MACDONALD-LAURIER INSTITUTE

MEDICARE'S MID-LIFE CRISIS 3

A European Flavour For Medicare

Learning from experiments in Switzerland and Sweden

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NOVEMBER 2013

A Macdonald-Laurier Institute Series

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Executive Summary

Most advanced nations share the goal of universal health coverage, but all use different policies to achieve this. Canada is near one end of the spectrum, with heavy government involvement in both the financing and the delivery of health care and limited private sector participation. At the other end of the spectrum, governments mostly regulate the private provision of health care services.

While there is a tendency in Canada to compare our system with our southern neighbour, the United States, it is in Europe that we will find nations which achieve a better balance in health care delivery. This paper compares Canada's health care system with those of Sweden and Switzerland, two countries firmly in the middle of the spectrum of public/private involvement which rank high internationally in delivering results. It also includes a compelling example of how Britain's Labour Party sold the British people on much-needed reforms to that country's socialized medical system.

Sweden is an example of a 'Beveridge'-type health care system, where the emphasis is on hierarchical control. This model emphasizes specialized care, and often lacks adherence to individual demands. This problem is partly addressed in Switzerland's 'Bismarck'-type of health care system, which provides insurance but not health care services *per se* to the population. While this gives an incentive to monitor overall health status, the system also produces incentives for too many health care procedures and interventions.

However, the real contrast between Canada and these nations is not the different combination of the comprehensiveness of the public model with the efficiency of private provision, although these are different. Rather, the most striking difference is the openness of European systems to new solutions. Starting in the 1990s, European nations like Sweden and Switzerland began to put the emphasis on what was in the patient's interest ahead of the interest of health care providers. Not all innovations proved successful, but overall the health care outcomes for both Sweden and Switzerland rank high and at a much lower cost than in Canada.

After analysis and comparison, Sweden and Switzerland yield many examples of reform that have the potential to raise Canada's health care outcomes. Some recommendations would be permitted under the *Canada Health Act:*

- Activity-based funding for surgical and hospital services
- Private provision of hospital/surgical services, ideally combined with activity-based funding
- Private parallel health care with dual practice
- Independent insurance (social insurance)

Two additional recommendations, which have demonstrated successful outcomes in numerous other OECD countries, would either be disallowed or penalized by the *Canada Health Act:* cost sharing/user fees and individual tailoring of insurance policies.

Both countries continue to experiment – indeed, the Swedish health care system can be regarded as nearly 20 different approaches at the regional level – unafraid to try new approaches to serve their population better despite the risk inherent in novelty. While Canada has been slow to innovate, this does allow it to study and learn from other countries as it embarks on the inevitable overhaul of medicare as the population ages and costs skyrocket. As part of the Macdonald-Laurier Institute's series, Medicare's Midlife Crisis, this paper is another contribution to that learning process.

Sommaire

La plupart des nations avancées souscrivent à l'objectif d'une couverture universelle des services de santé, mais utilisent des politiques différentes pour l'atteindre. Le Canada se situe tout près d'une partie extrême du balancier. En effet, au Canada, le gouvernement intervient de façon massive à la fois sur le plan du financement et sur le plan de la prestation des services, alors que la participation du secteur privé est limitée. À l'autre partie extrême se retrouvent les pays dont les gouvernements ont comme principale fonction de réglementer la prestation privée des services de santé.

Bien qu'au Canada, on compare souvent notre système à celui de notre voisin du sud, les États-Unis, c'est vers l'Europe qu'il faudra se tourner pour trouver des pays qui atteignent un meilleur équilibre en ce qui a trait à la prestation des soins de santé. Le présent article compare le système de santé du Canada à ceux de la Suède et de la Suisse, pays qui sont fermement positionnés au milieu du balancier entre l'engagement public et l'engagement privé et figurent parmi ceux qui génèrent les résultats parmi les plus élevés au monde. Il comprend également un exemple éloquent de la manière dont le parti travailliste en Grande-Bretagne a réussi à convaincre la population britannique du bien-fondé de réformes du système médical socialisé de leur pays.

L'exemple suédois propose un système de santé dit « Bévéridgien », où l'accent est mis sur la direction hiérarchique. Ce modèle insiste sur les soins spécialisés, mais n'adhère pas toujours aux besoins individuels. Ce problème d'adhérence aux besoins des individus est partiellement résolu dans le système de santé dit « Bismarkien » de la Suisse, qui fournit de l'assurance, mais ne procure aucun service de santé à la population. Bien que ce système ait comme répercussion positive la surveillance de l'état de santé général, il présente également l'inconvénient d'entraîner un trop grand nombre d'interventions et d'actes médicaux.

Toutefois, le contraste réel entre le Canada et ces pays ne tient pas à des assemblages différents allant d'un modèle public exhaustif jusqu'à une prestation privée fondée sur la rentabilité, bien que l'assemblage canadien soit en fait différent. La différence la plus frappante tient plutôt à l'ouverture des systèmes européens à de nouvelles solutions. À partir des années 1990, les pays européens comme la Suède et la Suisse ont commencé à faire valoir la primauté de l'intérêt du patient sur celui des fournisseurs de services de santé. Ce ne sont pas toutes les innovations qui ont porté fruit, mais, dans l'ensemble, les résultats tant pour la Suède que pour la Suisse ont été très élevés et ont été réalisés à bien meilleur compte qu'au Canada.

Les analyses et les comparaisons démontrent que la Suède et la Suisse fournissent de nombreux exemples de réformes qui ont le potentiel d'améliorer les résultats touchant les services de santé au Canada. Certaines recommandations pourraient être mises en œuvre sans contrevenir à la :

- Le financement des services chirurgicaux et hospitaliers fondé sur l'activité
- La prestation privée de services hospitaliers/chirurgicaux, idéalement combinée avec un financement fondé sur l'activité
- Les soins de santé privés en parallèle avec la double pratique
- L'assurance indépendante (assurance sociale).

Deux autres recommandations, qui ont fait leurs preuves dans de nombreux pays de l'OCDÉ, seraient soit rejetées ou sanctionnées par la : le partage des coûts/les frais d'utilisation et l'individualisation des polices d'assurance.

La Suède et la Suisse continuent toutes deux de mettre à l'essai de nouvelles méthodes – en effet, le système de santé suédois peut être perçu comme se déclinant en presque 20 différentes configurations au palier régional – et ne font montre d'aucune appréhension à tester de nouvelles stratégies pour mieux servir leur population, malgré le risque inhérent à la nouveauté. Le Canada a tardé à innover, mais il peut tirer de nombreux enseignements des expériences réalisées à l'étranger, au moment même où il s'apprête à entreprendre la révision de l'assurance-maladie, une étape maintenant incontournable en raison du vieillissement de la population et de la montée en flèche des coûts. Le présent document est une nouvelle contribution à ce processus d'apprentissage, diffusé dans le cadre de la série de l'Institut Macdonald-Laurier sur la crise de l'assurance-maladie intitulée « Medicare's Midlife Crisis ».

Introduction

Nearly every developed nation employs a series of policies intended to achieve universal coverage for health care insurance for its population. While the overarching aim of universal health insurance is common among developed nations, the policies guiding its achievement vary considerably. At one end of the spectrum, government is intimately involved in both the financing and delivery of universally accessible health care while the private sector's role is limited. At the other end of the spectrum, government focuses on a regulatory approach while playing a relatively smaller role in the operation of the health care system. Most others fall in between.

Across this spectrum of approaches to universal access health care policy there is a range of differences in access to and quality of health care. Developed nations vary widely in wait times, the availability of advanced and high-tech medical services, the availability of medical professionals, and in outcomes from the health care process. While some nations do an admirable job of delivering a high performance across these various measures, many other nations fare poorly in at least one area of access and quality. However, these differences in policy and performance accompany large differences in health expenditures.

Critical to the Canadian health care debate is the extent to which different health policy choices have resulted in different health system performances and differing levels of health expenditure. Have other developed nations who adhere to the goal of universality enshrined in Canada's health care system managed superior health system performances or lower expenditures or both by choosing different health system policies? Or are the opponents of health care reform in Canada correct in their assertion that Canada's health care policies are sufficient for the creation of a high quality, cost effective health care program?

If the current Canadian model really is superior to other possible approaches, we might as well focus more on exporting our own model than trying to import others. But if there are aspects about the models in other countries that Canada can learn from, we probably should. The worst that could happen would be confirming the smugness that envelops much of the public discussion of Canada's health care system.

If we do find that reforms are worth undertaking, then by studying other countries Canada could also learn from their mistakes. And as will be seen, many countries outside Canada seem willing to experiment with new ideas and models. Although not always successful, experimentation often yields results: many major medical breakthroughs have resulted from trials and experiments. So why couldn't experimentation and trials also result in organisational improvements?

Approaches to health care in Sweden and Switzerland use market mechanisms as well as private for-profit providers.

Two countries that have experimented a lot with different reimbursement models and ways to organise health care delivery are Sweden and Switzerland. Although similar in many ways to Canada, the approaches to health care in both these countries use market mechanisms as well as private for-profit providers.

Sweden and Switzerland also start their reforms from different premises. Sweden is a typical Beveridge country, in the sense that the model gets its basic structure from the ideas of Sir William Beveridge, the social reformer who designed the National Health Services in Britain. The model is hierarchical, although in Sweden – as in contrast to England – the responsibility for health care is delegated to county councils.

Switzerland, on the other hand, is a typical Bismarck country in the sense that it is based on the German approach of the Prussian Chancellor Otto von Bismarck. This model is based on providing social insurance to the population, rather than providing services in hand.
As we shall see, Bismarckian and Beveridge-type countries have different types of problems. The

insurance model provides little incentive to ration the provision of care and is usually more expensive. On the other hand, the hierarchical Beveridge system is commonly plagued by long waiting lists and access problems in general. However, both systems usually lack a coordinating mechanism and both systems tend to create fragmentised delivery processes (van der Zee and Kroneman 2007). Much of the thinking when reforming these models has thus focused on coordination and on putting more focus on the individual patient.

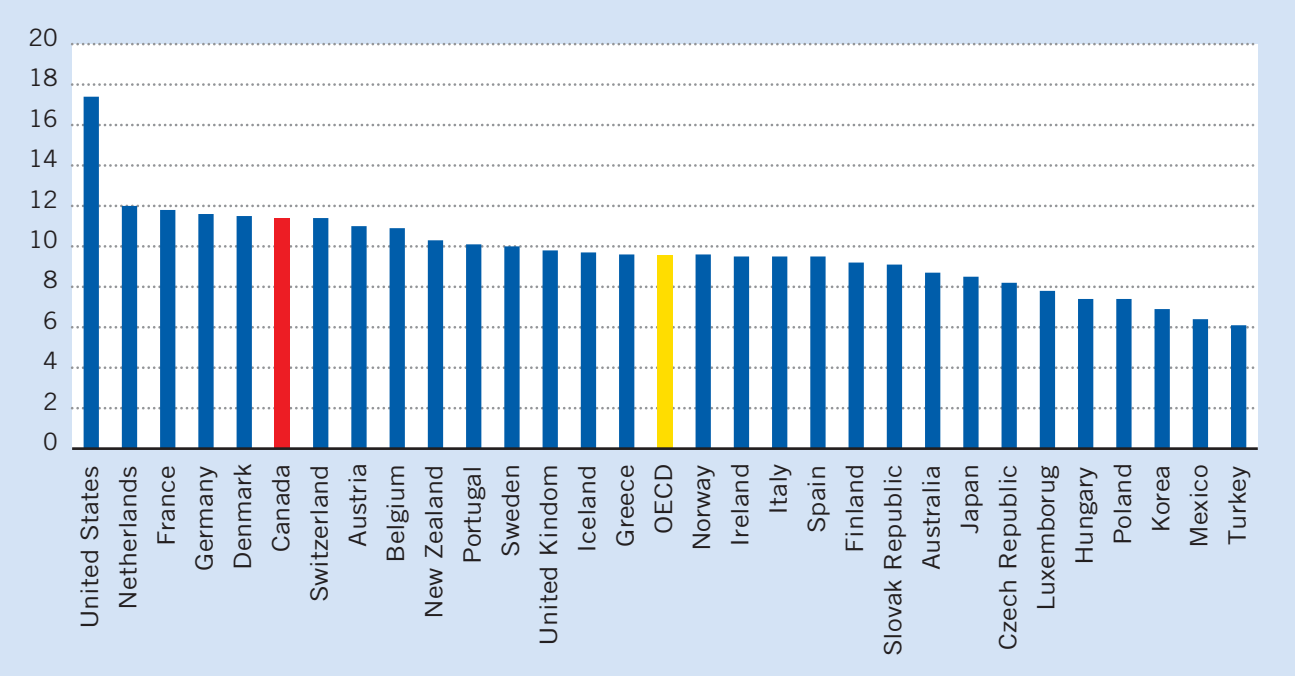
Can or should Canada learn from Sweden and Switzerland? This paper aims to provide some insight into this question by examining these respective models and the reforms undertaken there. It begins with a broad review of health system performance indicators in order to provide a clear understanding of the Canadian system's relative weaknesses and strengths. It then examines how the health policies of each of these two countries have changed over time to understand how different health care policies might affect the performance and cost-effectiveness of health care systems. A discussion of the lessons that can be learned from the Swedish and Swiss examples follows.

Health System Performance: The Indicators

This section examines the performance of Canada's health care system relative to other developed nations (with the exception of the United States and Mexico[1]) that also maintain universal approaches to health care insurance. From here forward, the terms "developed nations" and "OECD" will be used to refer only to the group of nations who were members of the Organisation for Economic Cooperation and Development (a group of the world's most developed nations) that in 2009 also maintained universal approaches to health care insurance. Unless otherwise noted, all data in this section are from the OECD's *Health at a Glance 2011* report.

With respect to health care expenditures (OECD 2011), Canada must be considered a relatively high expenditure country, as shown in chart 1. In 2009, Canada's total health expenditures (as a share of GDP) tied for 5th among developed nations that maintain universal approaches to health insurance. That year, Canada's health ex-

Chart 1 Total health expenditure as a percent of GDP, 2009 or nearest year



penditures at 11.4 percent of GDP were 19 percent higher than the average expenditure of 9.6 percent of GDP.

The availability of physicians in Canada is relatively poor compared to that in other developed nations; see chart 2 for a comparison. Canada had 2.4 practising physicians per 1000 population in 2009 compared to an average of 3.1. It is noteworthy that a number of developed nations, including both Sweden and Switzerland, had at least 3.5 physicians per 1000 population (OECD 2011).

Access to health care services in Canada does not reflect Canada's relatively high expenditures.

With respect to nurses, Canada manages a middling performance. Canada has slightly more nurses (9.4 per 1000 population) than the average developed nation that maintains a universal access health insurance program (9.1 per 1000 population), but much fewer than leading Western European and Scandinavian nations (OECD 2011).

The availability of medical technologies in Canada also lags that found in most developed nations. (See chart 3, which shows the number of MRI units per million population among OECD countries.) With respect to the availability of MRI

Chart 2 Practising doctors per 1000 population, 2009 or nearest year

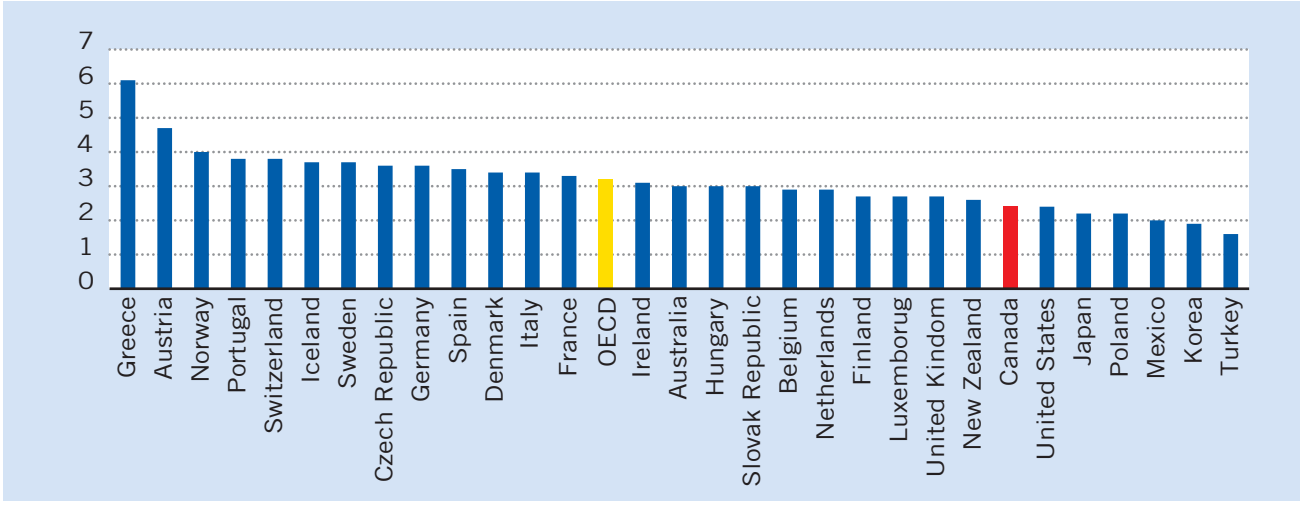
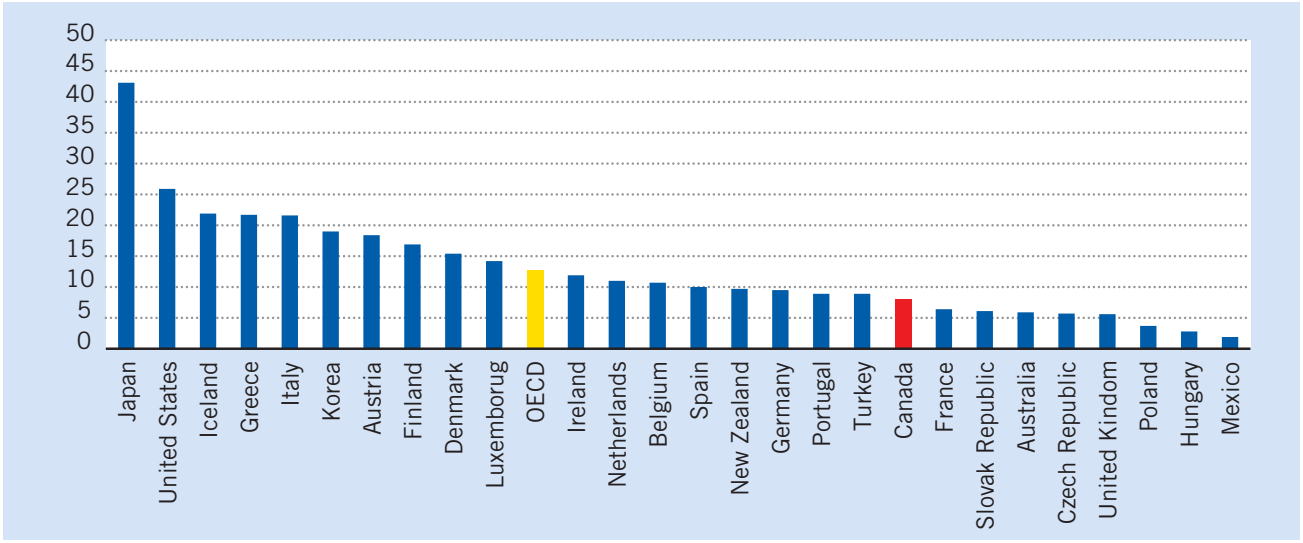


Chart 3 MRI units per million population, 2009 or nearest year



scanners, Canada's inventory of 8.0 machines per million population ranks well behind the average of 12.7 machines per million population (OECD 2011). Not surprisingly, the number of MRI scans per 1000 population (OECD 2011) also lags that provided to citizens in other developed nations, though by a smaller margin than the number of machines. While little can be said about the appropriateness of these scans, it is noteworthy that the rate of MRI scanning in Canada is below the OECD average and well below that of leading nations.

Canada's inventory of CT scanners is also much smaller than that in the average developed nation (OECD 2011). At 13.9 CT scanners per million population, Canada has an inventory of machines that is 59 percent the size of the inventory in the average universal access OECD country (23.4). Again, leading nations have inventories of CT scanners that are more than double Canada's on a per million population basis.

Importantly, research has also shown that machines in Canada are often old and outdated, and too often relatively simple and unsophisticated versions of the technology (Esmail 2008). While similar data on the quality of other nations' technology is not readily available, the substantial differences in overall investment shown above suggest that Canada may also be a laggard in the quality of its medical capital. Evidence from other studies of the availability of advanced technologies supports that conclusion (Esmail and Wrona 2008).[2]

Canada also has many fewer hospital beds[3] than the average universal access nation (OECD 2011). In 2009, Canada had 3.3 hospital beds per 1000 population compared to an average of 5.5. While Canada's relatively young population may mean a reduced demand for hospital beds relative to what is found in nations with older populations, this is nevertheless a sizable difference.

With respect to the availability of curative care beds, Canada lags the OECD average by an even greater margin. In 2009, Canada had just 1.8 curative care beds per 1000 population, compared to an average of 3.7 with several nations maintaining 4 or more beds per 1000 population. This large relative shortfall in hospital beds may provide some explanation for long wait times for medically necessary care in Canada (Siciliani and Hurst 2003).[4]

Although the number of hospital beds per capita can also reflect an efficient use of inpatient care and efficient ancillary services, such as rehabilitation centers and nursing homes, it should be noted that Canada also has rather long average stay of 7.7 days at acute hospitals. Sweden has an average length of stay of 5.7 days and Switzerland 9.6 days (the EU-25 average is 6.9 days). In Sweden, the low number can be traced to the use of global budgets for acute care hospitals and the Ädel Reform of the 1990s, which transferred the responsibility for medically treated patients to local communities.

The relative shortage of hospital beds in Canada may explain long wait times.

The relatively long length of hospital stays in Switzerland is not unique for a country with a Bismarck type of health care system, since hospitals in these countries have traditionally been reimbursed by per diem rates. However, as can also be seen in a number of other Bismarck countries that have introduced diagnosis-related group (DRG)-based models,[5] the average length of stay in Switzerland is decreasing rapidly.

While the availability measures above indirectly capture the accessibility of services, it is also possible to directly examine delays patients endure in accessing medical care using the Commonwealth Fund's international health policy surveys (Commonwealth Fund 2010). Broadly, the Commonwealth Fund's findings mirror Canada's relatively poor performance in the accessibility of medical services. Relative to those surveyed in the other 9 universal access nations, Canadians were the most likely to face long waits for medical care and were among the least likely to face relatively short waits for medical care. This holds true regardless of whether wait times are examined for emergency room care, primary care, specialist care, or elective surgery (OECD 2011).

Of course, there are two dimensions to quality health care. The first is providing access to health care services (including modern and advanced health care). The second is ensuring that those health care services are of an appropriate quality, which brings into consideration such factors as the ability of the health care system to provide healthy longevity, low levels of mortality from disease, and effective treatment for both chronic and terminal illnesses.

It is important to recognize that data on the quality of health care may capture more than only the effects of the health care system. Health outcomes are ultimately the result of several processes, of which the health care system is only one (Busse 2002). With this in mind, the indicators used for comparison below were selected both for their ability to measure as directly as possible the performance of the health care system and for their ability to be affected as little as possible by factors external to the application of health care.

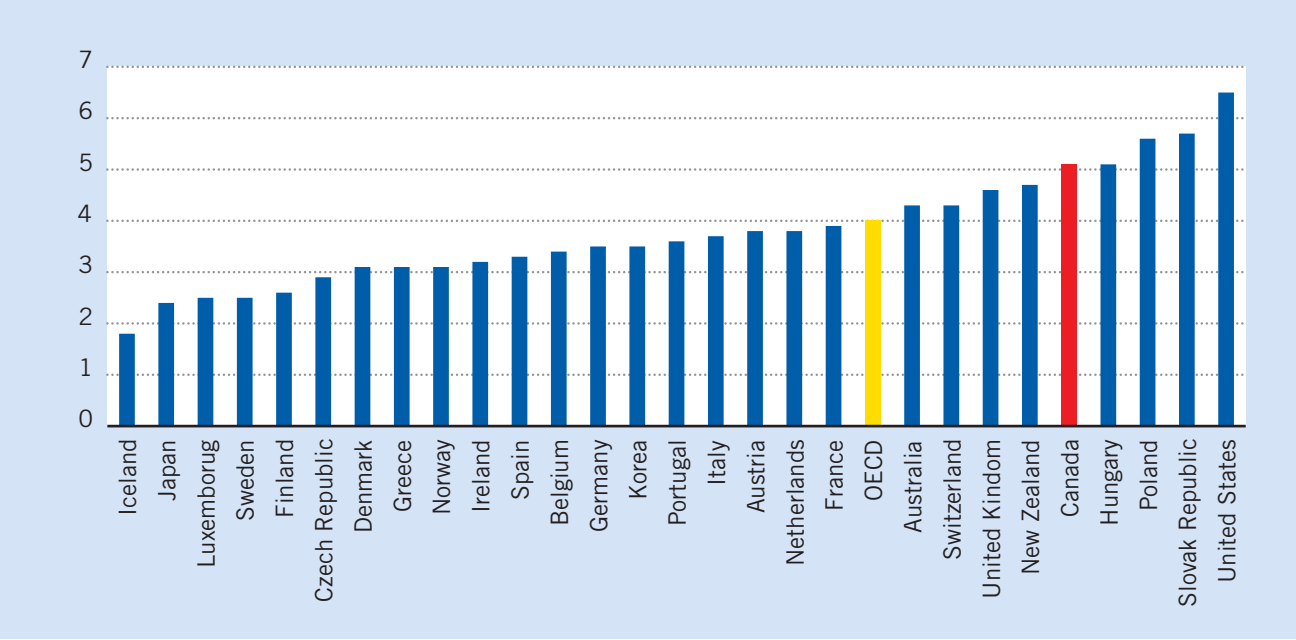
One of the most basic measures of mortality commonly used to compare health status is infant mortality rates. It should be noted that infant mortality rates can be affected by immigration from poor countries, unhealthy outlier populations, and other population demographics (Seeman 2003). However, they can also serve as indicators of a well-functioning health care system, in particular its capacity to prevent death at the youngest ages and the effectiveness of health care interventions during pregnancy and childbirth. For example, Or (2001) finds that OECD countries with higher physician-to-population ratios (used as a proxy measure for health care resources) have lower infant mortality rates.

Canada's infant mortality rate is more than double that of leading nations.

The infant mortality rates given for developed nations show that Canada lags the OECD average by a considerable margin (see chart 4). Canada's infant mortality rate, at 5.1 deaths per 1000 live births, is more than double the rates below 2.5 found in leading nations (OECD 2011).

Another way of looking at mortality is to examine deaths that were likely preventable with the application of appropriate health care, or deaths

Chart 4 Infant mortality rate per 1000 live births, 2009



that should not occur if effective health care is applied in a timely fashion. Gay et al. (2011) provide estimates of mortality amenable to health care that can be used to examine how Canada's health care system performs in saving lives that should not be lost with timely and effective health care.[6] Canada's performance is above the OECD average and superior to that of a number of other developed nations, but still lags the performances of leading nations (OECD 2011).

The final four measures of mortality examined here relate to survival rates for cancers of the breast, cervix, and colon and mortality rates following hospital admission for heart attacks.

Survival rates for cancers of the breast, cervix, and colon can provide some insight into the health care system's ability to detect disease early and treat disease effectively. With respect to survival rates for breast cancer, Canada is a relatively high performer (OECD 2011). Canada's performance with respect to colorectal cancer is above average but still behind leading nations. Finally, Canada's performance with respect to cancer of the cervix falls below the average of universal access nations (though not statistically significantly different from it).

In-hospital mortality rates for heart attacks (acute myocardial infarction) provide some insight into the ability to provide effective medical interventions quickly. Canada is a reasonably strong performer on this measure, ranking 8th among developed nations and above the universal access nation average. However, Canada's performance again lags that of top performing nations (OECD 2011).

It is also possible to examine the quality of primary care services in a health care system by looking at measures such as hospital admission rates for chronic obstructive pulmonary disease (COPD). Importantly, COPD need not result in hospitalization if properly managed in primary care settings, which means admission rates can serve as a measure of primary care quality, including co-ordination and care continuity, and may also be used as an indicator of structural constraints such as the supply of family physicians (OECD 2011). Perhaps not surprisingly, given the access issues and limited supply of physicians highlighted above, Canada's performance in COPD hospital admission rates (OECD 2011) is not impressive. However, Canada still manages an above average, though middling, performance.

On the other hand, Canada's asthma and uncontrolled diabetes hospital admission rates, which measure quality in a similar fashion to COPD hospital admission rates, are among the lowest in the developed world (OECD 2011).

Canada's performance with regards to patient safety is also relatively poor. For 2009 (or the nearest year), Canada had among the highest rates of obstetric trauma during vaginal delivery, either with or without an instrument. Canada also had among the highest rates of foreign body left in during a procedure, and accidental puncture or laceration. Conversely, Canada managed a mid-pack to top third performance in postoperative pulmonary embolism or deep vein thrombosis (blood clot) and postoperative sepsis (infection).

Clearly, Canada's health care system is neither a high performer with respect to preventing mortality (though there are pockets of high performance) nor a high performer with respect to access. In fact, Canada's health care system is perhaps one of the poorest systems in the developed world in terms of providing timely access to technologically advanced medical care.

OECD data also show that Canada's system is not among the most equitable in terms of providing equal access to care.

Canada is not a high performer when it comes to providing equal access to care.

The Canadian health care system more strongly favours the wealthy compared with other nations for whom data are available with respect to the likelihood of visiting a general practitioner (OECD 2011). The Canadian system also favours high income groups with respect to the proba-

bility of a specialist visit. There is also a notable difference between rates of screening for breast cancer and cervical cancer between low and high income Canadians, with Canada performing far below a number of other nations (for whom data are available), particularly for breast cancer screening.

A factual review of the performance of Canada's health care system does not paint a promising picture. To the contrary, it paints a picture of an expensive, difficult to access, and relatively inequitable health care system that provides reasonably good but not world-class care. The question that inevitably arises from such a picture is whether those nations that have managed to do better have employed health care policies that are markedly different from those employed in Canada.

Case Study: Sweden

While the Swedish system is less expensive than Canada's, it generally performs at a higher level in access and quality. Indeed, looking at the various measures of quality of health care in the international comparisons section above, Sweden tends to be among the top ranking nations in the large majority of quality measures. While Sweden's international comparative ranking in access is less impressive, it is nevertheless generally superior to Canada's (OECD 2011).

The Swedish health care system's ability to provide more and better health care services for 12 percent fewer financial resources (as a share of GDP), as well as its generally high performance of health service outcomes and quality of care, suggest it might provide an excellent model for health care reform in Canada.

General Overview

The Swedish health care system is federally organized in a manner broadly similar to Canada (OECD 2011). The federal government is responsible for overall health policy and provides grants in support of health care to the county councils, Sweden's regional governments. According to the Health and Medical Services Act of 1982, county councils and municipalities are responsible for ensuring universal access to good health care (Anell et al. 2012), and oversee both the financing and delivery of publicly funded/universally accessible health care. Unlike in Canada, municipalities carry responsibility for long term care/care of the elderly and the disabled.

Sweden provides more and better health care services than Canada for 12 percent less.

While the federal government does oversee health care policy, county councils have considerable freedom to determine the organization of health care services. Generally, the majority of resource allocation decisions for health services are undertaken by the county councils. There is however extensive collaboration with respect to highly specialized health services and certain investments in high technology health care. The federal government also provides evidence-based guidelines for the treatment of patients through various federal bodies (including the Swedish Council on Health Technology Assessment (SBU), Dental and Pharmaceutical Benefits Agency, (TLV), and National Board of Health and Welfare) and has in more recent years provided grants to support national health care "action plans" (Anell et al. 2012).

As is the case throughout the developed world, Sweden's health care system is in a constant state of reform as governments seek to improve quality and access while controlling costs. Much of this reform has taken place at the county council level, resulting in both differences between county councils but also learning and adoption of successful policies. Broadly, the focus of reform in recent years has been increasing the private sector's role in health care (in particular in primary care and pharmacy services), increasing patient choice and competition among providers in primary care, a greater focus on comparisons

of indicators of quality and efficiency, improvements to care coordination, and specialization and concentration of hospital services. These more recent reforms follow a period of reform in the 1990s during which many of Sweden's county councils undertook a purchaser-provider split (separating the function of providing health care from the function of paying for it) with increased choice for patients. However, despite this constant state of reform, many of the core health policy characteristics of the Swedish model have remained constant since at least the early 1990s.

Fiscal/Financing Arrangements

Sweden's health care system is, like Canada's, funded primarily through general taxation. Of the total health expenditure in Sweden, 82 percent is from public sources. The remaining 18 percent of total health expenditure comes from private sources, most of which is user charges. By contrast, some 70 percent of total health expenditure is from public sources in Canada, with the remaining 30 percent from private sources largely for out of pocket spending and private health insurance (CIHI 2012). Importantly, these public/private breakdowns are not directly comparable between Canada and Sweden because of differences in what is covered (breadth of coverage) and to what extent cost sharing applies (depth of coverage); Sweden's universal health care coverage is broader but less deep than Canada's. Further, as discussed below, while physician and hospital services in Canada are largely available exclusively from the public system, these services can be purchased privately in Sweden.

As is also the case in Canada (see for example Veldhuis and Clemens 2003), determining the federal government's share of county council funded health care is not straightforward. Of total county council revenue in 2009, taxes were the source of 71 percent, general state grants the source of 17 percent, with sales and other revenues, user charges and other charges, subsidies, and other sources of finance making up the balance. General state grants in Sweden are similar to federal transfers in Canada in that they are designed to equalize spending power across regional and local governments. There is no direct link between particular sources of revenue and health care expenditure.

Sweden's universal access health care system offers broad coverage encompassing primary care, specialist care, hospital care, pharmaceutical care, and dental care. However, typical of a Nordic approach to universal access health care, all of these services are subject to patient cost-sharing/co-payment (OECD 2011). While the requirement of cost sharing is uniform across Sweden, county councils do set varying rates of cost sharing for their residents.[7]

For more information on how Sweden implements user fees, please see *Canadian Policy Challenge: User Fees. Does Sweden's experience show they are right for Canada? An expert weighs in* on page 17.

Delivery of Primary Care

Primary health care services in Sweden are delivered by both public and private providers. Private primary care providers must have an agreement with the county council in order to be publicly reimbursed for services provided. Importantly, county councils cannot prevent the establishment of a private practice, and can only create a single set of conditions under which providers (both public and private) can be accredited. While private provision of primary care is permitted in Sweden, the number of private providers does vary across county councils: in some urban councils (including Stockholm), up to 60 percent of primary care providers may be private while in other councils only a few private providers can be found. Overall, approximately one-third of all primary care units are privately owned (Anell et al. 2012).

Approximately one third of primary care units in Sweden are privately owned.

Patients are free to register with any accredited primary care provider, whether public or private. The *Health and Medical Services Act,* passed by

the parliament in January 2010, made it mandatory for county councils to allow a choice of primary care provider and freedom of establishment for primary care providers who are accredited by the county council. Prior to the passing of this national legislation, the patient's right to choose a provider was not formally legislated, and county councils were left to adopt this approach on a voluntary basis (Anell et al. 2012). Patient choice of provider is supported by a biennial National Patient Survey coordinated by the Swedish Association of Local Authorities and Regions (SALAR) that allows patients to compare primary care providers. Private initiatives that provide comparative information about providers also exist in Sweden.

If a patient has not made an active choice of provider, most county councils will automatically register them with the primary care provider to whom they made their latest visit or to the primary care provider who is geographically most proximate.

Most primary care practices in Sweden are team-based facilities, with four to six general practitioners alongside other types of medical staff (including nurses, midwives, physiotherapists, psychologists, and gynaecologists). Solo private general practitioners are rare.

The health care system in Sweden also relies on nurses for primary care services. Often responsible for the first contact with the health care system, district nurses work both in primary care facilities and provide home visits, especially to older people. Importantly, District nurses do not have independent medical authority and operate under the supervision of physicians.

Access to primary care services falls under Sweden's "0-7-90-90" elective wait times guarantee.[8] This requires county councils to ensure zero delay for consultation and a GP visit within 7 days. According to the Commonwealth Fund's international health policy surveys, 57 percent of Swedes reported being able to get a same- or next-day appointment with a doctor or nurse when they were sick or needed care in 2010, with only 25 percent reporting having to wait six days or more. In Canada, where physicians are fewer in number (per 1000 population) and health spending higher, those numbers were 45 percent and 33 percent respectively (Commonwealth Fund 2010).

Unlike in Canada, primary care providers in Sweden do not have a formal gate-keeping role whereby patients must access specialist care through primary care providers. Usually, patients are free to contact specialists directly if they so choose. This does not seem to have increased wait times: Swedes were more likely than Canadians in 2010 to endure a relatively short wait to consult a specialist and less likely to experience a relatively long one (Commonwealth Fund 2010).[9]

As is the case with other aspects of the allocation of health care resources, county councils are able to determine the mechanisms by which primary care providers will be paid. Across Sweden, a blend of capitation (fixed prospective payment for registered patients), fee-for-service, and performance-based payment has occurred in recent years. Generally, there are two principal models for paying practitioners. The Stockholm county council bases approximately 40 percent of primary care compensation on capitation, with more than 55 percent being based on visits by both registered and non-registered patients, and another 3 percent is performance based payments for meeting targets (such as patient satisfaction rates and compliance with governmental treatment recommendations). In all other county councils, payment is dominated by capitation funding (80-98 percent) with the remainder consisting of payments for non-registered patients and a small performance-based payment for meeting targets.

Some county councils try to create incentives for moving the focus from specialised care to primary care. The county councils of Västra Götaland, Halland, and Skåne incentivise primary care providers to take care of problems that otherwise would have been referred to hospitals or specialised outpatient providers (Janlöv et al. 2013). Like Canada, Sweden is experiencing a primary care physician shortage. In some cases, physicians providing services on a temporary basis (known in Sweden as *hyrläkare)* have been employed to ensure services continue to be available for residents. However, this appears to have negatively impacted the continuity of patient care.

Delivery of Specialized, Hospital, and Surgical Care

Swedish hospitals fall into three categories: regional/university hospitals; acute care county

council hospitals; and local county council hospitals. There are 7 regional/university hospitals in Sweden. Of the 70 county council hospitals, approximately two-thirds are acute care hospitals.

Relative to local hospitals, acute care hospitals provide care 24 hours per day, 365 days per year and maintain a larger range of competencies. In addition, since the mid-1990s, several local hospitals have been transformed into specialized hospitals that offer elective treatments to a wider geographic area but offer no general acute care services.

Six of Sweden's top hospitals are privately operated; three of those are for-profit.

The seven regional/university hospitals cover six medical care regions[10] and provide highly specialized and advanced medical care. This regionalization is undertaken in an effort to maintain high levels of clinical competence through higher patient volumes.[11]

Six of Sweden's hospitals are privately operated. Sophiahemmet, Ersta, and Red Cross (*Röda Korset*) hospitals in Stockholm are not-for-profit organizations that have contracts with Stockholm county council to provide care for a certain number of patients annually. St Göran in Stockholm, Lundby in Gothenburg, and Simrishamn in the south of Sweden are for-profit hospitals that are fully financed by county councils on a contract basis. St Göran is the only private acute care hospital in Sweden.

Patients in Sweden are free to choose a hospital, whether public or private, as long as the hospital maintains a contract with the county council. Their choice is also not limited to their county council. Their choice of provider is supported by a biennial National Patient Survey, which is coordinated by SALAR, that allows patients to compare hospitals. Private initiatives that provide comparative information about providers also exist in Sweden. Comparable information on hospitals across some 50 indicators is also available as part of a collaboration between the National Board of Health and Welfare and SALAR.

Moving to activity-based funding saved Swedish city councils about 13 percent.

Access to hospital services on an elective basis falls under Sweden's "0-7-90-90" elective wait times guarantee,[12] which requires county councils to ensure specialist consultation in 90 days and elective treatment in 90 days after diagnosis. According to the Commonwealth Fund's international health policy surveys, 45 percent of Swedes reported waiting less than one month for a specialist appointment in 2010, while 31 percent reporting waiting two months or more. For elective surgery, 34 percent of Swedes reported waiting less than one month in 2010 and 22 percent reported waiting 4 months or more. In both cases, Swedish wait times are similar to those in Canada with the exception of more Canadians reporting relatively long waits to see a specialist (41, 41, 35, and 25 percent respectively) (Commonwealth Fund 2010). Note that Canada's similar, albeit slightly poorer, performance comes at increased cost in spite of fewer medical professionals and less capital.

As with primary care, the method of paying for hospital care varies across Sweden. The use of DRGs is common in Sweden, having been introduced in the early 1990s in a number of county councils. However, since payments to hospitals are generally capped at some predetermined volume, the system is more akin to a global budget model (Kastberg and Siverbo 2007). The DRG system is used as a way of distributing resources within hospitals, rather than between hospitals. However, some hospitals, like the private St Göran hospital in Stockholm, do get extra payment for increasing production above the preset level. So, while DRGs are being used as an administrative tool, the norm in Sweden is still global budgets for inpatient care. Hospitals in some Swedish county councils also receive pay-for-performance compensation in addition to activity-based funding, comprising up to 4 percent

of hospital payment. Generally, pay-for-performance programs in Sweden withhold payment if certain targets (such as wait times, patient safety, or clinical indicators) are not met.

Looking at the Stockholm county council, Håkansson (2000) measured an 8 percent increase in inpatient care, a 50 percent increase in day surgeries, and a 15 percent increase in outpatient visits as a result of introducing DRGs and activity based funding in 1993. Overall, Stockholm county council experienced an 11 percent increase in activity, while costs fell 1 percent due to a reduction in hospital employment and a 10 percent price decrease. Equally importantly, Håkansson (2000) found no evidence of a negative effect on patients (measured by re-admissions to hospital) or discrimination against elderly patients, while Svensson and Garelius (1994; cited in Håkansson 2000) found no evidence of providers giving treatment only to the simplest or most profitable cases. Gerdtham et al. (1999) found that Swedish county councils that moved to activity-based funding enjoyed potential cost savings of approximately 13 percent.

Physicians in Sweden are predominantly salaried employees.

The introduction of DRGs in Sweden in the 1990s is one reason for the increases in efficiency and cost effectiveness during the 1990s. Another important factor behind the increased productivity was the Ädel Reform (Meagher and Szebehely 2013). This reform transferred resources from the county councils to the local communities, but also stipulated that the local communities should pay for every patient in the county council hospitals waiting for nursing home care in the local community.

The Stockholm county council initially introduced uncapped activity based funding in 1989, but as the economy deteriorated the reimbursements for hospitals were later capped. Since the mid 1990s the capped reimbursement model has remained in place, which effectively converted the reimbursement model into a global budget model, although DRGs are used to distribute resources *within* the hospitals.

Unlike in Canada, physicians in Sweden are predominantly salaried employees. This is true across health care sectors (primary care, hospital care, and so on) for both public and private providers. In 2010, the average monthly salary for physicians employed by county councils was SEK 56,600 (CAN$8629) and for specialist nurses was SEK29,000 (CAN$4421).[13]

Privately Funded Options/ Alternatives

The universal access health care system in Sweden does not operate as a monopoly. Privately funded purchases of health care as well as private insurance for health care are permitted. Approximately 4 percent of the population has voluntary health insurance (Anell et al. 2012).

The primary focus of voluntary health insurance in Sweden is to expedite access to specialists and to avoid waiting lists for elective treatment. In 2010, more than 80 percent of all voluntary health insurance was paid for by employers. Another 12 percent was employees paying for coverage through group plans, while 6 percent was individual private insurance (Anell et al. 2012). Voluntary health insurance in Sweden is a non-deductible expense for employers and a non-taxable benefit for employees.

Sweden's privately funded health care sector shares medical resources with the universal sector. In particular, physicians in Sweden are permitted to practice in both the public/universal sector and the privately funded/insured sector (a system known as dual practice). However, specialists in Sweden cannot visit or treat private patients in public hospitals (Hurst and Siciliani 2003).

Case Study: Switzerland

The Swiss health care system in 2009 cost the same 11.4 percent of GDP as Canada's. Yet, in nearly every measure, the Swiss health care system far outperformed the Canadian system, with the exception of in-hospital mortality from heart attacks (OECD 2011, table 3-1). Put differently, the Swiss manage to buy substantially greater access to high quality medical resources than Canadians do, while spending no more on health care.

The Swiss spend the same amount as Canadians yet have substantially better access to higher quality health care.

While this alone should suggest that the Swiss health care model is an excellent model to examine for guidance on health care reform in Canada, it is also noteworthy that the Swiss health care model ranks among the highest performing nations across the measures of access and quality examined above. This strong relative performance internationally justifies its consideration as a model for health care reform.

General Overview

The Swiss health care system provides universal coverage based on competition between insurers and competition between providers, consumer choice of health plan characteristics, a high level of consumer responsibility, and government mandates for insurance purchase. These characteristics are markedly different from the tax-funded, monopolistic, government-dominated health care model pursued in Canada. They are also notably removed, and far more market oriented, than the structures of the majority of universal access health care systems, though nations are increasingly moving towards policies employed in Switzerland.

The Swiss health care system as it exists today was largely created by the 1994 Health Insurance Law (LAMal) which came into effect in 1996. Since that time, Swiss health care policy has seen little reform of its core characteristics. This may result from a high level satisfaction with the health care system's costly but impressive performance for both access and quality. It is noteworthy that in 2007, 71 percent of voters in Switzerland rejected a proposal to move from Switzerland's multiple-insurer with individual premiums model to a single public insurer with means tested premiums based on wealth and income.

The Swiss system is far more market oriented than most universal access health care systems.

As in both Canada and Sweden, responsibility for universal access health care in Switzerland is largely the responsibility of Switzerland's 26 cantons. The federal government's role is restricted by the Swiss constitution primarily to public health and regulation. In addition to setting national guidelines for the universal access health care system and providing federal regulatory oversight of insurance companies, the federal government also provides funding support for health care.

Fiscal/Financing Arrangements

The Swiss universal health insurance marketplace is probably best characterized as a sector with managed competition. Under the Swiss model of universal health care, the provision of health care and health insurance are largely in private/independent hands. However, the government maintains a high level of regulation for the industry to operate within.

All Swiss citizens are required to purchase universal health insurance coverage as a matter of law. The universal insurance package is determined by the federal government and includes inpatient and outpatient physician and hospital care (including physician home visits), long term

care (partial coverage), prescription drugs, and complementary and alternative therapies. While a broad range of services is covered, deductibles and co-payments apply.

Swiss citizens have a choice of insurer for the provision of their universal access health insurance product. This choice in Switzerland is supported by high levels of information on health insurance companies, including customer satisfaction ratings and financial data, while information on the quality of providers is more limited. In 2005, some 85 insurance companies (including subsidiaries of insurance conglomerates), which must be registered with the Federal Office of Public Health, provided universal health insurance in Switzerland. Because not all of these companies operated nationally, no canton had more than 65 insurers. While there are many options for insurers, recent estimates suggest that the top 10 insurance conglomerates account for some 80 percent of enrolment (Leu et al. 2009).

Insurers in Switzerland are able to offer four principal universal insurance arrangements. The basic Swiss universal insurance package includes the minimum annual deductible of CHF300[14] (CAN$336)[15] and the ability to change insurance companies at the end of every June and December. Three special insurance options are also available. Increased deductible plans offer deductibles up to CHF2500[16] (CAN$2797) in return for a reduction in insurance premiums. Managed care plans (discussed in more detail below) allow individuals to trade off lower premiums for reduced choice and more case management. Finally, bonus insurance plans offer premium reductions following years where no insurance claim was made, but require individuals to commit to the scheme for at least 5 years and disallow changing insurers during this period. Individuals opting for a special insurance option can only change insurers at the end of December.[17]

Beyond the deductible, Swiss citizens are also required to share in the cost of health care services up to an annual ceiling. Most insured services are subject to a 10 percent co-insurance payment, with an annual ceiling of CHF700[18] (CAN$783), after which care is fully subsidized. The co-insurance rate rises to 20 percent for brand name drugs when a generic option is available, unless a physician requests no substitution. Inpatient hospital stays are subject to a co-payment of CHF10 (CAN$11) per day.

While a high level of individual financial responsibility is central to the Swiss approach to universal health insurance, exemptions to cost sharing do apply. People with large families, pregnant women, those needing social-assistance, and recipients of supplementary old-age and disability benefits are exempt from the deductible. Some managed care plans also offer deductible-free insurance coverage. In addition, the hospital co-payment is graduated according to family income, and waived entirely for certain groups such as children and expectant mothers.

A high level of individual financial responsibility is central to Switzerland's universal health insurance scheme.

Under Swiss law, insurers in Switzerland must accept everyone for universal coverage. The aim is for insurers to compete for subscribers on the basis of price (insurance premiums) and quality/service rather than on the basis of risk selection. In order to support this aim, Swiss governments employ several regulatory strategies.

Swiss insurers are required to use community-rated premiums for the universal insurance product. In practice, this means Swiss health insurers are not permitted to charge different premiums to patients with differing medical histories and pre-existing conditions. Insurers must maintain the same premium for all individuals within federally defined age-ranges and regions, but are permitted to vary the premium between ranges and regions. The Federal Office of Public Health establishes premium regions for health insurers, with up to three regions per canton. Within regions, insurers can vary their premiums across three age categories: 0-18, 19-25, and 26+. Beyond the regional and age-category variations, premiums can vary only by insurance type and smoking status (non-smokers can receive premi-

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Canadian Policy Challenge: User Fees

Does Sweden's experience show they are right for Canada? An expert weighs in.

OSCAR HJERTQVIST

Sweden introduced patient fees in 1971. Each of the 21 county councils that administers and finances health care has its own fee system. In Stockholm, the patient fee for primary care is 200 Swedish crowns (SEK; 200SEK is roughly CAD30); an appointment with a specialist is SEK150 with a referral or SEK350 without one. A visit to the emergency room costs SEK400. Stockholm exempts gynaecological exams and mammograms from fees, but these cost SEK100-200 in the other county councils. Open care treatment is capped at SEK1100 over a 12-month period, meaning that over and above this amount, patients do not pay fees for this type of care. Hospitalized patients pay SEK80 daily.

In Sweden, patient fees serve three purposes:

1. to limit over-consumption of health care services;
2. to direct patients to the correct level of treatment; and
3. to implant an awareness of the costs of health care.

In total, patient fees represent no more than 1.8 percent of the income of the health care system overall, but the percentage varies in different parts of the system. In primary care, fees represent 13 percent of incomes, but in dentistry this rises to 60 percent (dentists tend to be private practitioners rather than public employees). For hospitals, patient fees are a negligible source of income.

The Swedish Experience

Swedish health care is among the best in the world in reporting and assessing treatment outcomes, but has far less of a tradition in following up and evaluating political reforms. Some lessons from the Swedish experience with patient fees, however, are obvious.

In 1998, all 21 county councils terminated fees for patients under 18 years of age, which led to an immediate 15-17 percent increase in medical visits for this age group – an effect that has endured. In 2012, a pediatrician in Orebro county council suggested reintroducing patient fees for children in the emergency room. The basis for his reasoning was that the growing number of young patients with low-risk, non-urgent conditions limited the resources needed to treat children with serious conditions such as diabetes and cancer. These two points together suggest that parents overuse these services, driving up overall health care costs, if there is no cost to them; and that parents have a misguided belief that they should have access to these services, even those that represent an inappropriate level of care.

Between 1997 and 2010, the number of visits to medical specialists in Sweden fell 11 percent while visits for primary care rose 3 percent. This could be because county councils took steps to steer patients to primary care instead of to specialists by differentiating patient fees for these

services. But it could also be that primary care improved its operating hours and shortened its waiting lists during the same period. Improving access to primary care also improves the quality of care and reduces health care costs to the system and to patients.

The Swedish Council on Health Technology Assessment recently surveyed the scientific literature regarding patient fees, and found raising fees by 10 percent lowers the volume of visits by 3 percent. The Swedish government's latest official report on patient fees declared that fees had some steering effect, but that most patients are fairly insensitive to cost. However, if fees were removed completely, the number of visits would rise dramatically.

Fees are Part of a System

Patient fees do not act in a vacuum within an existing health care system. They are not the only steering mechanism to which patients are exposed. Introducing high patient fees for emergency rooms would be meaningless if the waiting list for primary care were two weeks for even the most basic visits. People would go to the emergency room and pay the higher fee, since the "steering effect" of long waits is far stronger than any reasonable fee. In this case, it would be more efficient to shorten the wait times in primary care to make that option more attractive to patients.

Patient fees can be useful steering instruments – but they must be designed in intelligent and positive ways. If a fee schedule is so detailed that patients do not understand it, its steering effect vanishes. The cost to simply administer the fees will also be higher.

At the same time, introducing patient fees forces politicians and policy makers to strike a sensitive balance between curtailing unnecessary patient visits without denying access to necessary health care. For example, mammograms are essential health care, since the earlier breast cancer is discovered, the higher the chance of survival (often with less expensive treatment). All Swedish women aged 40–74 receive mammograms every other year. However, 20 out of 21 county councils charge fees for this, which in this case is counter-productive to the interests of both health care and patients.

A Matter of Culture

Health care depends on the "health care culture" of each country. At a glance, Sweden and Denmark appear identical: two Scandinavian welfare states with high taxes that finance health care. But their health care systems are different as well as the methods of directing patients to the proper health care practitioner.

In Denmark, steering is social rather than financial. Danes usually know their doctor in person, have maintained the relationship for decades and trust that the doctor acts on their behalf – not on behalf of the government or of a health board. Therefore, Danes do not visit their health care providers without good reason. Swedes lack this personal contact with their doctors, which is why cost incentives are much more important for directing patients in that country.

Conclusion

The Swedish experience indicates that patient fees are not a magic bullet that can solve all efficiency problems. Instead, they are one tool, with some proven effects, among many that designers and administrators of health care can adopt.

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ums that are substantially lower than smokers). In order to account for the potentially adverse effects of community rating and mandatory offer of insurance, Swiss cantons operate a risk-adjustment scheme that transfers funds between insurers in an effort to balance financial capacity between those with better-than-average risk pools and those with worse-than-average risk pools.[19] Prior to 2012, the risk formula for financial transfers included 15 age and two gender categories. As of January 2012, in response to much criticism of the inadequacy of using age and sex to proxy health status/morbidity between insurers, a history of hospital or nursing home stays of more than three days in the previous year have been added as a risk adjuster.

Finally, and perhaps less relevant to the successful operation of the marketplace given this restriction on profit does not exist in other nations with similarly market-oriented health care systems, Swiss insurers offering the universal product must operate on a not-for-profit basis and have a registered office in Switzerland.

The difference between the lowest and highest premium in Zurich was 89 percent.

Insurance contracts in Switzerland are made on an individual basis. Dependents are not covered by a parent's contract and there is no group or family coverage. Individuals are also responsible for paying the full premium for their health care insurance, which encourages cost consciousness. While employers are permitted to contribute part of the insurance premium, there is no tax benefit to doing so.

Insurance premiums can vary considerably in Switzerland. In 2005 for example, the difference between the lowest and highest premium for coverage in Zurich with the minimum deductible was 89 percent (Leu et al. 2009). Differences between regions can also be substantial: premiums in Geneva (the most costly canton) are approximately double what they are in the least costly canton. Rates of premium growth also vary considerably from canton to canton.

While differences in premiums should be expected in a competitive marketplace, there is concern that much of the difference in premiums is the result of risk selection among insurers. As noted above, many have pointed to the weakness of using age and sex exclusively to equalize risk. Simulations indicate that the revision to the risk-adjustment system for 2012 should significantly reduce incentives for risk discrimination (Leu et al. 2009).

Swiss governments also ensure that low-income people have access to the competitive insurance marketplace by placing an income/wealth-based ceiling on the cost of insurance for an average family. If the cost of the average premium in the individual's canton exceeds 8 to 10 percent of family income (depending on the canton), governments provide a premium subsidy to the individual through the income tax system. This subsidy reduces the cost of health insurance but still requires that individuals pay for insurance and be active participants in the universal insurance marketplace. An estimated 40 percent of Swiss households (or about one third of the population) receives premium assistance, with approximately 19 percent of all health insurance premiums paid with government funds.

Delivery of Primary Care

Switzerland effectively has two separate methods of delivering primary or ambulatory health care: one under managed care insurance organizations and the other under all other forms of insurance.

Patients covered by non-managed care insurance are able to receive services from any licensed provider in their canton. Specialists in ambulatory care settings can also be accessed directly without a referral. For the most part, these physicians are predominantly in private individual office-based practices, with group practices and hospital-based polyclinics playing a smaller role in the delivery of care. Insurers are obligated to pay on a fee-for-service basis at the rates established jointly by associations of insurers and providers at the canton level. Providers are obligated to accept this fee as full payment and are not allowed to balance-bill/extra-bill.[20]

Managed care organizations in Switzerland offer somewhat different models of primary care

depending on the type of organization: health maintenance organization (HMO), independent practice association (IPA), or fee-for-service plan with gatekeeping provisions. The latter uses few cost-containment measures[21] other than requiring enrollees to obtain a referral from their GP for specialty care.

HMOs in Switzerland fall under two models: staff models in which physicians are employees of the HMO, and group models in which a physician group owns the HMO and physicians are paid on a per capita basis. Generally, HMOs have group practices that include general practitioners, specialists, and other health care personnel. IPAs in Switzerland consist of a network of general practitioners who contract with an insurer to function as gatekeepers for patients. Typically, these providers are on a fee-for-service basis, although a few receive capitation payments. Patients maintain the freedom to choose their care provider, but often are totally or partly exempt from co-insurance and deductibles when using an in-network general practitioner.

In 2005, 12.1 percent of insured Swiss were enrolled in managed care, with some two-thirds opting for fee-for-service plans with gatekeeping provisions (Leu et al. 2009).

Delivery of Specialized, Hospital, and Surgical Care

Swiss individuals in need of hospital care can seek it from public hospitals in their canton, and from private hospitals included in the canton's hospital list. Highly complex and specialized care is provided by university hospitals, some large cantonal hospitals, and private clinics in some areas. Access to private hospitals can vary; in some cantons, individuals with the universal insurance plan must use public hospitals.

While Swiss citizens do have a choice of hospital in their canton, they do not have choice of doctor within the hospital under the universal insurance product. Generally, physicians practising in hospitals are employed by the hospital and paid a salary.

Prior to 2012, Swiss cantons operated a varying subsidy and per-diem model that treated public and private hospitals differently. As of 2012, a national DRG-based or activity-based funding model that applies equally to public and private hospitals has been introduced. The scheme is intended to discourage inefficiencies in Swiss hospitals and make it easier to compare providers. The new DRG system is overseen by SwissDRG and uses federation-wide prices for medical services.

Privately Funded Options/ Alternatives

The Swiss universal access health insurance system does not operate as a monopoly. Insurers are permitted to sell supplemental insurance in Switzerland on a risk-rated for-profit basis (even when they operate in the universal marketplace on community-rated non-profit basis) and individuals are permitted to purchase medical goods and services privately. The supplementary health insurance marketplace in Switzerland is regulated by the Federal Office of Private Insurance. As many as 40 percent of Swiss citizens have purchased some form of supplemental insurance (Tanner 2008).

Forty percent of Swiss citizens have purchased private, supplementary insurance.

Supplementary insurance provides a number of benefits beyond the universal access health insurance product: choice of doctor in hospital (including guaranteed access to the most senior physicians), access to private providers who are not on the canton's hospital list, dental care, and private rooms when being cared for under the universal scheme.

Switzerland's privately-funded health care sector shares medical resources with the universal sector. In particular, physicians in Switzerland are permitted to practice in both the universal sector and the supplementary sector (a system known as dual practice). Doctors with dual-practices may pay part of this income to the hospital.

Swiss and Swedish Lessons for Canada

Both of these case studies reveal policy constructs that are markedly different from the system put in place by Canada's federal and provincial governments. Most obviously, both Sweden and Switzerland rely on private competition (particularly in hospital/surgical care) and cost sharing to a much greater extent than does Canada. And yet neither compromised the universality or high quality that so many opponents of health care reform in Canada suggest would be the inevitable result.

Sweden and Switzerland use private competition and cost sharing while maintaining high quality care and accessibility.

This is perhaps the core lesson that can be gleaned for Canada's provinces from this review of health care policy. While neither Sweden nor Switzerland is without its health care struggles, their universal health care systems appear to have benefited from a greater role for the private sector and private financing, just as economic research and theory would predict. Applying that lesson should be the aim of provincial governments intent on improving the state of Medicare for their residents.

Of course, provincial governments intent on reforming health care policy in Canada do have limited freedom to do so if they wish to ensure continued access to federal cash transfers for health and social services under the *Canada Health Act*. While the *Act* is not as restrictive as many have suggested, it is nevertheless an important barrier to adopting some health policy constructs that are successfully operating in Sweden and Switzerland, specifically cost sharing/user fees for physician and hospital services and competitive social insurance models (Clemens and Esmail 2012).

Activity-based funding aligns the incentives of the provider with the interests of patients and payers.

Therefore, the recommendations for Canadian health care policy are separated into two groups: those that are permissible under the strict letter of the *Canada Health Act* and those that are not. Of course, Clemens and Esmail (2012) note that federal interpretation of an undefined clause in section 12 of the *Canada Health Act* (reasonable access) could create a barrier to certain health care reforms where none is explicitly found in the *Act*. However, as these interpretations cannot be predicted with certainty, they are not considered in the grouping of reforms below.

Recommendations Permitted Under the Canada Health Act

Activity-based funding for surgical and hospital services

Switzerland pays its hospitals on an activity-funded basis, unlike Canada where hospital care is predominantly funded through global budgets. While some provinces have made important steps in the direction of activity based funding, it has yet to be implemented as the principal method of payment for hospital and surgical care in a Canadian province. The result is a less efficient delivery of services than would be available if Canada's provinces were to adopt the Swiss approach.

Global budgets, under which hospitals receive a lump sum of money each period to provide care to patients, are not without their advantages. They are administratively simple for providers. They also permit provincial governments with a direct means of controlling hospital expenditures (Leonard et al. 2003; Park et al. 2007).

Unfortunately, these benefits come with a trade-off: fewer services and a lower standard of care for patients than is provided under activity-based funding. This occurs as a result of the disconnect between funding and the provision of services to patients under global budgets. There is little incentive under a lump sum payment scheme to provide higher or superior quality of care to patients (thus attracting patients to the provider) or to function efficiently, especially in the presence of soft budget constraints. Conversely, under lump sum budgets there is a benefit to discharging patients quickly, avoiding admitting costly patients, and shifting patients to other outside institutions (Leonard et al. 2003).

Activity-based funding, more technically known as prospective fee-for-service, better aligns the incentives of the provider with the interests of both patients and payers. Activity-based funding involves paying providers for each individual they care for, based on the expected costs of treating the patient's condition (including significant medical factors) at the time of admission. Importantly, activity-based funding is prospective and does not retrospectively pay for all services provided to the patient, which provides a strong incentive for cost control by the provider. On the other hand, incentives to treat more patients and use facilities more efficiently, to provide the services patients want, and to attract patients to the facility (instead of going elsewhere) are created under this funding model.

Studies of the European experience with activity-based funding show significant benefits from adopting this approach. In Denmark for example, a move to activity-based funding was associated with a 13 percent increase in activity across 18 common surgical procedures and a 17 percent decrease in average waiting times (Clemmesen and Hansen 2003, cited in Siciliani and Hurst 2003). This reduction in waiting times is supported by an OECD review of 20 countries that found waiting lists were less likely to be seen as a problem under activity-based funding (Siciliani and Hurst 2003). In Sweden, as noted above, a move to activity-based funding has been associated with a 13 percent cost savings and notable improvements in cost efficiency in the Stockholm county council in particular (Håkansson 2000; Gerdtham et al. 1999). At the same time, Swedish studies found these improvements were not associated with reductions in quality of or patient access to care.

Activity-based funding can also have a positive impact on access to advanced and high-tech medicine. For example, the OECD (2005) has noted that budgetary limits tend to dampen the overall rate of technology diffusion in a health care system. Similarly, TECH (2001) found that strict supply-side policy restrictions, including central planning of the availability of intensive services and global budget funding of hospital care are related to slower rates of growth in the provision of intensive or high tech treatments.

Of course, introducing activity-based financing for inpatient care requires that the incentives must be balanced to also encourage the substitution of inpatient care for outpatient procedures. As this is one of the main cost reducing developments in modern health care, the incentives for outpatient providers should not be tilted towards unnecessarily referring patients to hospitals.

This balance could be achieved by making either insurance companies or primary care providers bear a certain part of the costs related to inpatient care. Such incentives make cost reducing innovations favourable for health care providers and create incentives for organisational improvements.

Sweden's only private acute care hospital is also historically the most efficient.

The benefits that accrue from activity-based funding also result from competition between providers, who are vying for patients to increase financial revenues. According to the OECD, competition "can have a number of impacts including reducing excessive hospital stays, reducing costs of providing care and improving quality of care" and can lead to "more rapid diffusion of cost-reducing technological advances, best practice methods, and the elimination of waste" (OECD-DFEACC 2006, 23; 57).

Private provision of hospital/surgical services, ideally combined with activity-based funding

Both Sweden and Switzerland employ privately owned providers for the delivery of hospital care. In Canada, private providers are limited to the provision of surgical services in clinics but have not been contracted to operate acute care hospitals.[22] As a result, both Sweden and Switzerland are able to produce a higher volume and quality of services than Canada for the same financial outlay. (To read about how the UK introduced private surgical centres, please see *How do you introduce a new private sector into a socialized medicine system to improve patient access?* on page 24.)

Fundamentally, privately operated and publicly operated businesses behave differently from one another. Studies comparing public and private business in general have found that publicly operated businesses develop with less capital and operate more labour intensively than their private counterparts (Megginson and Netter 2001). That has implications for productivity. One of the causes of this difference might be a response to governments who view capital spending to be less important than distributing money to more visible areas demanded by the voting public (Butler 1992).

This difference has been borne out in practice. In France, the increase in MRI machines per capita occurred more rapidly in private hospitals than in public hospitals (US Congress 1995). Similarly in Greece, private clinics were the first purchasers of and continued to be the principal providers of high-tech diagnostic services (European Observatory 1996). In Sweden, the nation's only private acute care hospital (St Göran) is historically the most efficient hospital in Stockholm county council (Lofgren 2002).

While private provision of services has advantages over exclusively public provision, combining activity based funding with patient choice of their provider further improves quality and cost efficiency. This is because, armed with choice and financial backing, patients have the ability to reward providers while penalizing those who are unwilling or unable to meet their needs. Importantly, under activity-based funding, it is much simpler to introduce competition between privately-owned and -operated providers, and public providers because the cost of performing procedures is clearly identified. It is possible also to take this one step further and base the activity-based reimbursement for all providers on the most efficient provider's tender. The OECD finds that this can lead to as much as a 6 percent reduction in costs at less efficient providers (OECD-DFEACC 2006).

Systems based on social-insurance seem to outperform government-run models in terms of both timeliness and quality.

There is a further point that should be made with respect to private provision and activity-based funding. Research suggests that private providers are more responsive to financial incentives than are public providers (see for example Duggan 2000). If this is indeed the case, the benefits of activity-based funding are likely to be enhanced by the presence of private providers.

Private parallel health care with dual practice

Both Sweden and Switzerland allow individuals to seek care on their own terms with their own resources, potentially backed by private insurance when the public system is either unwilling or unable to meet their needs/demands. In Canada such activity is largely disallowed by nearly all provinces, ostensibly to promote equality and universality.[23] As a result, health care in Canada is more expensive and lower quality.

Again, the weight of evidence supports the Swiss and Swedish approach to health care policy. For example, Siciliani and Hurst (2005), in a review of wait time strategies in 12 countries, find that increases in private health insurance coverage may reduce wait times. Professor Ian Harper found that public support for private insurance purchases in Australia resulted in financial savings for taxpayers overall due to lower public hospital expenditures (2003).

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How do you introduce a new private sector into a socialized medicine system to improve patient access?

Tony Blair's New Labour government did just that, shortening patient waiting times and improving productivity within the NHS.

PAUL CORRIGAN

UK's New Labour government left one important legacy to governments that want to reform their socialized medicine systems. That is the vital importance of the development and deployment of *a compelling public narrative for change* as an integral part of the reform program. Unless the public thinks there is a very strong reason for challenging some of the preconceptions about their socialized medicine system, they will mistrust any government attempting reform.

Like most Canadians, the English electorate love their socialized medicine system, the National Health Service (NHS). The 10 minute representation of real nurses dancing at the opening of the London Olympics is more talked about than any other aspect of the ceremony. As the biggest gift that the British people have ever given to themselves, changing the NHS is something that governments do at their peril.

By 2001 the New Labour government had developed a strong narrative for change, based on public anxiety about waits for hospital and doctor appointments. From 2001 onwards, every time that the New Labour government said anything about reforming the NHS, it stressed that access was poor and needed improvement.

The 2001 Labour Manifesto pledges to "*cut maximum waiting times by the end of 2005 for out-patient appointments from six months to three months and for in patient appointments from 18 to 6 months.*"[1]

The politics of this was not a shot in the dark by the Labour Party. Every focus group and opinion poll showed that long wait times were the major issue the public had with NHS services. People were worried and wanted something done.

Interestingly, most staff and managers in the NHS did not see access as a problem in the same way that the public did. After all, if you provide a service, a long queue is simply a long order book, and the willingness of people to wait a long time suggests your service must be acceptable.

This meant that the New Labour government's compelling narrative for changing the NHS – decreasing maximum wait times – had originated *within the public as a criticism of the current*

1 2001 Labour Party General Election Manifesto.

NHS. The work of the government was to translate this criticism into successful policies that would reduce wait times.

It is within this context that the Independent Sector Treatment Centres (ISTC) program was developed. The 2001 Manifesto explicitly pledges that "*We will create a new type of hospital – specially built surgical units – managed by the NHS or the private sector – to guarantee shorter waiting times.*"[1] The government had a direct mandate to introduce something very new which could be run by the private sector.

This was not a universally popular idea within the Labour Party or the NHS. In developing this policy, we knew there would be sharp political debate from the very beginning. However, given the framing of the policy issue, when people within the NHS argued against ISTCs, they were arguing against a policy that would reduce wait times for NHS patients.

In terms of the politics of reform, this moved the argument from public versus private provision to reducing wait times for patients or not.

Britain historically has had a private health care system in secondary hospital care, paid for mainly by insurance but also with a strand that was "pay as you go". Traditionally, the NHS bought "spot purchase" operations from the private sector to fill gaps in provision (in 2003–2004 some 99,000 operations were purchased for NHS patients). However, the spot purchase price was expensive because they were bought individually and led to a 40 percent mark up for cost.

The ISTC program moved to a series of procurements for large numbers of procedures from new facilities. While the existing private sector providers could apply, new providers had to be introduced to get sufficient numbers of new procedures. In the first procurement, none of the existing providers of private health care won contracts and we had to create a new market of international providers.

That meant that we had to create a new market between December 2002 (when the Department of Health invited expressions of interest to run treatment centres) and September 2003 (when preferred bidders were announced).

The first attempt to create this market in the summer of 2002 simply did not work, as Department of Health civil servants had no experience or expertise with this. It was recognised that we needed external expertise. Ken Anderson, who had been working in private health care and had the experience create such a market, was appointed to head the Commercial Directorate. The fact that he was a Texan was a culture shock for the NHS and ensured that the prospective private sector providers knew there was a market-making competency within the Department of Health.

The aims of the Treatment Centre program were to

- help provide the extra capacity needed to deliver swifter access for NHS patients,
- spearhead diversity and choice in clinical service for NHS patients (the 2001 Manifesto also said that there would be a choice of provider for NHS patients), and
- stimulate innovative models of service delivery and increase productivity.

Several waves of ISTCs were planned and about 30 were opened by 2007. By 2006, 122,000 NHS patients had received elective surgery. The program was and remains controversial, but given the public desire to shorten maximum waiting times, the argument to go ahead with the additional capacity was a powerful one.

1 2001 Labour Party General Election Manifesto.

One of the arguments from within the NHS against the ISTCs was that they would not add to existing capacity because staff would simply transfer from the NHS to the ISTCs. This led to the principle of additionality – staff for the first wave of ISTCs had to come from overseas, ensuring no depletion of the existing NHS workforce.

But the ISTCs went beyond adding capacity and more staff. They introduced new, more efficient methods of providing services for NHS patients. For example, in mobile ISTCs that provided cataract surgery, 39 surgeries were carried out per day. Before the creation of ISTCs, the NHS carried out 270,000 cataract surgeries through 141 providers, about 5 cataracts per provider per day.[1]

The ISTCs were able to increase productivity because they concentrated on a single procedure in modern, purpose-built mobile units. Over time this provided existing NHS providers with competition from a new supplier.

Similarly, orthopaedic hospital stays in one hip and knee ISTC were reduced from 12 days to 5 and a half days for hip operations and about 6 days for knee operations as a result of new preoperative assessment procedures.

Over the last decade nearly every health service has improved its productivity in terms of procedures per day and length of stay. I am not saying that the creation of ISTCs was the only reason that productivity rose and length of stay for patients fell, but it was one of many reforms that achieved this.

Throughout the program, there were arguments against ISTCs from existing NHS providers and their organisations. In any reform of socialized medicine it is vital not to be surprised by the power and consistency of the argument against change. There is no guarantee of the long term survival of the ISTC program within the NHS.

However the outcome of the ISTC program demonstrated the success of one part of the narrative for reform – the reduction of maximum waiting times – over another – the need for the NHS to learn new methods of working.

By 2010 maximum wait times fell to 18 weeks from the time of a referral from a general practitioner to the start of a hospital inpatient procedure. Because of this drop, the public no longer felt that wait times were a problem. New Labour had succeeded in winning the argument for ISTCs as a method of reducing waiting times. However, once the extra capacity had helped to reduce wait times, governments subsequent to Tony Blair's could not stand up to the pressure from the NHS to reduce external competition. This meant that the support for the ISTC program diminished once maximum waiting times had gone down.

However, New Labour's wider political goals to reform the method of delivery of health services for NHS patients within the overall principles of NHS funding – with equal access for all with health care free at the point of access – was bolstered by the reforms, including the ISTC program. The drop in maximum waiting times meant that fewer people who had the income to buy private health insurance actually did so. In 2011, 700,000 fewer people bought health insurance than in 1997.

In the 2010 election, the proportion of the public that actively supported the basic principles of the NHS was greater than ever. The reform program succeeded in strengthening public support for the overall principles of the NHS.

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1 All figures from Treatment Centres Delivering Faster Quality Care and Choice for NHS Patients HMSO January 2005.

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Equally important, privately funded health care can provide faster introduction of advanced medical technologies, both advanced/cutting-edge diagnostic and surgical, and can ease their introduction into the publicly funded health care system (Esmail and Wrona 2008). It also may more efficiently allocate resources by allowing patients who could lose a significant amount of earnings to purchase care privately and return to their work while others can choose to wait and forego the private expenditure. Further, a parallel private health care sector may enhance equality in the universal system by allowing individuals to simply purchase expedited care outside the universal stream, instead of using their influence, clout, and connections to receive preferential treatment within the public sector. It is interesting to note that all of the nations in the first section of this paper whose health care systems are more equitable that Canada's in terms of access maintain private parallel health care sectors.

The private parallel health care sector in Canada's provinces should also allow physicians dual-practice, where physicians are permitted to work in both the private and universal sector. Such a practice makes better use of scarce and expensive physician resources and may provide an inducement for highly skilled senior physicians to remain in Canada because of the increase in their freedom of practice and earning power. It would also avoid potential negative consequences of highly skilled or regarded physicians self-selecting away from universal practice. It should be noted that dual practice is not unique to Switzerland and Sweden: Denmark, England, Ireland, New Zealand, Norway, Spain, Australia, Finland, and Italy all allow dual practice in their health care system, sometimes with certain limitations (Hurst and Siciliani 2003).

Independent insurance (social insurance)

Both Sweden and Switzerland are high performing nations with respect to outcomes from the health care process. However, for 12 percent higher expenditure, Switzerland is also a high performing nation with respect to rapid access to advanced medical services. The core difference between the two nations is the use of an independent premium-funded (with protections) insurance model rather than a tax-funded, government operated insurance model.[24]

A wealth of evidence supports the de-politicization of health care insurance and more direct connection between payers and funders that comes from employing an independent insurer or social insurance model for universal access health care. For example, Altenstetter and Björkman (1997) note that countries who employ social-insurance funding models appear to have fewer problems with wait times than those who employ government models. Various international reviews of health care also show that systems based on social-insurance seem to outperform government-run models in terms of both timeliness and quality (Matthews et al. 2012). Finally, research suggests that access to advanced medical technologies may be superior in social-insurance financed health care systems as compared to tax-funded government insurance systems (Rydén et al. 2004).

There is a tendency in both social insurance based as well as in tax-financed systems to promote integration and to make health care more "patient focused". Fragmentation has traditionally been a problem in both these systems, mainly because the economic responsibility for each individual patient has been split across different actors.

Many countries besides Sweden and Switzerland strive to rearrange incentives to make it possible for health care providers to gain from organisational and technical improvements (Enthoven 2009). In the UK this idea lies behind recent reforms to put primary care in the driver's seat (Ham et al. 2011). In Germany, models of disease management programs have successfully aligned incentives to promote an integrated approach (Stock et al. 2009).

One might say that both the social insurance and the tax-financed countries combat the same types of problems, but with slightly different reforms. Tax-financed countries, such as Sweden, try to shift the focus from specialised care to primary care and remove organisational "silos". Insurance based countries increasingly try to relax the tendency of their reimbursements models to focus too much on single procedures.

These reforms make the two systems more alike. The tendency is to allow providers to compete for providing an integrated health care concept for each individual patient. In the long run, this will make the differences between social insurance and tax financing less distinct. Even the US reforms could be described as a deliberate move towards a classic European social insurance based model (van de Ven and Schut 2008).

Medical expenses for the insurance plan fell as much as 33 percent with more cost sharing.

It must be clarified that while a social-insurance model in a Canadian province is not disallowed by the *Canada Health Act*, certain restrictions are imposed on provinces considering this reform. In order to comply with section 8 of the *Canada Health Act*, which defines the principle of Public Administration, the social insurer must operate as a monopoly. In order to comply with section 10 of the *Canada Health Act*, which defines the principle of Universality, the social insurer must offer one uniform policy to the population and not allow individual tailoring (Clemens and Esmail 2012). Thus, while a Canadian province is free to partially follow the Swiss social insurance model, emulating the features of insurer competition and policy flexibility are not permitted by the *Canada Health Act*.

An alternative to using competing insurers could be to use reimbursement models to create health care coordinators and to focus the economic responsibility for each individual patient to one single agent. Such a reform would aim at putting primary care in the driver's seat – effectively transforming primary care providers into competing insurance companies (Saltman et al. 2006).

Recommendations Disallowed/ Penalized by the *Canada Health Act*

Cost sharing/user fees

Both Sweden and Switzerland employ cost sharing for universally accessible health care services. In Canada, provinces are penalized for doing so under the *Canada Health Act* through reductions in federal cash transfers for health and social services (Clemens and Esmail 2012). The result is that both Switzerland and Sweden enjoy a more efficient allocation of health care resources than Canada.

Provinces cannot use cost sharing without losing federal transfers.

The basic concept behind cost sharing for medically necessary health care services is fairly straightforward: when patients are required to use their own finances to share in the cost of the care they consume, they make a more informed decision about when and where it is best to access the health care system. In the absence of cost sharing, the dollar cost of health care to the individual is zero, resulting in excess use of health care resources and their inefficient application.

The RAND Health Insurance Experiment is the seminal research project on cost sharing. The study encompassed more than 2000 families and examined the impact of cost sharing both on health expenditures and on the health of the insured population. The experiment found that medical expenses for the insurance plan fell as much as 33 percent with more cost sharing, and little or no net effect on health, risk of death, or measures of pain and worry (Newhouse et al. 1993). Both the experiences of Sweden and Switzerland, along with the experiences of other developed nations, are supportive of these findings (Ramsay 1998).

This is not to say that cost sharing should be applied to the entire population without excep-

tion. Both Sweden and Switzerland maintain exceptions for cost sharing, an approach that is supported by research on the subject. Importantly, while the RAND Health Insurance Experiment found that co-payments could improve the efficiency of health expenditures without negative health consequences, it did find that the health of the poor who were sick was adversely affected by co-payment arrangements (Newhouse et al. 1993). Work on the effects of co-payments in Nordic countries (Denmark, Finland, Iceland, Norway, and Sweden) emphasizes the need for appropriate and effective exemptions for low-income individuals in order to ensure that these individuals are able to access the health care system in times of need (Øvretveit 2001). Studies have shown that these exemptions should be pro-actively administered and automated as much as possible, in order to ensure that all who qualify receive an exemption, since a lack of knowledge of exemptions, social stigmas, and the need to complete special forms can result in many individuals not receiving appropriate assistance or protection (Warburton 2005; Øvretveit 2001).

It should be noted that provinces wishing to ensure access to their full federal cash contribution for health and social services under the *Canada Health Act* are not permitted to allow cost sharing for medically necessary physician and hospital services. Under sections 19 through 21 of the *Canada Health Act*, provinces will see a dollar-for-dollar reduction in their federal cash transfers for the amount that was charged to patients in a given year (Clemens and Esmail 2012). In order for this policy to be implemented in a province, the *Canada Health Act* must be reformed or the province willing to accept a reduction in cash transfers from Ottawa.

Individual tailoring of insurance policies

In Switzerland, individuals have more than access to a world-class universal-access health care system. They also have the ability to tailor their health insurance policy to their personal preferences, within bounds set by the federal government. Further, they are able to choose the company that will provide that insurance to them. This Swiss system of choice and competition generates a high level of consumer focus, consumer sovereignty, and responsiveness that is almost entirely absent from monopolistic insurance models like Canada's.

> *More choice puts the interests of those who pay for and use the health care system first.*

It is noteworthy that Switzerland is not alone in pursuing a universal access health care model that employs a high degree of choice in insurance provider and policy. Germany and the Netherlands among others have also moved to allow choice of insurer and in some cases limited flexibility in the particulars of the insurance policy. It would seem that putting the interests of those who pay for and use the health care system before the interests of those who run it is something governments in Europe are increasingly interested in.

Individual tailoring of universal access insurance policies could also be a way through which lifestyle-related health care externalities were resolved more efficiently. At present, governments impose sin taxes on cigarettes and are pursuing cigarette manufacturers in court to recoup a claimed higher-than-average cost of health care for smokers. Governments and lobbyists are also looking at ways to tax or regulate certain foods and activities as part of an effort to deal with suspected higher health care costs for the obese. Taxation, regulation, and litigation not only create economic inefficiencies but are blunt and indirect tools that do not directly resolve the cost potentially imposed on others through the universal access health care system. It makes much more sense for governments to capture any increased health costs directly through risk-rated premiums while ensuring that the risk-rating is only for those risks that are controllable through changes in individual behaviour.

It should be noted that provinces wishing to pursue policies related to individually-tailored health care and choice of health insurer would violate sections 8 and 10 of the *Canada Health Act*, putting at risk their full cash transfer from

the federal government. Section 8 of the *Canada Health Act* disallows multiple insurer constructs. Section 10 of the *Canada Health Act* requires universal insurance in Canada to be on "uniform terms and conditions" thus disallowing any modifications that are aimed at better suiting individual needs and preferences. In order for this policy to be implemented in a Canadian province, the *Canada Health Act* must be reformed or the province willing to accept a reduction in cash transfers from Ottawa.

Conclusion

The health care systems of Europe and North America are in a constant state of change. However, some common trends among health care systems can be identified. Reforms in continental Europe during the 1990s aimed at promoting patient choice between insurance boards/companies, and this trend seems to have been strengthened during the 2000s. Switzerland and the Netherlands have gone furthest in promoting not only patient choice of care providers, but also choice of insurance companies.

Patients in the continental Bismarck-type systems have always been able to choose their health care provider in primary care and often their provider of specialised care. So why bother choosing an insurer when all insurers allow access to almost all providers? The answer to this question might be that the continental models are prone to fragmentation of health care provision. When reimbursements are tied to specific procedures or admissions, care providers will be too focused on delivering these specific services – without having a more general concern for the long run health status of the population or the individual patient.

The early market movement of the 1980s, also called New Public Management, focused on making health care more productive (Dunleavy et al. 2005). The idea that public bodies could, and should, act as proxies for patients was popular in some of the non-insurance based health care systems, such as Britain's. Other countries with similar health care systems soon followed. The earlier mentioned Stockholm model was based on the idea of purchasers and providers and a greater reliance on private providers.

In the late 1980s the idea of a more integrated approach could be seen in Britain. In some parts of Britain, Total Purchasing Pilots (TPP) were introduced as a means of putting primary care in the driver's seat. A similar approach, called the Dala model, was introduced in Sweden, but it never became firmly established and was later forgotten.

Canada can prepare for its reforms by creating a well functioning infrastructure.

The remaining legacy of the New Public Management movement became the idea of contracting out some parts of the health care production to private providers. And while this probably did increase productivity, it did not solve the problems of fragmentation inherent in all hierarchically organised health care systems.

To a large extent, Canada has been unaffected by these trends. This means that some of the organisational developments that have improved productivity in other health care organisations have been unnoticed here. On the other hand, Canada has also managed to avoid some of the early mistakes of New Public Management. Thus, when opening up and reforming the Canada health care system to improve productivity and efficiency there are unique opportunities to learn from reforms that went well, while avoiding reforms that did not work.

The fact that Canada lags in making structural reforms of its health care system may not only be a disadvantage. Canada can thus prepare its reforms by creating a well functioning infrastructure. Being able to predict the health care costs of individual patients as well as describing and registering individual procedures in the care process of the individual patient is a crucial element in any patient centred reimbursements system.

These reforms had limited success, primarily because they did not establish which actor in the health care chain who was responsible for any

particular patient (Dunleavy et al. 2005).

While New Public Management did increase productivity markedly, it did not steer health care into a more optimal use of services. While some procedures might have had little or no benefit for some patients, the health care producers often still had strong economic incentives to provide as many procedures as possible.

The lack of freedom for producers to choose the means as to maximise patient benefits continues to be a major problem of Western European health care systems. In the last few years the focus has shifted from payment for procedures to payment for keeping the patients healthy.

While Sweden does try to integrate the health care process within specialised care, there is still much to do in bridging the gap between primary care and specialised and inpatient care. An integrated approach still remains elusive for most European health care systems.

In this regard, the insurance approach of Switzerland or Holland may be a better model to study. Although the insurance (or Bismarck) models of Europe have traditionally been plagued by the same type of fragmentation as the New Public Management systems, new approaches are emerging. The Swiss HMOs, although they only cover 12 percent of the population, are an interesting development. The viability of managed care, however, critically hinges on having a well functioning compensation system for co-morbidity and pre-existing conditions.

Canada's health care record is unimpressive, lagging on nearly every measure.

As Switzerland is increasingly using previous diagnoses and care episodes to compensate insurers, the interest in attracting patients with a history of bad health should increase. As the concept of integrated care becomes more attractive economically, the penetration of HMOs will likely increase over time. Thus, the dynamic development of the Swiss health care system will be of interest to countries considering reform of their health care system.

If there is a similar move towards integration in Sweden, it will probably take place through a simultaneous movement in primary care and specialised care. In primary care this might mean that primary care providers are given more responsibility for coordinating health care provision. By making primary care providers responsible for the cost of specialized and inpatient care, the primary care providers are given incentives to take on an expanded responsibility.

As in Switzerland, developments in Sweden will be interesting to follow. The multitude of care delivery models in Sweden makes the country a workshop for health care organisation. The disadvantage may be that the county councils are fairly small and often lack the capacity of landing truly new and innovative health care models. The development of health care organisation in Sweden may thus be 'path-dependent', with interludes of rapid bursts of organisational change and experimentation.

Neither the Swiss health care model nor the Swedish can be regarded as true "models" for health care organisation. The Swedish model is not even *one* model, but almost 20 different approaches to health care organisation. The Swiss health care financing system may have some common national principles, but like most continental health care systems the actual organisation of health care delivery ranges from ordinary fee-for-service to managed care.

The main difference is that while Canada has tried to stick to certain principles that are thought to be pillars of universal health care on equal terms, Sweden and Switzerland have opened up to new solutions. As we have seen, not everything has been successful. But over time, the systems have improved and tend to rank high internationally.

Of course, as health care organisation develops and new ways of delivering good care emerge, the cost of not experimenting gets progressively higher. If and when Sweden and Switzerland find a consolidated model that combines the comprehensiveness of the public model with the efficiency of private provision, these countries will be at the frontline of health care organ-

isation. Trying to stick to the traditional public bureaucracy will then be fruitless and the Canadian system will then need much more invasive surgery to regain competitiveness.

Even today, signs show that Canada is falling behind. In comparison with the performance of other universal access health care systems in the developed world, Canada's record is unimpressive. The data clearly show Canada's health care system is a relatively poor performer for access to health care, whether measured in terms of the timeliness of care, the availability of basic medical resources (physicians, beds, and more), or the availability of advanced medical technologies. Canada's health care system is also not a high performer in outcomes from the health care process, though it is also not a poor performer. This mediocre performance comes at a high cost: Canada's health care system is the developed world's 5th most expensive universal access health care systems.

A closer look at two of the world's top performing universal access health care systems reveals a markedly different approach to health care policy than that pursued by Canada's provinces. In both Sweden and Switzerland, patients have access to privately owned and operated hospitals under the universal access health care system. The Swedes and Swiss are also not prisoners of the bureaucratic approach, and are able to purchase medically necessary health care privately. In Switzerland, the universal access health insurance system is run by independent insurers, who compete with one another and are permitted some flexibility in tailoring the universal scheme to individual preferences. Finally, patients in both Sweden and Switzerland must share in the cost of health care they consume.

These marked differences in approach provide a beacon to health care reform in Canada. Indeed, research on the experience of these nations, and other international experience, all suggests that Canada's health care system would benefit greatly from a more Swiss or Swedish approach to health care.

About the Author

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With contributions from Paul Corrigan and Oscar Hjertqvist and research services by Nadeem Esmail.

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Endnotes

1 Data for both the US and Mexico are shown in the OECD charts where available, but are not included in the averages discussed in this paper.

2 Esmail and Wrona 2008 provide a good overview of a number of international analyses of medical technology investments.

3 *Hospital beds* includes all beds that are regularly maintained and staffed and are immediately available for use including beds in general hospitals and other specialty hospitals as well as mental health and substance abuse hospitals. Beds in nursing and residential care facilities are excluded (OECD 2011).

4 Canada's bed occupancy rate is also relatively high in comparison with other OECD countries. Specifically, Canada's occupancy rate in 2009 was 93.0 percent, the highest rate among developed nations with universal access health care systems. The average OECD country maintained a rate of 76.8 percent. While this high occupancy rate might be viewed as a highly efficient use of resources, it undoubtedly reduces flexibility and responsiveness and may limit efficient allocation of health care resources. It may also limit the health care system's ability to deal with sudden spikes in demand.

5 "This system is a per-case reimbursement mechanism under which inpatient admission cases are divided into relatively homogeneous categories called diagnosis-related groups (DRGs). In [a] DRG prospective payment system, hospitals [are paid] a flat rate per case for inpatient hospital care so that efficient hospitals are rewarded for their efficiency and inefficient hospitals have an incentive to become more efficient" (Gottlober et al. 2001).

6 Gay et al. (2011) provide calculations of mortality amenable to health care using two widely used lists of causes amenable to health care: the list published by Tobias and Yeh, and the list published by Nolte and McKee. For consistency with other Canadian examinations of mortality amenable to health care, this paper uses the calculations based on the Nolte and McKee list of causes.

7 This contrasts with Canada where coverage for hospital and physician services is universally provided free-of-charge with private purchase often precluded, giving Canada a higher public share of funding for physician and hospital services than Sweden. On the other hand, Canada's health care system has comparatively lower shares of public spending on other categories including pharmaceuticals and dental care.

8 The guarantee was introduced in 2005 and incorporated into national legislation in 2010 (*Health and Medical Services Act*). County councils are responsible for providing alternatives for patients whose wait exceeds the guaranteed time.

9 Allowing patients to access specialists directly without the need for a GP consultation would be expected to increase efficiency in the allocation of medical resources to the extent informational barriers (knowing which specialist to see) are not a problem. Of course, Swedes can still see a GP for referral if they feel they have insufficient information.

10 Each medical care region covers a population of (on average) 1 million or more Swedes.

11 Future health care reforms in Sweden may include further concentrations of highly specialized health care in national health centres.

12 The guarantee was introduced in 2005 and incorporated into national legislation in 2010 (Health and Medical Services Act). County councils are responsible for providing alternatives for patients whose wait exceeds the guaranteed time.

13 Canadian dollar conversions are based on the average currency conversion for 2011 provided by the Bank of Canada at http://www.bankofcanada.ca/rates/exchange/10-year-converter/. Converted dollar values are rounded to the nearest dollar.

14 The minimum annual deductible for children is CHF100 (CAN$112).

15 Canadian dollar conversions are based on the average currency conversion for 2011 provided by the Bank of Canada at http://www.bankofcanada.ca/rates/exchange/10-year-converter/. Converted dollar values are rounded to the nearest dollar.

16 Enrollees may opt for a deductible between CHF500 (CAN$559) and CHF2,500 in CHF500 increments; the maximum allowable annual deductible for children is CHF600 (CAN$671).

17 Current reform discussions in Switzerland include measures to promote further managed care enrolment and further care management potentially by requiring 3 year contracts for managed care plans rather than the current single year enrolments (Leu et al. 2009).

18 CHF350 (CAN$392) for children.

19 Initially, risk equalization was planned to last only 10 years. The assumption was that consumer mobility would level risk profiles among insurers over time. In practice, mobility has been lower than expected and good risks proven to be more mobile than bad risks. As a result, risk adjustment remains a core feature of the Swiss health insurance marketplace.

20 If insurers and providers are unable to agree to a fee schedule, canton governments are empowered to impose one on both parties. Also, while physicians must accept the fee schedule as payment in full, there are no restrictions on the setting up of practices. This has resulted in physicians locating in higher paying areas with physician shortages being created in others.

21 HMOs and IPAs are more likely than fee-for-service gatekeeping plans to employ prior authorizations, utilization reviews, and other methods to manage care.

22 Canadian hospitals are legally considered private, not-for-profit entities. However, in practice and particularly in international comparisons, they are best considered public institutions. Indeed, Detsky and Naylor, in a discussion on the ownership status and structure of Canadian hospitals state: “For all intents and purposes, they are public institutions” (2003, 805).

23 It should be noted that the Supreme Court of Canada, in what has come to be commonly known as the *Chaoulli case*, found that an insurance monopoly (or the prohibition of private parallel insurance) was not necessary to achieve the goal of a quality public health care system (Supreme Court of Canada 2005).

24 In the Canadian federal transfer model, federal cash transfers to a province could simply be repurposed to either assist with the taxpayer-funded cost of insurance for those who are unable to afford the premiums (similar to how tax funding is used in Switzerland), to subsidize premiums for all payers, or for any other form of financial assistance for provincial insurance programs.

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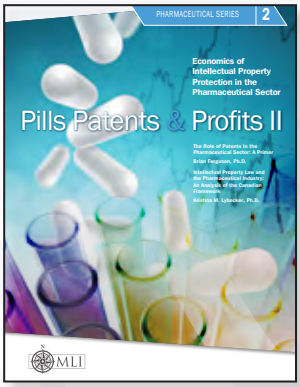

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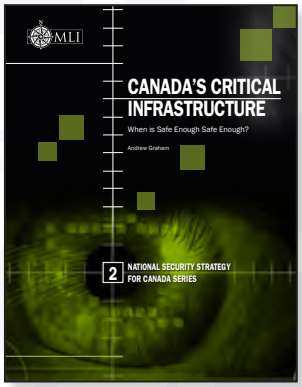

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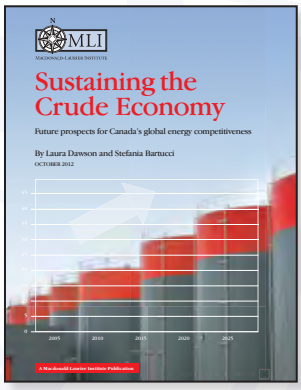

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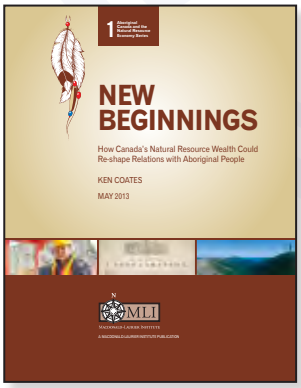

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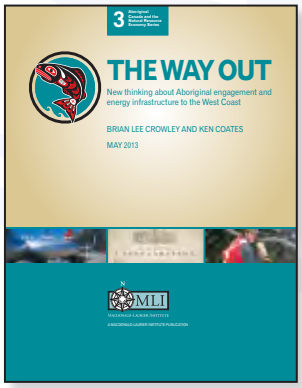

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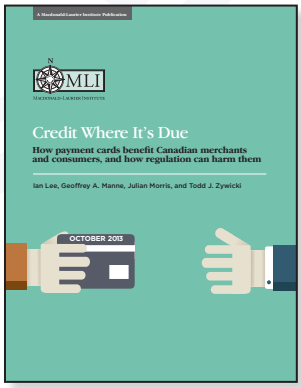

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