A new financial framework: lessons from Canada

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Prologue: In April 1989, the board of The Commonwealth Fund authorized $1 million for the development and funding of a program to examine lessons from Canada for a revised financial framework for American health care. This research program will be developed by staff and consultants and announced this fall. This GrantWatch essay, drawn from a report to the directors of The Commonwealth Fund, represents an opportunity to show an example of the actual content of the case for such a step as presented to a foundation’s board of directors. It illustrates how issues are framed and the depth and sophistication with which they are presented and discussed. More particularly, it illustrates how health services research features in and is credited for ideas presented in such discussions and, conversely, what kinds of policy questions such discussions offer for health services research. This report also deals with a timely subject. In the past year, a growing number of legislators, policy analysts, and organizations have advanced proposals that, if implemented, would dramatically restructure America’s health care enterprise. The concept of universal health insurance is back in our midst because of a view among some policymakers that nothing less encompassing will lead to the kind of change needed to address our current health care financing and delivery problems. In the course of this work and the ongoing discussion of the health policy community, one approach that has drawn attention is Canada’s provincially administered network of health insurance plans. The authors, Thomas Moloney and Barbara Paul (senior vice-president and program officer, respectively, of The Commonwealth Fund), have used recent health services research findings to develop their own view of an emerging consensus about the directions for a revised American health system. We hope that publishing this report will encourage other private foundations to articulate their views on how the United States should reform health care delivery and finance to address the problems of soaring costs, less than universal access, and questions about the quality of some delivered care.
I. ESSAY

A New Financial Framework: Lessons From Canada
by Thomas W. Moloney and Barbara Paul.

A growing consensus warns that the financial structure of the American health care system is in need of fundamental change. Much of what Americans would like to preserve and improve in their health care system may already exist in Canada. Therefore, this is an opportune time to examine the Canadian system—not to transplant it whole to the United States, but to learn about major aspects of it that could be highly beneficial in a new American context.

This essay describes the basic problems in the existing American system, the emerging consensus regarding the essential elements of a revised American system, the qualities that make the Canadian system uniquely intriguing, precisely what aspects of the Canadian system need to be investigated, and why those investigations might assist the shaping of a revised American system.

Problems With the American Health Care System

The perception that the American health care system is the best in the world has come under increasing fire. Health spending in the United States is escalating at a disturbing rate. Millions of citizens lack adequate protection from medical expenses. Attempts to solve these problems have been ineffective and have in many ways belied Americans’ values and preferences.

Rapidly rising costs. Health expenditures in the United States are the highest in the world, both per person and as a share of gross national product (GNP). No clear criteria exist for deciding how much is enough for any country to spend on health care, but it is clear that continuing escalation of costs relative to national resources is not sustainable. Health care costs are forecast to claim a steadily increasing share of U.S. GNP—rising from 11.5 percent in 1987 to 15 percent by 2000. Unmoderated spending on health adds to deficits in the public sector—already a national crisis. It threatens the competitive position and future profitability of American businesses in global markets. Major U.S. corporations are beginning to advocate change publicly. Some go so far as to urge that a prospective national budget be set for health each year, as happens in Canada. The new Canada/U.S. Free Trade Agreement will make plant locations in Canada an even more attractive way for U.S. manufacturers
to lower product costs. Rising costs also lead to cutbacks in employer-provided health insurance coverage and Medicaid eligibility, which creates serious financial burdens for many individuals who are uninsured or underinsured.

As a result of insurance cutbacks, half of the nation’s urban hospitals and two-thirds of its rural hospitals lost money on patient care in 1986. In addition, physicians are experiencing unprecedented intrusions into their clinical practice, as hospitals, insurers, and employers impose more attempts to control costs. Constraints on nurses’ salaries have contributed to the shortage that now threatens the care of hospitalized patients and has led to rapidly rising wages.

Diminishing access and financial protection. More than thirty-five million Americans have no protection from medical expenses—no health insurance or other coverage, either public or private. Their numbers have grown by 25 percent since 1980. Millions more have inadequate coverage and are left vulnerable to large financial risks. Recent surveys have shown that 7.5 percent of Americans—about eighteen million people—reported not receiving needed medical care because of financial reasons. Most surprisingly, only 36 percent of these people were entirely without insurance: two-thirds had some, albeit inadequate, insurance coverage.

Growing disillusionment with “marketplace” approaches. In the 1970s, regulatory efforts sought to control the rise of health expenditures; beginning in 1980, competition and the marketplace dominated. However, market forces have proved even less successful than regulation. For example, contrary to competitive market theory, the increasing supply of physicians in the United States has been associated with an acceleration in fee increases. In 1986, the rise in fees relative to the consumer price index (CPI) was one of the largest on record. In addition, the majority of employers offering health maintenance organizations (HMOs) or other managed care arrangements surveyed by Louis Harris and Associates in 1987 report that participation in managed care has had little effect on slowing the growth in their health care costs and shows dim prospects for doing so in the near future.

Increasing uneasiness is reported about the effects of market forces on the interests of patients. The Wall Street Journal recently examined the consequences and concluded the problems are worsening: “The hottest commodities in the patient-care business these days are patients. Hospitals with empty beds and testing centers with idle equipment are buying. Doctors are selling.” In a follow-up story, the Journal concluded, “The issue of profiting from patient referrals is one of the most important to confront the medical community in years. There is evidence that self-
referral affects the quality and cost of care. But few patients, employers and insurers, who pay the bills, are aware the practice exists. “Physician-investors” can also be an important cause of rising costs. A 1983 survey by Blue Cross and Blue Shield of Michigan found that diagnostic laboratories owned by referring physicians charged almost double the fees of other labs and did nearly twice as many tests on the average patient.

Many also argue that the “market expectation” of close monitoring of providers’ actions by vigilant patients assumes too much about patients’ technical medical knowledge. It puts too much responsibility on patients as managers of their own care, negotiating between specialists and bargaining for medical products and services. So-called consumer sovereignty also must deal with the realities of a professionally controlled and publicly regulated market; yet few propose a genuinely free market with no public or private regulation of who may provide services and how.

Critics of a market-driven system also note that it can deny sick people care when they cannot afford to pay for it. This practice, known as patient dumping, runs counter to the purposes and origins of American hospitals. Yet private insurers cannot cover the poor and ill and remain competitive. The incentives set up by the market are not to insure those most likely to need care and thus protect shareholders from the costs associated with insuring those who are very sick.

Indemnity insurance also creates incentives for employers to hire those who are least likely to run up large medical expenses, particularly younger people. As insurers abandoned “community rating,” employers came to realize that one of the surest ways to slow the growth of health care costs was to employ a younger work force.

A Call For Change

A growing consensus asserts that the current financial framework of the American health care system cannot continue on its current path. In a recent poll, 90 percent of Americans surveyed agreed with the statement that the system requires “fundamental change” or “complete rebuilding.” The majority surveyed chose an alternative financing system—most often, the one in place in Canada. This suggests unprecedented levels of frustration and dissatisfaction, as previous surveys have never found Americans prepared to embrace any other health system.

Influential private groups also have concluded that the American health system is in crisis. For example, in January 1989 the National Leadership Commission on Health Care, an ad hoc group of national leaders and organizations concerned about the health care system, concluded: “What we find is a system under great stress with serious cost, access, and
quality problems which are inextricably intertwined . . . . These critical problems . . . present a clear and compelling case for change.”

Physicians for a National Health Program, a group representing 1,200 doctors across the country, also wrote in January 1989: “Our health care system is failing. Tens of millions of people are uninsured, costs are skyrocketing, and the bureaucracy is expanding. Patchwork reforms succeed only in exchanging old problems for new ones. It is time for basic change in American medicine.”

A number of prominent health care leaders are sounding the same call. The New England Journal of Medicine editor Arnold S. Relman wrote recently, “There is now a growing sense that the time has come for a more basic and systematic realignment of our health system that will not only constrain costs but provide all citizens access to care and ensure the quality and efficacy of services.” Health economist Victor R. Fuchs predicted, “Sometime during the next decade the United States will probably embark on major reform of our pluralistic system of health care finance.”

Alain Enthoven, a health economist and advocate of competitive strategies, concluded, “America’s health care economy is a paradox of excess and deprivation. . . . To an increasing degree, the present financing system is inflationary, unfair, and wasteful. In its place, we need a strategy that addresses the whole system, offers financial protection from health care expenses to all, and promotes the development of economical financing and delivery arrangements.”

**Directions For Change**

A variety of experts, leaders, and surveys of the American public agree substantially on many essential elements of a revised American health financing system. Two major things must be done simultaneously: (1) everyone must be provided financial protection from health care expenditures, and (2) economical financing and delivery arrangements must be developed and put in place. Further, both must be done in a socially acceptable way—that is, compatible with American cultural preferences. The extent of this agreement is often overshadowed by the attention paid to the points over which there is disagreement.

**Providing financial protection to all.** There is considerable agreement that any revised American health system should provide adequate and affordable health coverage for all citizens. Providing adequate coverage will mean offering everyone a minimum standard set of benefits. Providing affordable coverage for everyone will mean subsidizing its cost for some people. There is debate over how subsidized costs should be divided among employees, employers, and taxpayers. There is also debate regard-
ing the conditions of participation among those who receive subsidized insurance: for example, the extent and nature of cost-sharing arrangements and whether participation in managed care programs should be required.

**Developing economical financing and delivery arrangements.** There is general agreement on these points. First, too little is known about the value of many medical technologies and procedures. Far more needs to be done to evaluate the efficacy of medical practices. Second, incentives should be introduced to use medical approaches that produce, at less cost, the same or better health outcomes. There is considerable agreement that very little in the current system promotes cost-conscious use of resources or effective organization of the delivery system. There is debate about how much relative incentives and responsibility to control costs should be put on individuals versus providers.

Third, and perhaps most important, there is a growing consensus on the need for hospitals and physicians to treat patients within the framework of total budgets set in advance. Observers agree that to date the partial implementation of competitive strategies (such as HMOs; independent practice associations, or IPAs; and other managed care plans) has been rendered ineffective by widespread availability of options that have no efficiency incentives. There is basic disagreement regarding whether, in any practical sense, a truly competitive environment can or should be created or, alternatively, whether competition should take place within a framework of total budgets set through a regulatory process.

**Making change culturally acceptable.** Universal health insurance has never attracted overwhelming public support in part because it conjures up features that are objectionable to large numbers of the American public as well as key interest groups. The general public has been suspicious of universal insurance because of an underlying lack of faith in government's ability to run so large a service efficiently and effectively. In addition, universal insurance has been seen to require substantial additional taxes and large-scale redistribution of income. Key interest groups have bristled at the notion for additional reasons. Physicians have seen universal coverage as "socialized medicine." Private insurance companies see it extinguishing large segments of their business. Most provider groups and many health care recipients fear that it would lead to excessive regulatory coercion.

To be politically feasible, a revised American financing system may have to continue private health insurance, still linked to employment; a predominantly payroll tax rather than a general revenue tax-financed system; patient choice of physicians and hospitals and a privately owned hospital system with fee-for-service physician reimbursement. It likely will also include a stronger pro-employment orientation for subsidized
low-income groups. It may just be possible to preserve these features and add affordable insurance for all and strong controls over the rate of growth in future expenditures.

**Why Study Canada?**

These objectives provide compelling reasons for looking to Canada for lessons relevant to developing a revised financial framework for the American health system. The Canadian approach both avoids and deals with several of the more intractable problems facing the United States. The Canadians have substantially lowered health expenditures and have provided universal coverage, while continuing many key features of the American system.

Studying Canada does not imply any simplistic notion of transporting the Canadian system across the border and solving all of America’s problems. Each nation’s health care system is a reflection of its culture; its arrangements are part of the general organization of its society. However, it is possible to learn a great deal from the Canadian experience. The potential is particularly great because of both the similarities and the differences between the two countries. They are similar in the training of physicians and other health professionals, in many aspects of their political and economic institutions, and in their popular culture. Important differences include Canada’s parliamentary system and its smaller and more homogeneous population. The two nations’ health care financing systems were rather similar in 1970 but have diverged widely since then.

Lower costs. Overall health expenditures in Canada have been limited to a stable share of national income. Until 1971, health costs consumed a share of national income virtually identical in both countries and were rising at similar rates. In 1971, health spending was 7.4 percent of national income in Canada and 7.6 percent in the United States. By 1985, Canada was spending 20 percent less per person on health than the United States. By 1987, health costs in the United States had risen to 11.5 percent of national income, whereas in Canada they had stabilized at 8.6 percent. By 1987, if the United States had had Canada’s rates of increase since 1970, health spending would have been $450 less per capita—or at least $100 billion less overall.

Universal insurance. Canada has eliminated the problem of uncompensated care. As a result of universal coverage, 0.6 percent of Canadians report that they could not get medical care for financial reasons, compared to 7.5 percent of Americans surveyed during the same period. The Canadian system does not allow separate financial arrangements between providers and individual patients for services covered by the
public health plans, and physicians cannot bill patients for payments above negotiated fee schedules.

**Features important to Americans.** The Canadian system retains these features valued by American patients: (1) everyone is protected from medical expenses; (2) patients cannot be billed above the negotiated fee schedules by physicians; (3) benefits are comprehensive; (4) patients have free choice of doctors and hospitals; (5) benefits are portable from one locale and employer to another; and (6) the system is stable; patients need not worry about frequent changes or cutbacks in benefits.

In addition, the Canadian system retains important features valued by American physicians: (1) physicians are in private practice; they do not work for the government; (2) they are paid on a fee-for-service basis and negotiate their fee schedules; (3) there is a high level of clinical autonomy (government does not have a mandate to determine the content of medical practice); (4) physicians have hospital-admitting privileges; they are not hospital employees; (5) physicians have free choice of patients; and (6) the professional community negotiates the amount of support for facilities and equipment.

**Growing interest in studying Canada,** Descriptions of the Canadian system and theories as to why it may be better than the American have appeared recently in *The New England Journal of Medicine and Health Affairs.* Physicians for a National Health Program recently called for dismantling the private health insurance system in America and providing universal coverage through a public program similar to Canada’s.

Some opposition has been expressed by organized medicine. James Todd, executive vice-president of the American Medical Association (AMA), commented recently, “The AMA believes that the American public would strenuously object to the ‘price’ Canadians pay for ‘national health care’—imitations, cutbacks, and delays in service and treatments.” Contrary to Todd’s belief, a recent poll shows that 60 percent of Americans would favor a system more like that of Canada. Support for a Canadian-like system cuts across income and skill groups and is highest among middle-income Americans and business and government executives; more than two-thirds of group members polled said they would prefer such a change.

Concern about increasing health costs among business leaders has led business groups across the country to call a number of meetings to examine the Canadian approach. In March 1989, Commonwealth Fund staff participated in such a meeting called by the Ford Motor Company, which included representatives from General Motors, General Electric, Hewlett-Packard, Chrysler, and Xerox. While no specific positions were endorsed, the directions for change we described earlier were presented
and discussed at this meeting by health policy experts.

Probing Canada’s Success: Opportunities For Further Study

Three major reasons have been postulated as to why Canada has lower health costs than the United States. Each merits closer scrutiny to determine whether the facts behind it are correct, how the Canadian system actually works, the consequences and side-effects of its various policies, its potential utility and consequences in a revised American framework, and, conversely, which policies should be avoided.

Reason one: central control over capital expenditures. In Canada, new facilities, equipment, and major renovations require the approval of a government agency, which generally also contributes the major share of financing. This process of centralized approval prohibits hospitals from gaining direct access to private capital markets. Limiting capital suggests investigating: (1) How does the Canadian system of capital financing affect the availability of services? (2) How readily available is modern technology? How rapid and extensive is the rate of diffusion of new medical technologies? (3) How updated, convenient, and functional are the physical plants?

Reason two: less-intensive hospital care. Patients hospitalized in Canada undergo fewer diagnostic and therapeutic procedures per day, requiring fewer nurses, fewer drugs, and less use of complex technology. As a result, Canadian health expenditures per person are 40 percent less than in the United States. Growth in intensity of services is the major reason for the rapid increase in hospital costs in the United States. Less-intensive care suggests the following inquiries: (1) Measure the relative appropriateness of care. As differences in intensity appear to account for the bulk of the difference in hospital spending between the two countries, the ultimate question is: Which country is buying more appropriate care? (2) Measure patient satisfaction. What are the differences in hospitalized patients’ preferences and satisfaction with care between the United States and Canada? How do the different systems respond to patients’ preferences? (3) Examine the general availability of services; investigate claims of long waiting lines or rationing in Canada. (4) Compare the delivery of inpatient care. Does the Canadian system produce hospital services more efficiently? Does the Canadian system make better use of personnel or labor-saving technologies? Are highly trained health professionals used more effectively? Is the physical layout of hospital facilities more labor-saving? (5) Examine the relative prices paid to physicians, to drug companies, and to other suppliers of goods and services. (6) Examine relative administrative costs of hospital care.
Some undetermined portion of the relative increase in service intensity reflects the increasing administrative costs of the American hospital system. (7) Does the Canadian system better enable hospital leaders to retain the responsibility and authority necessary to respond rapidly to opportunities and problems? How does it handle the classic potential regulatory problem of too much centralized control for the efficient operation of individual hospitals?

**Reason three: control over physician fees.** The growth in physician fees in Canada has been substantially less than in the United States. From 1971 to 1985, the share of GNP going to physicians increased 10 percent in Canada, compared to 40 percent in the United States. The rapid growth of physician fees in the United States is now the most pressing part of the cost increase faced by the Medicare program nationwide.

The difference is that in Canada, increases in the general levels of physician fees and the rules of payment are negotiated periodically between medical associations and the provincial governments. Virtually all providers have negotiated contracts setting limits on aggregate billings. Centralized, negotiated fees suggest the following questions: (1) What type and degree of protection from malpractice claims does the Canadian system afford physicians? (2) What is the effect of the Canadian fee structure on practice style, location, specialty choice, office hours, availability of services, and net incomes? (3) How are fees divided among various generalists and specialists versus the relative rates in the United States? (4) Have physician fees been successfully rebundled in the Canadian system? (5) How many practitioners actually reach the quarterly ceilings on gross billings? What do they do with their time once these ceilings are reached?

Unlike their U.S. counterparts, physicians in Canada have to accept the reimbursement fee as full payment. They cannot bill patients for whatever additional monies they think appropriate. Canadians regard their “no extra-billing” rule as an essential element to their guarantee of universal access and complete protection from medical expenses. This suggests the following questions: (1) Does the “no extra-billing” provision provide better access and financial protection to older citizens than the American Medicare system of voluntary compliance with no extra-billing? (2) What is the difference in the effect on total system costs?

**Conclusion**

These questions should be addressed if Americans are to understand how the Canadian system of health financing works, determine its
consequences, and evaluate its potential utility to the United States. The results of this work are eagerly awaited in the United States by physicians, hospital groups, leading private citizens' groups, and the general public. Experienced policy and research specialists stand ready to investigate the issues. As the notes in this essay indicate, leading American experts have already begun to turn their attention to Canada. The answers to the questions raised in this essay could have important bearing on the choice of the road to be traveled by the American health care system.

NOTES

12. Under community rating, employers’ premiums were based on average cost of care in the community rather than on specific costs of their employees.
13. Adults in the United States, Canada, and Great Britain were surveyed simultaneously as to their views on the performance and desirability of their nation’s health care system. See Blendon and Taylor, “Views on Health Care;” and Blendon, “Three Systems.”
22. The exigencies of employment insurance discourage employment among the poor, as many report fear of leaving welfare because of the loss of health insurance coverage.
23. This essay refers to “the Canadian system.” There are literally ten provincial systems, but there is a common pattern, as the form of organization and payment is essentially the same across the provinces.
24. Fuchs, ‘Learning from the Canadian Experience.”
30. Ibid.
31. There are other causes as well. For example, insurance overhead is estimated to account for as much as one-quarter of the difference in insurance costs between Canada and the United States. Canada’s tax-financed, universal system is much less costly to administer, since all of the costs of determining coverage and eligibility are avoided. Virtually all of the analytic work related to this point has been completed.
32. Lower costs are achieved even though Canada has higher rates of hospitalization and longer average lengths-of-stay.
33. Newhouse et al., “Hospital Spending in the United States and Canada.”
34. Ibid.
35. Evans et al., “Controlling Health Expenditures.”