HEALTH REFORM IN CANADA: HOW DO WE COMPARE? THE POLITICAL LANDSCAPE FOR HEALTH CARE REFORM IN OECD COUNTRIES

Antonia Maioni
McGill University

- How do we compare?
  - some methodological insights from political science
- What should we compare?
  - Asking the right questions
- How can healthy comparisons lead to healthier societies?

HOW DO WE COMPARE?

Why compare?

- Context: Situate our system
- Classification: View alternatives
- Change: Understand conditions for change
- Construct (causality?): Develop explanations

How to compare?

- Search for causal regularities or patterns across countries or cases
- Cross-national analyses to identify, track, and hypothesize about change across time and space
- Logically inductive analysis that combines generalizable explanation with historical and institutional specificity

How not to compare!

- Compare countries that … begin with the letter "S" : say, Sweden, Singapore, South Africa
- Emulate countries that … rank # 1 in a survey of health care systems
- Shop abroad for solutions … transplant as needed
- Allow ideology to trump evidence

Where in the world should Canada compare?

- Wider context of welfare state
  - Canada considered "liberal" welfare state (Esping-Andersen 1990)

- Logic of "close-case comparison"
  - Canada and the US remain both "most similar" (in terms of delivery of care, professional practice) and "least alike" (in terms of financing and insurance)

WHAT SHOULD WE COMPARE?

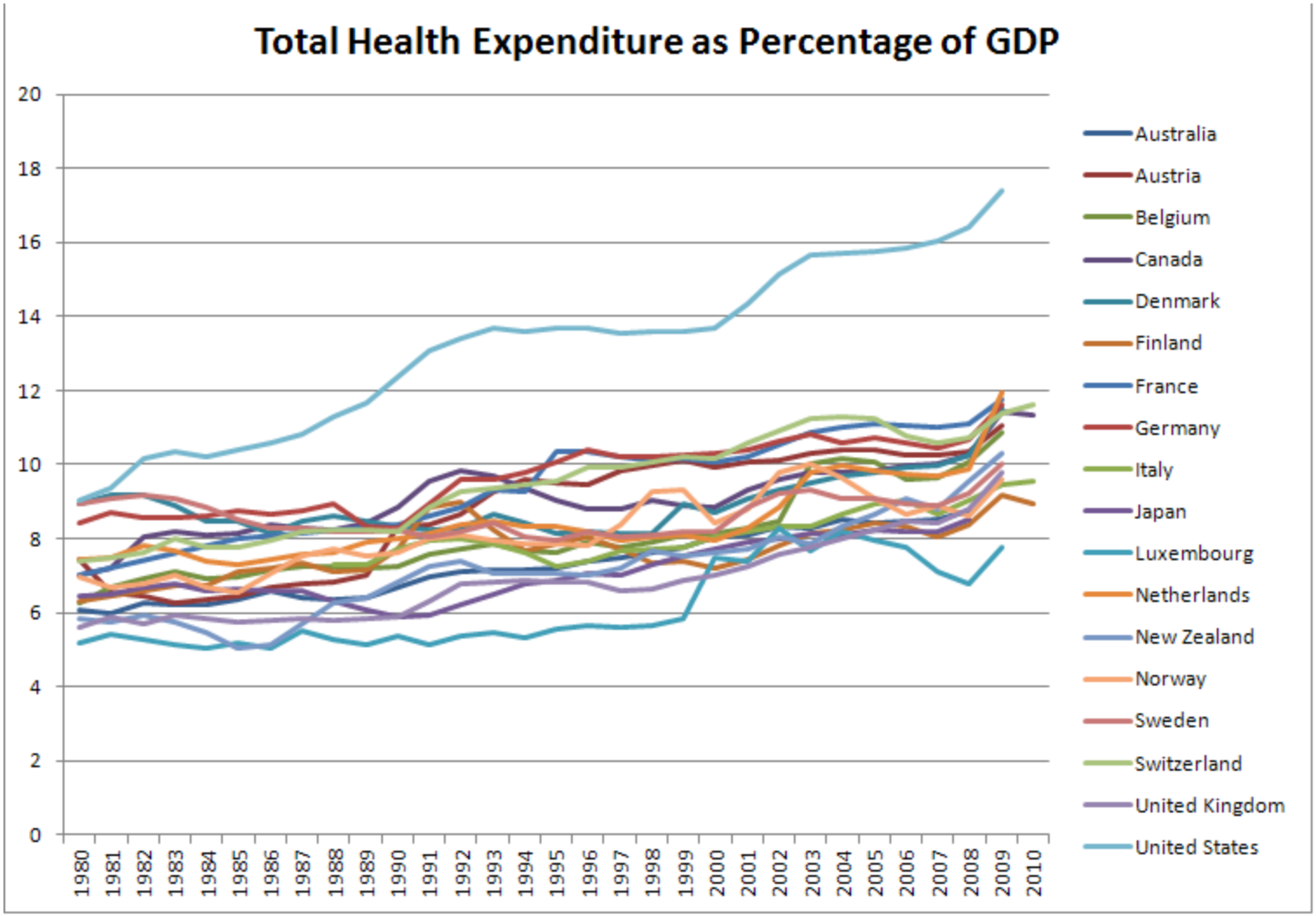
What should we compare?

- Contours of health care system :
  - Who pays? How much?
  - Who delivers? What outcomes?
- Structure of political landscape :
  - Who decides?
  - Who gets what, when and where?

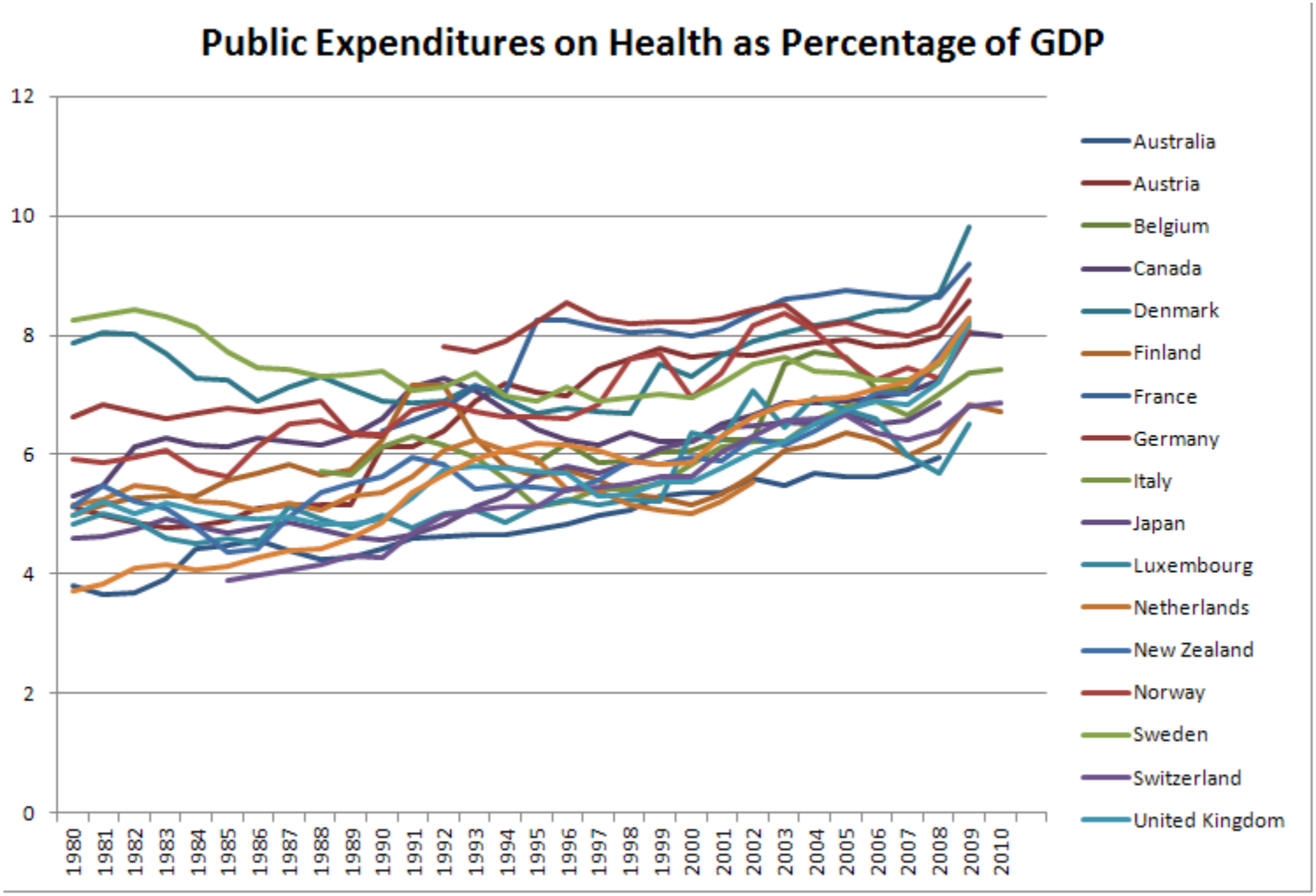
Health care spending

- **Trends in *Total* Health Expenditure among OECD countries (1980-2007):**

- Per capita health expenditure increase averaged 171% while GDP grew by 91 %
- Total health costs as GDP averaged 2.6 % increase
- Overall, greater portion of income is being devoted to health care


Total Health Expenditure as Percentage of GDP
20
18
16
14
12
10
8
6
4
2
0
1980
1981
1982
1983
1984
1985
1986
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
Australia
Austria
Belgium
Canada
Denmark
Finland
France
Germany
Italy
Japan
Luxembourg
Netherlands
New Zealand
Norway
Sweden
Switzerland
United Kingdom
United States

- **Trends in *Public* Health Expenditure among OECD countries (1980-2007):**
  - Per capita public health expenditure increase averaged 277%
  - From an average of 10.9 % in 1980 to 16.0%
  - Of core OECD 18 countries, average increase over this period was 1.84 percentage points


Public Expenditures on Health as Percentage of GDP
12
10
8
6
4
2
0
1980
1981
1982
1983
1984
1985
1986
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
Australia
Austria
Belgium
Canada
Denmark
Finland
France
Germany
Italy
Japan
Luxembourg
Netherlands
New Zealand
Norway
Sweden
Switzerland
United Kingdom

Situating Canada: spending

- In Canada, health care accounts for 11% of GDP
- Canada's spending on health care comparable to the "big" spenders in Europe, higher than OECD average, considerably less than the US
- Canada's rate of increase in health care spending has been higher over past decade
- Canada's share of public spending remains lower than the OECD average : only 70 % of total spending is public
- We need to know more about the cost drivers in both public and non-public spending

Health care delivery

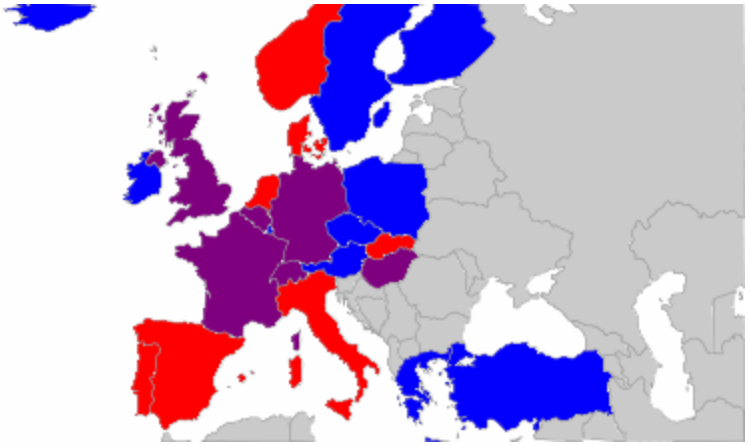
- Role and organization of provider groups
- Relationship between health care facilities
- Access point(s) into the health care system
- Basket of publicly-funded health care services
- Cost-sharing for services

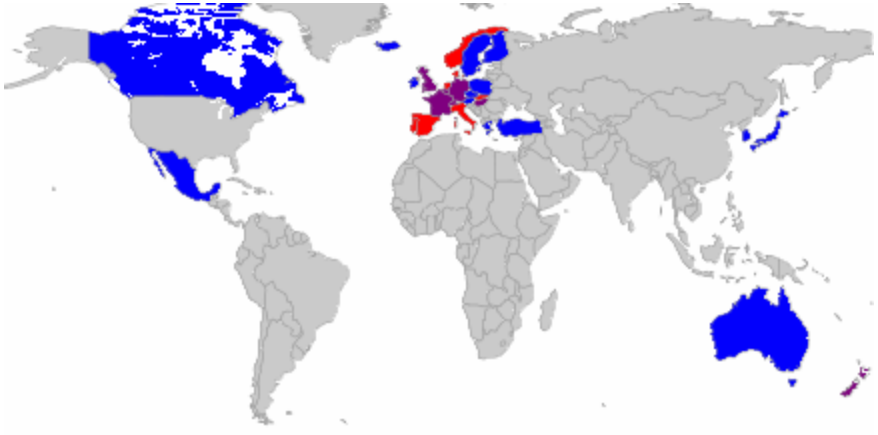
Registration with Primary Care Physician

- https://sites.google.com/site/healthiersocieties/oecd-health-systems/registration-with-primary-care-physician

Registration with Primary Care Physician

- Blue: no obligation and no incentive to enroll
- Purple: financially encouraged
- Red: Compulsory enrollment





Situating Canada: Delivery

- Compromise between “public” payment and “private delivery” for physicians
- Imposes global budgets on hospitals
- Limits reach of private insurance
- Universal eligibility, comprehensive but not complete basket of services
- “First-dollar coverage” of insured services

Situating Canada: Political landscape

- Political institutions:
  - Provincial jurisdiction of health care system
  - Considerable financial reach of federal government
- Parties and Ideologies:
  - Politics of centrism; influence of social-democracy
- Stakeholders:
  - Powerful, but with but limited veto points in legislative system

Canada Health Act (1984)

- equal access
- comprehensive services
- public administration
- universal eligibility
- portability of benefits

Typologies of health care systems

- Canada: Single payer model
- Germany, Japan, France: Social insurance model
- UK, Italy, Sweden: National health service model
- United States: “Skewed” model

Timing of health systems development

- European trendsetting:
  - sickness insurance: 1883 (Germany), 1891 (Sweden), 1910 (France), 1911 (UK)
  - national health insurance 1945 (France), 1946 (Sweden, UK), 1955 (Germany)
- Canadian "laggard" ?
  - Saskatchewan innovations: hospital insurance (1946), medical insurance (1962)
  - Federal cost-sharing for hospital (1957) and medical care (1966) insurance

Strength of social consensus

- health care seen as a “social good” as opposed to a “market commodity”
- societal level consensus but contested political space
- social-democratic influence in design and payment
- enduring values of solidarity, fairness, participation, regulation

CONCLUSIONS

How can healthy comparisons lead to healthier societies?

Different contexts, similar challenges:

- Demographic pressures
- New technologies
- Rising expectations and diminishing confidence
- Changing market for health human resources
- Emerging epidemics
- Persistent health inequalities

Where is Canada headed?

- Good news:
  - Canada's health care costs are within the norm of the OECD; only 60% of US per capita costs
  - Public administration means administrative overhead remains low
  - Access based on need, not ability to pay, means effective allocation of resources

- Cost control

- Pressing concerns:
  - Unpacking demographic challenges
  - Bringing coherence to primary care, better treatment of chronic care
  - Careful management of *symptoms* of wait times and waiting lists
  - New dialogue about physician supply and distribution

An "adult conversation" about health care reform in Canada

- What we hear
  - *"sustainability of funding"*
  - *"information technologies"*
  - *"stakeholder collaboration "*
  - *"continuum of healthcare"*
- What we know:
  - *2014 end of the Accord: pressures on provinces*
  - *Canadians are concerned as to whether the health care system can live up to their needs*

We need to ask the right questions

- About money
  - "why" is the money needed
  - "where" will it be most cost-effective
  - "what" do we want health care system to accomplish
- About outcomes
  - Coherence in access to care
  - Impact of reform on health inequalities
  - Better understanding of social determinants, cost drivers, medical inflation
  - Incentive structures that lead to better outcomes

What matters?

- Good management and coherence of both supply and demand for health care
- Sustained commitment to quality and research
- Better understanding of what works or doesn't here and elsewhere
- More engaged policy-makers, more informed citizens