so that money is available to procure the expensive ciprofloxacin for the few patients who really need the drug. The MPA patient would not wish to waste valuable funds on a drug that is simply more expensive.

There can be little doubt that these types of arrangements are far superior in terms of efficacy and patient satisfaction than the situation that currently exists in B.C. whereby a remote, government-appointed committee makes decisions regarding patient care. Budget holding and MPAs bring the focus back on patient care in a setting that promotes fiscal responsibility.

Fixing the hospitals

Inefficiencies in the hospitals and in the way they are operated and financed was documented earlier. Here, we discuss suggestions for reform which are designed to introduce incentives for efficiency and competition.

Reorganizing hospital care

Canadian hospitals need to be reorganized by implementing the following key policies:

1. A clear division must be created between the hospitals as the providers and the public as the purchasers of services.
2. A substantial proportion of the now publicly owned hospitals should be sold or turned over to the private sector.
3. A system is needed whereby the public and private sectors compete on a level playing field for the opportunity to provide in-patient acute care services.

Private sector hospital care is an essential and inevitable change which should be introduced as soon as possible. Reorganization of the hospital sector in any province could proceed rapidly with each facility falling into one of four fundamentally different categories.

Public Sector Hospitals, becoming crown corporations, would compete with the other hospital categories to provide service to all types of patients. These hospitals would be administered by boards appointed by the provincial government. However, it is desirable that the present board selection process, under which some individuals appointed to such bodies are patronage appointments with little in the way of qualifications or experience for the task, be replaced by a more competent and competitive selection process. These crown corporations should, like all other hospitals, be subject to all provincial and federal legislation governing corporate activities in their jurisdiction. They should be required to pay taxes to government and they should be expected to pay dividends to their shareholders—the taxpayers. Failure to perform adequately in this respect should be a cause for dismissal of both the chief executive officer and, in some circumstances, the board. The Toronto Hospital at its various sites in Toronto and the Vancouver Hospital at its two sites are examples of hospitals that might be organized in this fashion.

Charitable and Religious Hospitals have always played a significant role in health care in most countries, but in recent years in Canada their role has diminished, in part because the religious orders have experienced increasing difficulty in attracting sufficient personnel, and in part because of the government takeover of hospital care. This is an unfortunate change that needs to be reversed. A variety of religious orders have

run hospitals around the world for over 100 years and many of them provide exemplary care and management. St. Paul's Hospital in Vancouver and Mount Sinai Hospital in Toronto have strong religious affiliations and should be turned over to the Catholic and Jewish bodies that started them. They would then be in a position to compete head-to-head with the large publicly owned hospitals in Vancouver and Toronto. In these circumstances, patients acting through their physicians and insurers would quickly decide which hospital provided the service most to their individual taste. The outcome would likely produce innovations in service, improvements in efficiency, effectiveness, and appropriateness of care, and a considerable thrust to improve bed utilization.

Community Hospitals owned and operated by the communities which they serve should be encouraged. This would provide a degree of local input into a hospital which is not possible within the government-owned crown corporation structure. This type of arrangement would do much to improve the service and responsiveness of community hospitals in rural settings. People in rural communities often feel that their needs are ignored or at least misunderstood by remote government bureaucrats, and locally owned hospitals would do much to correct this feeling of powerless isolation. In this setting the shareholders would be the community, which would have the power and choice to create profits or accept losses as its members chose. They would receive funding by whatever contractual arrangement was reached with the RPA but could supplement this in the manner of their choosing—local fund raising, municipal tax levies, endowments, charitable donations, or other means appropriate to the setting and the community. As more and more rural hospitals are closed in response to increasing budgetary pressures, the prospect of a local financing option may be increasingly attractive to many communities.

For-Profit Private Enterprise Hospitals would provide an important competitive incentive to the Canadian health care scene. These facilities, owned and operated by privately or publicly owned companies, would have the opportunity to compete on an equal basis with the other hospitals. Across the country there are many hospitals, particularly in larger cities with several institutions, that could and should be put up for sale to the private sector.

It must be emphasized that all hospitals of all categories should be encouraged to compete for the opportunity to provide service to all

types of patients. Private and public hospitals of all types would compete for patients regardless whether their insurance was with the public or private sector. This has happened in other countries with significant benefits to everyone. In the U.K., many public patients now receive their treatment in private facilities, with the result that enormous pressure has been put on the public sector hospitals to enhance and improve service and productivity to meet private sector standards. In New Zealand and most European countries, private sector hospitals have always been a vital part of the secondary care scene, and it seems that in those jurisdictions few would consider changing this.

In Canada, some are apprehensive that introducing private sector hospitals will in some way lead to a two-tier system with quality care available only to the well-to-do. This would occur only if the system were badly configured, and certainly does not need to be the case. Most people familiar with the situation in New Zealand claim that while the private hospitals may provide more choice in treatment and services, the best-quality high-technology care is available in the publicly run facilities. This is perfectly reasonable and comprehensible. An adult requiring relatively uncomplicated surgery, such as removal of an appendix, may prefer this to be performed in a hospital where a well-appointed private room is available with unlimited family visiting and other benefits. The same person requiring complicated surgery to remove a life-threatening brain tumour is going to be concerned primarily with the quality and sophistication of care available in the operating room and, subsequently, in the recovery and intensive care rooms. In many circumstances, this may well be in the crown-owned public hospital.

Solving the labour dilemma in the hospital sector

Reducing costs in the health care sector will require flexibility and innovation, as unions can impose sizeable economic costs. If the law gives them excessive power, they can act as monopolies gaining wage increases for their members at the expense of patients and non-unionized workers. As monopolies, unions can hinder progress in times of rapid

technological and economic change, and they can block increases in productivity that raise societies' standards of living.[76]

Workers must be permitted to unionize if they so desire in order to address particular concerns. However, the benefits of collective action must be captured while minimizing costs. This can be accomplished only by giving unions the freedom to operate while also giving individuals freedom of choice: being free to join trade unions must also mean being free not to join them. If a union doesn't get the required voluntary support to negotiate on behalf of its members, then it probably doesn't reflect the demands of the workers it represents and should be allowed to go out of business. The introduction of right-to-work (RTW) laws in British Columbia which encompass all sectors of the economy, including the health care sector, would be a step towards minimizing the costs and maximizing the benefits of unionization.[77]

New Zealand: a labour policy example for Canada[78]

Between 1984 and 1991, New Zealand changed its economy from the most heavily regulated to the least regulated system among the OECD countries. Among its reforms was the *Employment Contracts Act* (ECA), the cornerstone of New Zealand's comprehensive economic and social reform program. Freely negotiated labour contracts are now the basis for responsive, diverse labour markets.[79] Labour is now treated as a marketable service and the wage as market price, agreed upon freely by employers and individuals or groups in decentralized contact negotiations. The ECA has greatly reduced the role of government and unions in wage setting in the workplace.

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76 Fazil Mihlar, "The Economic Benefits of Right-to-Work Legislation," submission to the Joint Review Committee on Right-to-Work Study, The Alberta Economic Development Authority, The Fraser Institute, 1995.

77 *Ibid*.

78 The New Zealand example is taken from Fazil Mihlar, "The Economic Benefits of Right-to-Work Legislation."

79 Wolfgang Kasper, *Liberating Labour: The New Zealand Employment Contracts Act*, Kiel: The Institute of World Economics, June 1995, p. 1.

In 1991, in an attempt to mobilize public resistance against the bill, opponents warned New Zealand of the dire consequences of labour reforms. The main thrust of the arguments was that real wages would fall, creating low-paying jobs. Subsequent events have shown these fears to have been unfounded. Indeed, the New Zealand economy appears to have benefited from RTW laws. From 1986 to 1993, "at least one percentage point of the employment growth rate [of the 4.4 percent growth rate since the ECA] can be attributed to the ECA legislation."[80] As well, several other indicators suggest that RTW legislation has had a positive economic impact.

The health labour market has no legitimate claim to exemption from competition, and right-to-work legislation should be implemented immediately. The Seaton Commission urged the adoption of a "strategy to maintain equality between the wages and benefits of health care workers and the general wage level in the British Columbia economy." Right-to-work legislation would be a step in the right direction.

Summary

The hospital sector in Canada suffers from significant deficiencies in efficiency, effectiveness, and productivity. This situation constitutes a critical issue in the Canadian health care debate since hospitals consume 38 percent of the total Canadian health care budget and most of this comes from taxpayers' pockets. Various groups, and in particular the Working Group On Hospital Utilization, have outlined measures that need to be applied to bring hospital expenditure and performance into line. These proposals, while well thought out and practical, nevertheless lack the critical component of an incentive mechanism. This problem is not one that Canada alone faces; it is observed in most OECD countries.

Two countries that have preceded Canada in facing fiscal and health care crises are the U.K. and New Zealand. In both places, mechanisms have been implemented to separate purchasers and providers in the secondary and tertiary care sectors. Purchasing agencies have been

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80 Tim Maloney, "Has New Zealand's Employment Contracts Act Increased Employment and Reduced Wages?" Department of Economics, University of Auckland, July 1994, pp. 12-17.

established to act on behalf of the consuming public to negotiate and monitor contractual relationships for the provision of hospital and related services. In addition, in New Zealand, reform of the labour sector legislation has helped to bring these costs into line. These competition-oriented mechanisms have been functioning well and are producing beneficial effects.

Concluding remarks

The exact mechanisms used in New Zealand, the U.K., and the other countries discussed in this book are unlikely to fit the Canadian scene precisely. However, they provide guiding principles for the much-needed reform of Canada's health care system. They indicate that reforms must involve both the public and the private sectors in the financing and delivery of health care. Only the incentives provided by market mechanisms, and the political resolve to implement them, can bring about a better health care system in Canada.