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I. CONFERENCE REPORT

Health Systems In Three Nations

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An examination of the approaches employed by Canada, the United Kingdom, and the United States (and, for that matter, all other industrialized countries) to finance and provide medical care makes clear that no one system represents a gold standard to which all nations should aspire. Rather, these medical insurance and care systems reflect priorities that are inherent in the culture, politics, and professionalism of the nations in which they evolved. All three countries are democracies driven by capitalism, but their approaches to the payment for and provision of health care underscore how differently that task is accomplished even by countries that share many of the same fundamental values. One constant fact is that physicians, regardless of how they are paid, dominate the allocation of clinical resources in all of the systems.

The U.S. medical care system (which is often referred to as a "nonsystem") mirrors its belief in pluralism, private enterprise, biomedical research, and a circumscribed role for government. Canada's health insurance scheme underscores its confidence in a tax-financed system administered by provincial governments and in which private fee-for-service physicians provide the care. And the United Kingdom's National Health Service (NHS) is the classic example of a centrally financed and directed system operating in a pluralistic political environment. The approaches of Canada and the United Kingdom reflect an overriding commitment to providing primary care to their populations, a fundamental feature that is absent in

the United States.

Despite the differences that separate these systems, a 1990 Trilateral Conference on Health Care concluded that all three nations are pursuing an elusive but critical goal: a more cost-effective allocation of resources based on better definitions of what works in clinical medicine and more appropriate incentives that encourage patients, payers, and providers of care to recognize more clearly a medical commons from which all must draw. A reality of the American and British systems is that in neither country is there an equilibrium between these interests that meets the satisfaction of the respective societies. The earlier balances struck in Canada's system are showing signs of serious wear as well. All health financing systems are dynamic institutions in need of adjustment as their political and economic circumstances change.

The United Kingdom. The British NHS faces the sternest immediate challenge as a consequence of reforms enacted by Parliament in 1990 that will change the balance of power between patients, providers, and government as the overwhelmingly dominant payer. Put most simply, general practitioners will gain influence, specialists will likely lose it, and the fate of consumers—the most neglected participants in NHS decision making—in the power equation remains an open question. The reforms, promoted by former Prime Minister Margaret Thatcher, seek to restructure the service along lines that make it less reliant on the state and more subject to the structured incentives of an internal market. (Thatcher's successor, Prime Minister John Major, supported the reforms from his previous government post and was a coauthor of the *Working for Patients* White Paper upon which the

reforms are based. In the three years before his elevation to prime minister, Major, as chancellor of the exchequer, advocated that the NHS be a priority recipient for additional resources that amounted to 20 percent above inflation.)

British participants in the Trilateral Conference expressed a decidedly mixed range of views on the likelihood that Thatcher's reforms would improve the NHS's capacity to provide high-quality service to the population, while maintaining the autonomy of its practitioners. Managers tended to favor the reforms; physicians generally spoke against them.

Canada. Canada's provincial health insurance plans face a future of greater stress, too, because the federal government is reducing its annual financial contribution to the plans, patient and professional demands are increasing, and the Canadian economy is in recession. Nevertheless, politicians and the public alike strongly support Canada's approach to providing its citizens with universal access to care.

One of the central questions facing Canada is whether that society can afford to maintain its heavy reliance on tax-financed care without allowing for a private infusion of resources by individuals who are capable of purchasing additional protection or better service. Currently, private health insurers are prohibited from selling insurance benefits that are covered by the provincial plans. In this regard, the contrast with the NHS is instructive. While the NHS finances the bulk of the care, British citizens can seek care from a private system, to which about 10 percent of the population have access, usually through their employers, as a way to avoid queues and receive care provided with more amenities. Canada allows no such safety valve in its system, although an increasing (but still very small) number of Canadians are traveling to the United States for medical care when faced with prolonged waits for necessary treatments.

The United States. The United States presents the most confusing picture of all, given its large uninsured population, the massive (but proportionately still smaller than Canada's) federal budget deficit that

retards the likelihood of real reform, and the medical profession's ambivalence about promoting changes that could lead to a greater government role in the financing and provision of care. Compounding these difficulties is the absence in the United States of an agreed-upon societywide approach to health care delivery and finance, a policy threshold long ago reached in both Canada and the United Kingdom. The current question being addressed far more aggressively in the United States than in Canada or the United Kingdom is, What are the actual outcomes for patients of treatments provided by medical practitioners? This question will reverberate through the systems of all industrialized countries before the end of the decade.

The conference. The 1990 Trilateral Conference brought together an impressive array of individuals well recognized for their contributions to health care management and provision and medical education. Most of the participants came from leadership posts in academic medicine, but other sectors of the health economy were represented as well. The (U.S.) Association of Academic Health Centers organized and hosted the three-day meeting in collaboration with the American Medical Association and the Association of American Medical Colleges. The conference was supported through grants from The Robert Wood Johnson Foundation (U.S.), The Pew Charitable Trusts (U.S.), and the Nuffield Provincial Hospitals Trust (U.K.). The meeting was held at the National Academy of Sciences' California conference center.

The Role Of Government

As the conference underscored, the health care systems of the three countries are different in many respects, but no difference is perhaps more profound than the role played by government in the financing and provision of care. In Canada, ten provincial governments administer and largely finance through taxes the medical care to which all citizens have access. The federal government provides partial financing through an annual (though declining) transfer of monies to the provinces (initially 50 percent

and now about 37 percent on average, depending on the wealth of the individual jurisdiction) and a statutory framework on which the provincial systems operate. This framework requires provinces to meet basic requirements to be eligible for the federal transfer payment: coverage must be universal, benefits must be comprehensive and portable, care must be accessible, and the health insurance plans must be administered by public agencies. Otherwise, Canada's federal government provides "very minimal moral authority" to the provincial health insurance plans, said John M. Home, of Manitoba's Health Sciences Centre.

In the United Kingdom, the national government finances through taxation all care provided by the NHS. Regional and local health authorities play important roles in the administration of the NHS, but these are not general-purpose governments as are the provinces that manage the Canadian plans.

In sharp contrast, the U.S. health care system is dominated by the private sector, particularly in the manner in which care is financed and provided. Of 211 million people (87 percent of the civilian noninstitutionalized population) with health insurance in 1988, more than 188 million were covered by private policies through their employers or by individual purchase. The remaining individuals with health insurance were covered through public programs—Medicare, Medicaid, CHAMPUS, and the Department of Veterans Affairs (VA) system. Based on Current Population Survey estimates, the number of uninsured Americans grew from 28.4 million in 1979 to 31.5 million in 1988, an increase of almost 25 percent.

Britain's National Health Service

Recent clashes between government and the medical profession over the future directions of the NHS and the enacted reforms that followed have not changed the basic values upon which the NHS is built, conference participants learned from Brian Edwards, general manager of the Trent Regional Health Authority. That is, service is

still free to patients at the time of delivery, and a workable, if not ideal, balance remains between government managers, who control the overall budget, and physicians, who are charged with allocating those resources on behalf of patients. Edwards characterized the clinical freedom enjoyed by physicians as "a strong foundation of the NHS . . . that is an asset and a strength rather than a problem." But he conceded that the choices practitioners must make in the "rationing process—and that's what it is—are becoming increasingly difficult for physicians."

Edwards said that the NHS places a strong emphasis on primary care and that every citizen registers with a general practitioner (GP), who serves as a gatekeeper to medical specialists and to the hospitalization of patients. Michael A. Wilson, a self-employed GP, noted that GPs handle 90 percent of NHS patient contacts with doctors. GPs strictly control the number of referrals they make to consultants and thus help to constrain expenditures. Recently, Wilson said, the profession and government have been engaged in "a particularly bitter struggle" over the future directions proposed by Thatcher's reform proposals.

John Lister of Britain's Royal College of Physicians summarized the major goals of the reforms proposed by Thatcher in the document, *Working for Patients*, which was published in January 1989. (For detailed discussion of the reforms, see Patricia Day and Rudolf Klein, "Britain's Health Care Experiment," in this volume of *Health Affairs*.)

The description of the reforms prompted two general lines of questions from participants: How would the newly structured incentives affect physicians financially; and would the reforms cost money? In response to the first, Lister said that medical consultants would not receive additional funds as a consequence of the reforms. Indeed, he said, the appropriateness of their merit pay awards would be reviewed every five years, rather than being bestowed automatically. Wilson said he was concerned about the consequences of a new incentive placed on GPs to "shop around and find the best buy within the budget we hold" because "personal gain [to doctors] would come out of it.

We do not believe that physicians should be influenced by a search for savings which, in essence, makes the cost, rather than the care, the priority."

On the cost question, Edwards and Sir Raymond Hoffenberg (Wolfson College, Oxford) were the most outspoken in their views that the reforms would likely increase the proportion of gross national product (GNP) spent on the NHS (currently 6 percent). "The system is bound to soak up more than 6 percent of GNP," Edwards said. "The question is, How much more?" Hoffenberg replied: "It is very doubtful that expenditures will be held to 6 percent because the administrative costs of the service, which are very low [4.5 percent of total expenditures], are bound to go up considerably."

Canada's Provincial Health Insurance Plans

Harvey Barkun, executive director of the Association of Canadian Medical Colleges and former chief executive officer of Montreal General Hospital, briefly described the evolution and operation of Canada's provincially administered health insurance plans. The evolution of Canada's scheme dates from 1914, when the first Municipal Doctor Plan was introduced in the province of Saskatchewan. Eliminating financial barriers to access to medical care was the guiding principle behind Canada's moves to develop separate hospital and medical insurance plans. Barkun said: "Universal availability of care are sacred words in Canada; means testing care (relating its cost and thus availability to one's economic status) are dirty words."

Physician fees are negotiated periodically by the provincial medical associations and the provincial governments. Provincial health ministries also negotiate annual budgets with the hospitals, the vast majority of which are private, not-for-profit institutions. Given that almost all of their resources derive from the provincial health insurance plans, most of Canada's hospitals are quasi-public in their character, although their boards are composed of private citizens. Given the reliance on public resources,

most hospitals that spent beyond their negotiated budgets have been rescued by cash infusions from provincial ministries. Recently, though, ministries have become more tight-fisted in this regard, refusing to bail out every hospital that spends beyond its means. However, no institution has been closed as a consequence of such shortfalls. Barkun said that "the most difficult part" of the negotiations over establishing hospital budgets is covering the cost of new medical technologies.

Many of Canada's ten provincial health insurance plans have entered a difficult period. The federal government is slowing the growth of its annual financial transfer to these plans, the number of practicing physicians is increasing more rapidly than is the population, and patients are demanding high-quality service without undue delays. Barkun conceded that many patients—those whose situations do not demand immediate attention—do wait for selected diagnostic technologies such as magnetic resonance imaging and computed tomography. "Temporal rationing of services certainly does exist in Canada," Barkun said.

Since 1977, Canada's federal government has employed a variety of means to reduce its initial commitment to paying for half of the costs of provincial health insurance. To illustrate, Ottawa provided 44.6 percent of the total revenues of \$14.1 billion spent by the provincial plans in fiscal 1979 and 1980. A decade later, Health and Welfare Canada estimated that the provincial plans spent \$39.2 billion in 1989 and 1990, only 36.7 percent of which was provided by the national government. In future years, the federal government estimates that federal transfer payments, as a proportion of provincial health expenditures, will drop to percentages in the low thirties, although the precise projections are kept confidential.

Despite the difficulties that Canada's provincial plans are currently encountering in balancing their resources with heavy demands for service, training to become a physician remains "a very attractive career choice," Barkun said. On average, four individuals apply for every medical school position. Once students are admitted, medical

training is an inexpensive proposition for them. All medical schools and teaching hospitals are public institutions, and most of their costs are financed through tax monies. Annual student costs are estimated to range from \$719 at McGill University in Montreal to \$3,000 at the University of British Columbia in Vancouver.

American Health Care

J. Alexander McMahon, former president of the American Hospital Association and currently professor and chairman of the Department of Health Administration at Duke University, provided a philosophical description of the U.S. health care system and the beliefs in which it is rooted. McMahon said, reflecting American institutions in general, U.S. health care was “more individual, more pragmatic than orderly. . . . The nature of American institutions and of democracy itself springs from the American Revolution and our resistance to central authority. The American economy grew out of a frontier mentality, and recent events in Eastern Europe only strengthen our beliefs in freedom and less powerful central governments.”

McMahon said that “the United States does not want to imitate other nations” but rather favors following an approach based more clearly on its own values. At this time, he conceded, the lack of trust in government—what he characterized as “one of those periodic valleys that all democracies experience”—is inhibiting health care reform efforts. “We are probably marking time until a real crisis erupts,” he said.

Alan R. Nelson, a Utah internist and a former president of the American Medical Association (AMA), focused his opening remarks on his “dislikes of the [U.S. health care] system:” the occasional lack of patient access to effective medical technologies, the “mess” over professional liability, the loss of professional freedom that is reflected in “indiscriminate government-based patient claim denials,” and duplicative efforts at assuring physician accountability through various private and public agencies. This situation is a consequence of what Nelson

characterized as “the information revolution.”

In his remarks, Nelson paid a particular (and, given his close ties to the AMA, an important) compliment to the health maintenance organization (HMO) model and, in his expressed opinion, the favorable impact that competition between different delivery approaches was having on the provision of care in Utah. The AMA has generally opposed the growth of the HMO model as a competitive threat to fee-for-service medicine, the approach favored by an overwhelming majority of its physician members. “The HMO in my town [Salt Lake City] makes me hum,” Nelson said. “It employs an ombudsman in its facility, it attracts very good doctors, and it engages in very active peer review. On balance, the entry of HMOs in the market has been good for everybody.”

Barkun responded to Nelson’s assertion that the U.S. government as third-party payer hassles physicians by saying that one of the “great myths about Canadian health care is that an overbearing government interferes with the clinical autonomy of physicians or inappropriately questions payment claims. No government clerk or bureaucrat seeks to dictate to practitioners or influence their professional practices.” Nelson retorted: “Love it [clinical autonomy] while you have got it, because it’s only temporary.” At a later point, John Wyn Owen, director of the Welsh office of the NHS, said the British government believes that “medical audit is a matter for the profession. We hope to be able to resist those pressures, which are there, to involve government deeply in the practice of medicine.”

Strengths And Weaknesses Of The Three Systems

Throughout the conference, participants discussed what they regarded as the strengths and weaknesses of the three systems. On balance, more participants were impressed with Canada’s health care system than those of the United Kingdom or the United States. But the perceptions of the participants varied in relation to their fa-

miliarity with the system under discussion, their philosophical preference, and whether or not it was one's own system or that of another country.

Canada's system attracted support for its universal coverage (a feature, of course, that it shares with the NHS), its decentralized administration (and thus greater accountability to the electorate) at the provincial level, its joint provincial/federal financing, and the level of tax-financed resources the nation commits to it. As Sir Maurice Shock, a British participant, put it: "Canada's funding level is beyond our reach. The United States' funding level is beyond our dreams."

The American health care system was subjected to the sharpest criticism on the central issue that current U.S. reform efforts are striving to address: the lack of access to care that millions of Americans face because their employers do not provide coverage, they are unemployed and/or ineligible for public health financing programs, or they are self-employed individuals who cannot afford or choose not to purchase care. Non-American participants also commented on the absence of a global structure through which public policies are framed and care is rendered and on the interventionist tendencies of private and public third parties in relation to the practice of medicine. Canadian and British participants were appalled by the accelerating pace at which American third parties are seeking to micromanage the provision of care, asserting that practitioners in their own countries would never stand for such interference.

American participants expressed admiration for some of the features of Canadian and British health care that represented the reverse of the above. They admired in particular the universal access to care enjoyed by British and Canadian citizens, regardless of their ability to pay; the coordinated structures that provide a stability to these systems that is unmatched in the United States; and the high-degree of autonomy that physicians in both of those countries have been able to maintain. McMahon, speaking for the Americans, said the group also was impressed by the humaneness of the Canadian and British systems and the relative absence

of litigation with which physicians must contend. America's tort system encourages litigation by the way it assesses liability and damages, he said. In the United Kingdom and Canada, legal counsel must be paid a retainer, as opposed to most U.S. malpractice attorneys, who are paid on a contingency basis, and plaintiffs are held responsible for the defendant's court fees if the judgment is in favor of the defendant. McMahon noted, "American obstetricians have a 100 percent probability of being sued every three years."

Barkun, in his summation of the views of Canadian participants, emphasized the fundamental difference between the constitutional watchwords of Canada ("peace, order, and good government") and those of the United States ("life, liberty, and the pursuit of happiness"). Barkun said that Canadians were most impressed with the NHS's effective use of medical consultants and the closer system integration found in Britain complicated with the systems of Canada and the United States.

In contrast, and reflecting the fact that any comparative study of health systems usually produces a phenomenon one might characterize as "the grass is always greener in the other fellow's pasture," Lister of the British delegation said that the NHS has too few consultants. "We need more consultants, and we need to know more accurately what they do with their clinical time," he said. Barkun said that the NHS seemed to suffer from chronic underfunding. As a consequence, many of its hospitals and other health care facilities were "antiquated and run-down," and their capacity to acquire the latest technology was sadly lacking compared with such institutions in the other two countries.

Barkun noted that both Canadian and British patients are less demanding of care providers than is the average American who seeks treatment. Shock put it another way, criticizing the NHS for its insensitivity to the consumer voice. Barkun also said, "English physicians are more conservative in their approach to treatment. They tend not to push treatment and are less interventionist than most American physicians." Shock,

speaking for the British participants, echoed the Canadian concern regarding the slow pace at which the NHS diffuses new technologies, a function of the strict limits on available resources.

Rationing Of Care

The participants generally agreed that all three systems ration care, but do so differently. Canada and the United Kingdom ration care by making individuals wait for a period before performing elective procedures or certain diagnostic tests. The NHS also has implicit policies that discourage general practitioners from referring individuals over age sixty to renal dialysis units and other scarce technologies. Shock said: "We do not know the extent of rationing, nor how fair the rationing that does occur is, but we are very concerned over the numbers of queues that exist for elective treatments and the increasing amount of queue jumping that is going on." He added that "one of the great strengths of the American system is its capacity to respond quickly to a medical problem. By comparison, the NHS is slower to respond to patient needs. General practitioners are not so much gatekeepers as practitioners who soothe patients who must wait for treatment."

The United States, on the other hand, has an abundance of medical resources that its practitioners can bring to bear on a clinical problem, as long as the patient has health insurance or some other means to cover the cost. U.S. rationing is based on price; thus, it discriminates against people who cannot afford the price of care. These people are left to either their own devices or the uncertain arrangements that uninsured individuals find when they must fend for care as indigent patients.

Forgone Opportunities

Some of the most provocative comments and exchanges voiced at the meeting came from participants speaking critically of features of their own system or commenting upon the expressed views of their fellow

citizens. The failure of all three systems to engage adequately in technology assessment was a recurring theme. Another dimension that provoked criticism of all three systems was the manner in which they treat or decline to treat people afflicted with physical or mental disabilities. British economist Allan Maynard said: "Look at the links to [physically] handicapped people and the mentally ill. The NHS is a very fragmented system and a system with very perverse incentives when it comes to treating people who suffer from these problems."

Another subject that drew critical comment was the failure of all three systems to more effectively promote efforts that prevent disease. Walter Holland, of Guy's and St. Thomas's Hospitals in London, said expenditures on behalf of disease prevention and health promotion were more beneficial on a population-based scale than were acute care services. He asked: "What has happened in Canada since publication of the Lalonde Report [a 1974 report named for that country's minister of health and welfare at the time, Marc Lalonde]? In the preface to the report, Lalonde wrote: 'The Government of Canada now intends to give to human biology, the environment and lifestyle as much attention as it has to the financing of the health care organization so that all four avenues to improved health are pursued with equal vigour'."

In response to Holland's question, Home said: "In the fifteen years since publication of the Lalonde Report, there is precious little evidence of any redistribution of resources favoring prevention and health education initiatives. The 5 percent figure used to estimate prevention expenditures hasn't really changed, although there is a growing, if belated, recognition that there's more to health than medical care."

Peter Glynn, an assistant deputy minister of Health and Welfare Canada, asserted in his remarks that the provincial health insurance plans were accomplished at macro-managing their plans but performed poorly at the micro level. Amplifying Glynn's comment about the inadequacy of micromanagement efforts, Home pointed out that the provincial plans broadened their benefits in

the 1970s to cover prescription drugs. In the process, he said, "vast amounts of data have been collected regarding which drugs are prescribed and by whom. The opportunities for much closer surveillance on how drugs are used are abundant, but provincial ministries suffer from inertia and cling to a bill-paying mentality that has prevented progress on this front."

Conclusion

The pursuit of more acceptable balances between the three major actors in health care—patient, payer, and provider—may well be a search for an impossible dream. Almost fifty years ago, Lord Beveridge, whose vision largely shaped Britain's National Health Service, held to the view that once a backlog of neglected illness had been tended to and health standards improved following World War II, the demand for services would stabilize. The anticipated leveling off of demand never occurred. Neither in Britain or any other industrialized country that has invested heavily in financing medical care are there any signs that health needs and health resources are approaching a natural balance or ever will. The demands will always be infinite, the resources always limited. Perhaps the best we can hope for is striking acceptable balances for the moment and recognizing that inevitably they will change, because disease states, available resources, and political will are dynamic dimensions of the equation that require constant scrutiny and adjustment.

Participants

William G. Anlyan, Duke University (U.S.); Michael Ashley-Miller, Nuffield Provincial Hospitals Trust (U.K.); John R. Ball, American College of Physicians (U.S.); Harvey Barkun, Association of Canadian Medical Colleges (Canada); Arnold Beckman, The Arnold and Mabel Beckman Foundation (U.S.); Paul B. Beeson (U.S.); Robert Bishop, Allergan Corporation (U.S.); Roger Bulger, Association of Academic Health Centers (U.S.); Ruth Bulger, Institute of Medicine (U.S.); Gerard

Burrow, University of California, San Diego (U.S.); joy Calkin, University of Calgary (Canada); Leighton Cluff, The Robert Wood Johnson Foundation (U.S.); Richard L. Cruess (Canada); Brian Edwards, Trent Regional Health Authority (U.K.); Spencer Foreman, Montefiore Medical Center (U.S.); Peter A.R. Glynn, Department of National Health and Welfare (Canada); Graham Allan Hart, Department of Health (U.K.); Sir Raymond Hoffenberg, Wolfson College, Oxford (U.K.); John Hogness (U.S.); Walter Werner Holland, Guy's and St. Thomas's Hospitals (U.K.); John MacGregor Home, Health Sciences Centre, Manitoba (Canada); John K. Iglehart, Health Affairs (U.S.); Leo Paul Landry, Canadian Medical Association (Canada); Marion Ein Lewin, Institute of Medicine (U.S.); John Lister, Royal College of Physicians (U.K.); George Maddox, Duke University (U.S.); Alan Maynard, University of York (U.K.); J. Alexander McMahon, Duke University Medical Center (U.S.); J. Alexander McPherson (Canada); James E. Mulvihill, University of Connecticut (U.S.); Alan R. Nelson, Memorial Medical Center (U.S.); Marian Osterweis, Association of Academic Health Centers (U.S.); John Wyn Owen, National Health Service (U.K.); Robert G. Petersdorf, Association of American Medical Colleges (U.S.); Clayton Rich, University of Oklahoma (U.S.); Raymond Schultze, University of California, Los Angeles Medical Center (U.S.); Roy M. Schwarz, American Medical Association (U.S.); Sir Maurice Shock, London College, Oxford (U.K.); Michael Teitelbaum, Alfred P. Sloan Foundation (U.S.); Joseph Van Der Meulen, University of Southern California (U.S.); Neal Vanselow, Tulane Medical Center (U.S.); Michael Whitcomb, University of Washington (U.S.); Michael Anthony Wilson, York Medical Society (U.K.); and Karl Yordy, Institute of Medicine (U.S.).