Lessons from Abroad for Health Reform in the U.S.

March 2009

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IPN conducts, commissions and disseminates research, directly and indirectly with partner organizations, in the realms of health, environment, trade and development. IPN hopes that as a result of its programs, individuals will be better able to achieve their aspirations, regardless of race, color, creed, nationality or human condition.

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The Galen Institute, Inc., is a not-for-profit, free-market research organization devoted exclusively to health policy. It was founded in 1995 to promote a more informed public debate over individual freedom, consumer choice, competition, and diversity in the health sector.

The Galen Institute believes that:

- Consumers and their physicians should have authority and responsibility over their own health care decisions.
- A consumer-driven market will lower costs, promote innovation, expand choice, and increase access to better medical care.
- The vibrant free market will encourage research and innovation and provide better access to new medical technologies.
- Updating outmoded tax policy will facilitate greater access to more affordable health insurance.

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Introduction

Philip Stevens and Grace-Marie Turner

At the heart of Barack Obama’s presidential campaign was a promise to transform the health sector in the United States by bringing down costs, improving quality, and broadening coverage so that all Americans, starting with children, will have health insurance. The outlines of the specific policies he has offered to achieve those goals would lead to a fundamental shift in the way that the U.S. health sector is organized.

Many of the proposals that have been offered, both from the White House and in Congress, have a distinctly European flavor. For years, influential pundits and policymakers have said that European health care systems have been able to achieve what America finds so difficult: namely, providing universal coverage with high-quality care delivered at a low cost.

As a result of these perceptions, Mr. Obama and congressional leaders are looking to import many elements of these European health systems to the U.S. Some of the leading ideas include: a legal requirement that all employers provide health insurance to employees (somewhat analogous to the French system of largely employer-provided insurance); a big expansion of health care directly provided by the government (taking the U.S. in the direction of Canada, Italy, and Britain); and measures aimed specifically at keeping costs under control (akin to Britain’s “comparative effectiveness” agency, the National Institute for Health and Clinical Excellence or NICE).

Many of those who are taking the lead in advancing these initiatives have visited with government leaders and policy experts who work within and study these systems on a daily basis.

For this reason, International Policy Network and the Galen Institute are co-sponsoring this conference on Lessons from Abroad for Health Reform in the U.S., to bring some of these voices to America. This short booklet is a summary of the presentations prepared for delivery at the conference in Washington, D.C., on March 9, 2009.

Compulsory insurance: panacea or pain?

The reality of European health care is often far less rosy than is popularly portrayed in the U.S. media. Compulsory, regulated health insurance, for example, has been cited as a method of ensuring equitable access to health care coverage while reining in costs. In reality, containing costs is one area in which such systems have failed spectacularly.

The French system of compulsory, employer-based insurance, for instance, is the third most expensive in the world (behind Switzerland and the U.S.) and runs a regular deficit, despite the fact that French citizens pay an effective 18.8% income tax for their health coverage.

There are significant variations in the quality of care in different regions, and contrary to the notion of solidarity, the rich can pay to jump queues, choose their provider and pay whatever is necessary to obtain their care.

The story is similar in Switzerland, where health care costs and premiums continue to rise, despite the introduction in 1994 of a system of compulsory private health insurance for all residents.

In both France and Switzerland, the mandatory nature of insurance has led to regulations that remove the
freedom of insurers to price risk properly, one of the factors leading to higher premiums. In response, many people have opted for plans that are less expensive and less comprehensive and have higher deductibles. This means that in addition to the high taxes Europeans pay to finance their public insurance systems, they also must pay more out of pocket for their health care.

Growing costs have resulted in all manner of counter-productive and clinically unjustifiable government cost-cutting, such as de-listing of drugs from their reimbursement formularies.

As U.S. officials contemplate expansion of government-run health systems, including Medicare, Medicaid, and the State Children’s Health Insurance Program, they could learn from the pressures facing government-run, taxpayer-funded systems abroad.

Single-payer models are in the minority among countries that are members of the Organization for Economic Co-Operation and Development (OECD), but notable examples include the U.K., Canada, Italy, and Norway. While single-payer systems have proven comparatively more successful at controlling costs, this has come at the expense of high-quality patient care. All of these systems are characterized by waiting lists and other forms of rationing. Uptake of new medical technologies also is low.

Proponents boast of the “equitable access” afforded by such systems, but in reality many patients face long waits for treatment and simply opt out of the public system into the private sector (with the exception of Canada, where such freedom is limited). While public systems are nominally “free” at the point of use, many patients are forced to pay out of pocket for treatment and also for innovative drugs not available on national formularies. In addition, these systems are facing increasing cost pressures as demands for health care increase with aging, more demanding, and better informed populations.

The costs of cost-containing

One contentious part of the recent stimulus bill was the $1.1 billion allocated for the establishment of a federal board to coordinate research into the comparative effectiveness of new treatments, drugs, and medical devices. Some congressional leaders have said they believe such studies will produce savings by ensuring that only the most cost-effective treatments are used.

Such techniques, also known as “health technology assessments,” already are widely used in other countries. The United Kingdom, for example, has relied since 1999 on the guidelines established by NICE, which produces clinical appraisals on the cost-effectiveness of treatments. These are then used by the government to decide which treatments can be procured by the public health system. A similar body exists in Germany, called the Institute for Quality and Efficiency in Health Care. In Canada, all treatments must first gain approval via the public health system’s “Common Drug Review.”

While these assessments may, in some cases, achieve the short-term goal of controlling current expenditures, they also face numerous criticisms. Comparative effectiveness studies may not take into account the different effects of a treatment on different types of patients, may rely too much on the Quality Adjusted Life Year (QALY) as a universal and comprehensive measure of benefit, and may disregard the impact of a treatment on patients with multiple conditions.

Moreover, these assessments may be prone to outside interference when decisions about payment for treatment are made more on political than clinical grounds, as has sometimes occurred in both Germany and Britain. In Britain, the NICE guidelines have in many cases denied patients access to the latest innovative medicines, with uptake of such drugs well below peer European countries that spend equal or smaller amounts of their GDP on health care.

At their roots, many of these European experiments have involved a decisive shift in the balance of power away from patients and their individual needs, as governments put collective needs over those of the individual. Under such circumstances, the erosion of personal choice and competition is inevitable, even though these are the two pillars that drive innovation, efficiency and quality.
unfortunate reality that the collective quality of health care deteriorates when the wishes of individual patients are removed from the equation.

There is another important lesson that is often overlooked. National health systems in Europe have safety valves. People can go to other countries, including the U.S., for care – which would not be a feasible alternative for U.S. citizens should we adopt something like a European system. Also, doctors in European public systems are permitted to practice privately, outside the state system. Our Medicare system essentially prohibits doing this, and this is likely to carry over into a broader reform plan. This would give the public system a monopoly that would not be in the interests of Americans.

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GOVERNMENT INVOLVEMENT IN HEALTH SYSTEMS: AN OVERVIEW
Lessons from Abroad for Health Reform in the U.S.

How mandatory health insurance altered Swiss health care

By Alphonse Crespo, M.D.

For decades, Switzerland’s pluralist health care model managed to combine extremely high standards with very wide coverage. It attracted countless foreign patients and was envied by many. Isadora Duncan, Fyodor Dostoevsky, and Friedrich Nietzsche are amongst the multitude of historical figures who came to Switzerland seeking treatment in the soothing atmosphere of its romantic lake-sides or its fabled Alpine sanatoriums.

These days, famous foreign visitors are more likely to come for the skiing. Houston and Cleveland have taken over as world centers for medical excellence, while Singapore and Bombay offer life-saving alternatives to patients threatened by rationed medical technology or by regulated organ shortages. Some Swiss now travel to the U.S. for second opinions or for complex cancer treatments that cost-obsessed insurers are reluctant to finance.

A turning point in Swiss health care: compulsory insurance

The second half of the 20th Century saw health care costs rise as a result of technical progress, higher life expectancy and multiple other social and evolutionary factors. At the same time, governments in Europe became more involved in the collective provision of health care.

In Switzerland, health care rose from consuming 3.5% of Swiss GDP in 1950 to 8.5% by 1990. Along with many of their European peers, Swiss policymakers came to believe the only way to deliver health care in a cost-efficient way was a greater role for government in redistributing and regulating health care. This culminated in 1994 legislation which made it henceforth mandatory for all residents to purchase health insurance. Physicians accepted this as a necessary evil; some believed that the profession might even gain from it. They did not predict that this measure would spawn a powerful insurance cartel whose power would be used against them and their patients.

These reforms were somewhat analogous to the 1993 Clinton health care plan, or the 2006 Massachusetts health reforms, under which citizens are legally obligated to purchase insurance from one of several competing health insurers. Unlike these systems, in Switzerland sickness insurance is purchased individually, rather than through an employer.

These compulsory insurance premiums cover 35% of Swiss health expenditures. Taxes finance approximately 25%. Supplementary insurance and contributions from private institutions account for 10%. The rest is met by out-of-pocket payments and deductibles that range from $250 to $2,100 per year. Patients pay for 10% of outpatient care. Insurers want parliament to raise this to 20%. Co-payments for branded drugs have already been boosted to 20%, when “equivalent generics” are available, regardless of the wishes of the physician.

Although patients pay the regulated health piper through taxes, premiums, co-payments or deductibles, in reality it is insurers who call the tune.

One unforeseen consequence of the move to compulsory insurance was the emergence of a powerful cartel of health insurers. Prior to the 1994 reforms, decentralized
surgeons from performing more complicated elective surgery. This has led to waiting lists in some disease areas, particularly in university hospitals.

Meanwhile, complications linked to medical errors, hospital infections and premature dismissals at large public hospitals have become a cause of public concern. A 2007 survey revealed rates of “critical incidents” of up to 40% at the university hospitals of Geneva and Lausanne.* Scary newspaper headlines about elementary hospital errors are no longer confined to neighboring France: last Christmas, a 4-year-old girl died of a fever after being incorrectly discharged from Aarau Canton Hospital.

Hitting physicians and their tools†

In 2004, doctors and insurers reached agreement on a time-based fee scale (TARMED), meaning higher pay for so-called “intellectual work.” The “neutrality of costs” clause included in the deal involved a substantial reduction in fees for technical procedures. This has resulted in detailed monitoring of all aspects of medical activity, such as the length of consultations, the daily number of visits or average costs of prescriptions. TARMED has significantly increased doctors’ administrative paperwork, taking time and energy away from patients.

There are 25,000 doctors in Switzerland, 55% of whom practice privately. Based on the questionable assumption that total health costs depend on the number of practicing physicians, the federal government introduced a ban on new private medical offices in 2002. This decree was actively supported by the insurance cartel, even though it circumvents constitutional rights. Predictably, there is now a looming shortage of GPs, forcing the government to exploit loopholes to allow more practices to open. Bizarrely, the federal government intends to extend the ban until 2011.

* Comparis study (www.comparis.ch/comparis/press/studien/kk/Studie_Patientenzufriedenheit_WIF_2007_DE.pdf)
† A.Crespo, The Hazards of Harassing Doctors, 2008 (https://cmpi.org/PDFs/Reports/Hazards.pdf)
Increasing regulation and the attendant bureaucratization of health care is undermining the morale of physicians. Frustrations climaxed in an unprecedented demonstration of 12,000 doctors in Bern in 2006. Further unrest lies ahead. Pascal Couchepin, president of Switzerland, and a known ally of a dominant health insurer, announced that the cartel of insurers would be entitled to slash lab-test reimbursements by approximately 20% in 2009. This controversial move will inevitably lead general practitioners to close their labs, forcing simple diagnostic tasks to be sent elsewhere. This will slow down diagnosis, causing unnecessary delays to sick patients. Geneva GPs have announced strikes in protest, and other Canton medical associations are expected follow.

Conclusion

Increasing regulation in Switzerland has led to arbitrary bans on medical practices, rationing of hospital beds, a weakening of the diagnostic tools available to doctors, and the irresponsible promotion of generics. It has mainly been pushed by the powerful cartel (Santé-Suisse) that emerged from mandatory health insurance legislation of 1994. Setting aside its morally questionable coercive essence, mandatory insurance ultimately damaged the quality of Swiss medical care without reducing costs.

Sadly, the relative decline of Swiss health care is becoming increasingly apparent. Long ranked amongst the top four in world health care, Switzerland sank to 8th position in the 2008 Euro Health Consumer Index,* lagging behind countries such as Holland, Austria and Luxembourg. On the other hand, total health expenditures (11.3% of GDP in 2006) remain well above the OECD average of 8.9%.

Some parliamentarians are beginning to challenge the disproportionate influence of the insurance cartel on health lawmakers. One socialist MP, Jacqueline Fehr, presented a motion designed to bar MPs associated with sickness insurance from key legislative health care commissions. Her proposal is currently under debate at the Swiss federal parliament.

Ms. Fehr faces a tough task. Once cartels have entrenched themselves, there is no easy way to dislodge them. Americans should think twice before opting for compulsory insurance, unless they believe that cartelized and rationed health care is really in the interest of patients.

Dr. Alphonse Crespo, an orthopedic surgeon, is the research director for the Institut Constant de Rebecque.

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Quality improvement and cost containment through managed competition in the Dutch health insurance system

By Wim Groot, Ph.D. and Pieter Vos

In 2006 the Netherlands began a major reform of its system of health insurance in order to better use the principle of competition. Health care costs in the Netherlands had been rising rapidly, absorbing 20% of all economic growth. About one-third of all increases in public spending went to health care. The old system, in which all residents below a certain income had to enroll in one of the government’s 30 “sickness funds,” was proving highly inefficient.

The new insurance law represented a considerable liberalization of the Dutch health care system. It obliges all residents to purchase basic health insurance from one of 41 competing private insurance companies. Insurers are required to accept each applicant at a community-rated premium regardless of pre-existing conditions.

The basic health insurance includes a package of care determined by government, including hospital care, care by general practitioners and medical specialists, prescription drugs, maternity care, obstetrics, technical aids and dental care for children. Insurers are obliged to accept every eligible applicant, regardless of their risk profile. Once a year there is a six-week period in which individuals have the opportunity to switch health insurers.

In order to ensure that insurance providers can continue to operate profitably despite carrying such a wide range of risks, the government has also created a “risk equalization fund” to which premium payers are obliged to contribute. On average, 50% of total health expenditures are financed by income-related contributions. These contributions are paid into the Risk Equalization Fund, out of which insurers receive equalization payments to compensate for high-risk enrollees. About 45% of total expenditures are financed through insurance premiums.

The cost to consumers of this system is moderate: the average insurance premium for an individual is approximately $1,400 per year. These premiums are paid directly to the insurer and are community-rated for all insured. Insurers compete to offer the basic insurance at the lowest possible premium (and the best possible quality). There is a compulsory deductible of $200 per year and the option for a maximum voluntary deductible of $640 (i.e. $840 in total). For care that is not included in the basic package – such as dental care for adults and physiotherapy – there is voluntary supplementary insurance with risk-related premiums. There is a modest rebate on the premium if the insured does not seek any care during the year.

Children are exempted from paying insurance premiums. The government finances medical care for children up to the age of 18 through the Risk Equalization Fund. People with low income are directly compensated for the costs of the nominal insurance premium. This compensation is paid out of general taxation.

Approximately 98% of the population has basic health insurance. Nearly 2% of the population is uninsured, while a similar percentage has insurance but is late with its premiums.

The introduction of the new insurance system has had several notable benefits. Most obviously, it has led to fierce price competition and a large number of consumers switching health insurers. Insurers have created considerable efficiencies in their back office administration.

However, price competition has declined over the years, as the health insurance sector has consolidated through mergers and takeovers. The four major health insurers now cover approximately 80% of the market.
Lessons from Abroad for Health Reform in the U.S.

In 2008 a number of health insurance companies started to work together with local, regional and national patients’ groups to develop patient-centered criteria for contracting care providers. Insurers have become more and more interested in the preferences of patients for the sake of purchasing. After all, it makes good business sense.

This coalition of insurance providers and patients seems to be quite effective. It has provided a counterbalance to the strong health care providers, traditionally the most powerful player in this market. It improves the position of the patient and it entitles the insurer as the formal representative on the demand side. Moreover, it provides a strong incentive for the insurer to concentrate on patient-oriented care and on quality, instead of focusing on the price of their policies.

Insurers also use selective contracting to steer patients. Selective contracting enables insurers to offer quicker access to care in one hospital while at the same time lengthening waiting times at others. Insurers are able to guide patients to their preferred providers.

For about a third of all hospital interventions, prices are freely negotiable. These mainly include elective surgery. Hospitals compete on price and quality of care in contracting insurers for these procedures. Insurers use these cost and quality differences to steer patients. By contracting more with hospitals that offer lower prices and better quality, insurers reduce waiting times at these hospitals. Shorter waiting times are used by insurers to steer patients to these hospitals.

The risk equalization system provides incentives to insurers for cost control. For insurers, the greatest costs are for general practitioners and pharmaceuticals. For hospital costs, there is a risk-sharing mechanism that considerably reduces the financial risks for insurers and consequently the incentives for insurers to force hospitals to reduce costs and increase efficiency.

The risk equalization system – especially the risk sharing of hospital costs – substantially reduces the costs of high-risk customers. It has even become possible to make profits on some chronic patient groups, such as diabetes patients. As a result, some insurers now offer special diabetes insurance policies. By better organizing care for diabetes patients, the insurer’s costs for these patients can be less than the reimbursement for the patients from the risk equalization fund.

Insurers have been most active in reducing costs of generic pharmaceuticals. Most insurers have introduced a so-called preference policy for generics, under which only the cheapest drug within a class of identical generic drugs is reimbursed. This policy has reduced spending on pharmaceuticals by approximately 5% to 10% per year.

The Dutch government has tried to bring greater transparency to the performance of health care providers. Within a few years, providers will be obliged to quantify the quality of the care they provide, in a way that will enable patients to make an informed choice about the different options. Patients will be able to “vote with their feet” to determine which insurance companies offer the best value.

The role of the government in the new system is to encourage competition and create countervailing power on the care contracting, the health insurance and the care provision markets. Transparency and choice in health care depend on the existence of solid, preferably legally based, quality standards. These standards are not yet in place in the Netherlands, but the government is working towards their development. It is likely that an independent executive council will be created to set these standards.

By now, there is overwhelming evidence for a positive relation between quality and efficiency in health care. It is this connection that will eventually force health insurance companies to make purchasing decisions based on quality instead of exclusively on price. Having said that, the reforms are still a work in progress, and there is still a great deal of room for further efficiency gains from health care providers in the Dutch health care system.

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France’s compulsory public health insurance is no model for U.S. health reform

By Valentin Petkantchin, Ph.D.

Government Involvement in Health Systems: An Overview

Americans look with envy at the French health care system, which appears to have married universal access with the highest standards of care. The system – based on compulsory occupation-based insurance – regularly tops global health care ranking indices, most notably that of the World Health Organization. Look a little closer, though, and all is not well. The pillars responsible for its relatively good performance – patients’ choice of care and private sector involvement in its delivery – are increasingly threatened by misplaced public cost-containment and bureaucratization at all levels.

If the U.S. is looking to control health care costs, France is definitely not a model. Health spending is among the highest in the world, whatever the indicator, and, as elsewhere, is continually increasing for various reasons (aging population, more expensive new treatments, inadequate incentives to limit individual consumption because of compulsory health insurance, etc.). The government has also failed to control public health budgets, which have been in the red since 1988.

The government has repeatedly tried to control health expenditures. But successive plans in the 1980s and 1990s for rationalizing public health insurance failed to deliver meaningful cost savings, as did the more recent reforms of 1996 and 2004.

In 1996, the government imposed a “national target for health insurance spending,” which is an attempt to put a cap on health care expenditures over a given period. The target is fixed by Parliament on a yearly basis, and has never been met, except in 1997. The cumulative deficit for 1997 to 2006 reached nearly 49 billion euros (adjusted for inflation).* This was almost twice as much as deficits in the previous decade when such “cost-containment” measures did not exist. In 2007 and 2008 deficits again were high, standing at 4 billion euros and 4.1 billion euros respectively.

More efficient use of resources and incentives to cut costs could be achieved through greater individual responsibility, broader choice and more competition. But French public authorities have opted for the opposite approach and tried to impose cost savings by bureaucratic fiat. Centrally imposed regulations have proliferated in France, resulting in a stultifying bureaucratization of the system, which has had a pernicious impact on patients and health care professionals.

Patients’ choice of care, private office-based physicians and existence of private providers (such as clinics) have been traditionally well developed in France. In 2005, private for-profit care alone represented 21% of all hospital beds, for instance, while in the U.S. the figure stood at 12%.† Such private involvement stimulates competition among providers and is responsible for the relatively high quality of the French system. There are very few waiting lists in France, in strong contrast to monopolistic

* See database Eco-santé France 2009, OECD; calculations by the author.
systems such as those found in the United Kingdom and Canada.

In its pursuit of cost containment, however, the government is undermining these pillars of choice and competition. In so doing, France risks making the same mistakes as other countries that are now saddled with waiting lists and other forms of rationing.

There are many examples of such cost-containing bureaucratic interventions.

For instance, France has recently imposed a new “coordinated care pathway” for patients, similar to the “gate-keeper” system in Canadian and British health care, in which government determines which doctor a patient should see. In the event of non-compliance with the regulation, financial sanctions through lower reimbursements penalize the insured in France. If a patient sees a non-approved physician or specialist, since Jan. 31, 2009, his reimbursement can be cut by up to 61%.*

Little by little, patient choice is dying in France. Patients are powerless to prevent this, as they have to continue paying compulsory public insurance, even if they suffer from the results of the centrally imposed cost-containment measures.

Regulations affect health care providers as well. Currently, private office-based physicians have the freedom to choose the location of their practices. The government, however, is threatening to remove these freedoms, in order to reduce what it judges to be wasteful “over supply.” It has declared that it may impose financial penalties on physicians who decide to practice in places where it judges there are already too many of them. Similar restrictions have already been imposed on private independent nurses. With such penalizing regulation and the retirement of current professionals, real shortages across France are to be expected in the future.

There are other examples. New bureaucratic treatment “guidelines” may easily be used against physicians who do not comply with government health expenditure targets. Rather than focusing on providing the best quality care possible, they will increasingly have to focus their energies on complying with central mandates and requirements.

The operations of clinics and hospitals are also becoming increasingly regulated. Since 2004, financing has been determined by a bureaucratically mandated payment structure (called “case-mix-based financing”) for whole classes of disease and hospital stays, which are treated as if they are homogenous.

But patients and their diseases are rarely homogenous, and each patient will cost differing amounts to treat. Failing to recognize this and creating mandatory tariffs that do not reflect these differences could lead clinics and hospitals to refuse to treat people with these diseases – especially if it costs more to treat them than is recognized by the authorities.

In order to reduce deficits, public authorities are thus more and more engaged in cost-containment programs. Such political efforts will not only end up bureaucratizing and rationing health care – causing waiting lists – but also risk having no significant results in reducing overall health care costs, which should include patients’ costs in terms of waiting and suffering before receiving the adequate care.

When the entire health care system finds itself legally subjected to the overall control of a centralising monopoly, patients are bound to suffer from its pernicious effects without having the least choice in their health coverage or the way they get their health care.

For the U.S., a compulsory insurance system à la française may be tempting, but it is also fraught with risks.

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* Source: French Public Health Insurance / tariffs for GP and specialists under convention with the public health insurer; calculations by the author.
Canada: how dominant public ownership of health care has undermined patient care

By Brian Lee Crowley, Ph.D.

The Canadian health care system, because it is an extreme example of one direction that health care provision can go, offers some clear lessons for other countries planning to increase the role of government in health care.

Canadian Medicare is a tax-financed, pay-as-you-go monopoly. Provincial governments are the monopoly providers of health care. They finance, govern, administer and evaluate the services they themselves provide. They define what constitutes “medically necessary services” and then pay for virtually all of them.

They forbid the provision of private insurance and negotiate payment schedules with the powerful provider groups. They set the budgets for nominally private health care institutions, appoint the majority of their board members, and have the explicit or implicit power to override management decisions.

Those who doubt the claim that government has all-encompassing power over health care should note this incident from several years ago from my home province.

The CEO of the nominally independent local hospital obtained almost all his budget from the provincial government. He had been given strict instructions not to run a deficit, and he got into some difficult labor negotiations. Then the phone rang and it was the premier of the province telling him to settle. The politicisation of health care thus strips responsibility and initiative from managers, because decisions will always be second-guessed by those in political power. It becomes pointless to act in a managerially rational way.

The only way to ease politics out of health care is by introducing competition and consumer choice, which transfers power to those whose decisions produce rewards for producers.

In a competitive environment, consumers are free to “vote with their feet.” They did so in the 1970s, when they abandoned North American cars for Japanese imports that were cheaper and better. Over the years, they have come to prefer calculators to slide rules, and e-mail to “snail mail,” even though in most cases the old dominant industry that was being abandoned was powerful, rich, and well-connected.

But in a regulated monopoly, the relative power of consumers and suppliers is completely reversed.

“We frequently hear in Canada that we have the best health care system in the world. But the citizens of Canada—especially the poor and elderly—disagree.”

Before the advent of competition in the telephone industry, dissatisfied customers faced the massive indifference of a bureaucracy that could take their business for granted. Service was poor-quality and expensive even though politicians, answerable to voters, had theoretical oversight through powerful regulatory agencies.

The administrators of the Canadian health-care system also enjoy this monopolist immunity from dissatisfied customers. The only options for unhappy patients are individual complaints to politicians, letters to the editor, and calls to open-line shows.

The old public-sector monopoly model also confers huge power on ever-bigger hospitals and trade unions who, together, exercise a stranglehold on the production of medical services. Without alternative suppliers of services, provincial governments have little leverage over these giant provider organizations.
Lessons from Abroad for Health Reform in the U.S.

Poor service, lengthening queues, high prices, inadequate technology; what's the alternative?

Unbundling functions

The key is to inject competition into what is essentially a sluggish public-sector monopoly. Saying government should ensure that no one goes without medically necessary services is not the same thing as saying only government should provide those services.

In fact, when government is everything — payer and provider, evaluator and regulator of health care services — service to the public suffers. It is therefore essential to unbundle these functions.

A proper separation of the payment from the service function would allow provincial governments to set strict performance requirements (like appropriate waiting times) and put the actual services up for contract bidding.

Since the province would no longer be evaluating the performance of its own institutions, but the performance of competing contracted providers, the cost of getting rid of poor performers is significantly reduced. Replacing an underperforming contractor is relatively straightforward.

And having many competing suppliers means greater opportunities for managerial innovation and experimentation. Such cost-saving experimentation is impossible when dealing with inflexible and highly unionized public-sector monopoly providers.

To win contracts, bidders would have to meet the performance level for access and results, as well as costs. There would be commercial penalties for non-performance in the contract. As Sweden, among other countries, has shown, this approach can result in significant cost savings and increased efficiencies while improving patient satisfaction.*

Critics would claim that such a system can never work, because patients do not have enough information to make rational decisions for themselves. This argument is increasingly untenable.

Virtually any kind of pharmaceutical product can now be purchased over the Internet from foreign providers who can evade our government’s controls. X-rays can be read just as easily by a radiologist in Boston or Bombay as in Toronto or Truro. Recently, the brain repair team at Dalhousie University, Halifax operated on a patient hundreds of kilometers away in Saint John, New Brunswick, using video and computer operated robotic arms. This increasingly common technology destroys the notion of a closed national health system in which people must take what public authorities decide they should have.

We frequently hear in Canada that we have the best health care system in the world. But the citizens of Canada – especially the poor and elderly – disagree.

A Harvard study several years ago compared the U.N. health care system rankings with the opinions of the population of each country; it found that Canadians’ level of satisfaction with their system was 12th in the industrialized countries, lagging a long list of countries with more formalized multi-tier access and a broader range of services covered by public insurance. Poor and elderly Canadians both ranked their country lower, at 14th.

In sum, much of our debate about how to run our health care system has little to do with the quality of care, and more to do with ideology. We cling to a system that outlaws private spending on publicly insured services, usually on the basis that parallel systems of care rob the public system of resources. By contrast, international rankings show that multiple tiers of access produce high-quality public systems with high levels of patient satisfaction.

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A GLOBAL PERSPECTIVE ON COMPARATIVE EFFECTIVENESS PROGRAMS
The art and science of measuring patient preferences in the world of comparative (and cost) effectiveness

By John F. P. Bridges, Ph.D.

Comparative effectiveness, and soon cost-effectiveness, are now becoming as equally important as safety, efficacy and quality in the evaluation of medicine around the world. With it comes the notion – at the heart of many European health technology assessment systems – that government intervention in the health care system is needed to standardize clinical practice and to improve the quality of health care.

This revolves around a “one-size-fits-all” approach to medicine based on the idea that if we delay using an innovative medicine until we know everything about its benefits and risks (and even broader social implications), then we can make better medical decisions.

Here I am reminded of the economic definition of the long run, “a state far enough in the future that a firm can adjust all its inputs.” This is what is implied in comparative effectiveness – let’s wait until we have more information and then adjust accordingly.

I am likewise reminded of the famous words of John Maynard Keynes, “we are all dead in the long run.” My biggest problem with comparative effectiveness and other health technology assessment systems is that they delay access to life-saving drugs and radically distort the innovation pathway by de facto shortening the lives of patents.

Economics teaches us one further thing about comparative effectiveness: incentives matter. The U.S. foray into comparative effectiveness has been explicitly motivated by the perceived need to reduce health care spending (paradoxically placed in an economic stimulus package that is aimed at increasing spending across the entire economy). But at what wider cost are these savings achieved?

International experience shows that cost savings come from the arbitrary delay of medical innovations and using the threat of further delay to negotiate steep price discounts. There is no evidence that comparative effectiveness actually does find better solutions to health care, and previous government-funded comparative effectiveness studies have been criticized for having little impact on prescription behavior. Again, we won’t really know the true impact until much further down the line.

My major concern is that a benevolent health technology assessment evaluation system, concerned only with identifying the bad apples, looks and acts exactly the same way as a malevolent one that seeks only to contain costs by delaying access. Unfortunately, the incentives for those funding the studies are skewed in favor of delaying access to innovative medicines.

Government plans for comparative effectiveness leave a lot of unanswered questions, even if we assume it will be focused on saving lives and not saving money. How would such a system work? How would it differentiate between good aspects of medicine and bad aspects of medicine? How would it make trade-offs across these risks and benefits? Most importantly, how would it account for variations across patients – both in clinical outcomes and in terms of patient preferences?

The international experience demonstrates that these are all complexities that health technology assessment systems find difficult to address. Rather, health technology assessors have to assume that a medicine works the same for all people and as such can be defined as either universally acceptable or universally unacceptable. To make things worse, it is not like a jury
where a culprit is assumed to be innocent; rather, the absence of evidence proving a drug is beneficial generally means it is unacceptable.

Second, health technology assessment systems internationally reject the need to understand the preferences of patients (generally assuming that they are incompetent, unreliable or otherwise unavailable for comment). Instead, they opt for so-called “societal preferences,” which are abstract and artificial mechanisms that aim to encompass all the benefits and risks of all health care interventions. Most countries that take this path use the quality-adjusted life year (QALY) as their metric, although it is important to note that Germany has rejected the notion of a QALY as being unscientific and against the fundamental principles of the health care system.

If we reject the idea of societal preferences to assess the value of medications, I would like to argue that we must instead engage patients in the art and science of evidence-based medicine from the beginning. Patients need to be involved in the generation of clinical hypotheses, the development of clinical trial protocols, the selection of relevant outcomes measures, the interpretation of results and setting of guidelines. Many might argue that patients lack the skills to do this, but that is only because we have paternalistically excluded them. Nike, Ford, Microsoft, and Coke certainly do not exclude their consumers from decision-making about products.

Nor do these companies form grand councils or appoint a “consumer czar.” They do market research – from the point their products are first conceived to points long after they have been launched. Indeed, every other industry but health care has a major focus on the measurement of the preferences of its consumers.

These methods have been repeatedly shown to have useful and scientifically valid results in health care. Measures like willingness to pay, conjoint analysis, focus groups, patient and citizen juries and many other methods are available, but are unfortunately not common in medicine. This is partly because of market regulation and monopoly structures in medicine, but perhaps a deeper cause is society’s deeply engrained attitudes.

Change will not come until there is a revolution in the evaluation of medicine – one in which the patient becomes the center. A few years ago I argued that to achieve patient-based health technology assessment, we needed to abandon all our evaluation methods used in evidence-based medicine and start again.

As I have traveled the globe advocating this, I have found hundreds of others who feel the same way, and more importantly, in their own ways have started the patient-centered revolution. As I spoke with these people, they too expressed a feeling of isolation. This was one of the main reasons for my starting *The Patient*, the first medical journal in the world to take only the patient’s perspective.

So returning to the problem of comparative effectiveness in the U.S., would it not have been more stimulating to fund a National Institute of Patients’ Needs and Wants, to improve medicine, generate innovation and ensure that the patient is placed at the center of medicine? This must be preferable to a comparative effectiveness witch hunt that attempts to correct past wrongs, motivated by immediate cost savings and paternalism. Maybe we will be able to find some middle ground between these two paths over the course of the next administration – at least I have the audacity to hope.

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Ageing populations, technological innovation and increasingly informed, demanding patients are causing financial meltdown in all health care systems across the world. Insurance schemes, such as Britain’s National Health Service (NHS), that rely on tax as the main source of funding are doomed. The elderly and retired pay little tax yet consume the majority of health care. So the young have to pay for innovative medicines for the old out of their paychecks. This is just not sustainable.

Innovation is everywhere. The human genome project, robotics, nanotechnology, new imaging methods and gene therapy are all leading to new drugs and procedures to improve our quality and length of life. We are converting previous killers such as coronary artery disease, stroke and cancer into chronic, controllable illnesses. Stem cells from different organs will be used to create tissue banks to replace defective body parts.

If patients can gain access to these technologies as they come onto the market, the downstream savings for the NHS would be immense. Less money will be spent on surgical interventions, and patients will spend less time in hospital. In cancer care, my specialty, the next generation of medicines could eliminate the need for time-consuming, expensive and unpleasant radio and chemotherapy.

In a tax-based system that is “free” at the point of use, however, there are limits to the sums the government can spend on these new technologies. In the old days, doctors covertly rationed care by making discretionary decisions on a case-by-case basis. This ad hoc approach is untenable in the era of Google. Recent research shows that over 50% of newly diagnosed cancer patients in British inner city hospitals accessed medical information over the internet.

Denying the existence of new treatments is no longer acceptable in a democracy where patients can access all the information. So, the government now relies on the decisions of the National Institute for Health and Clinical Excellence (NICE) to ration new treatments. All local providers within the NHS are legally obliged to fund treatments recommended by NICE. Conversely, if NICE deems a new treatment to be not cost-effective, then all NHS providers will be prohibited from offering it to patients.

This system has attracted interest from policymakers all over the world, keen to learn how to cut costs – including the United States. And with good reason: it has proved highly effective at keeping expensive new medicines out of the state formulary. Recent research by Sweden’s Karolinska Institute shows that the uptake of a large range of innovative oncology drugs in Britain is far below the majority of peer European countries. The NHS is currently using only about a tenth the amount of drugs marketed in the last two years compared to France.

This inevitably translates into frequently substandard care for patients. The international comparisons are stark: while 60.3% of men and 61.7% of women in Sweden survive a cancer diagnosis, in Britain the figure ranges between 40.2% to 48.1% for men and 48% to 54.1% for women. This is in spite of the government massively increasing health spending since 2000 to bring the U.K. into line with other European countries.

Although NICE publishes no official “cut-offs” for the price of a treatment it will recommend, in practice it
tends not approve drugs that cost more than $43,000. Since its inception, NICE has used this value with no allowance for inflation. A simple inflationary factor would put it at $72,000 today. If medical inflation is added it is nearer $90,000. This level precludes many innovative cancer drugs.

NICE is also hostage to short-term political considerations, despite claims by the government that it is completely independent. Politicians frequently intervene directly in the workings of NICE when they are faced with negative press coverage, often generated by dying NHS patients aggrieved that they cannot get hold of life-extending medicines easily available to private patients in the U.K. or public patients in other European countries.

For years, NICE tried to block the approval of the breast cancer drug Herceptin. Outraged patient groups, including many terminally ill women, took to the streets to demonstrate against the ruling. In 2006, the then-health minister suddenly announced the drug would be available to women with early stages of the disease, even though it had not fully gone through the NICE approval process.

A more recent example was the refusal to allow the use of Sutent for kidney cancer. In January, NICE reversed course because of pressure on politicians from patients and doctors. Twenty-six professors of cancer medicine signed a protest letter to a national newspaper – a unique event. And yet this drug has been available in all Western European countries for nearly two years.

The reality is that these life-and-death decisions are frequently driven by electoral politics rather than clinical need. That is no way to run a modern health system.

To make matters worse, NICE has forced the government into all kinds of ideological contortions as it attempts to preserve the notion of “equity” as enshrined in the NHS. In particular, the government has until recently forbidden NHS patients to purchase non-NICE approved medicines in the private sector, or else sacrifice all NHS care. When the consequences of this abhorrent policy for sick individuals began to play themselves out regularly in the media, the government was forced into an embarrassing U-turn.

While NICE may save the government small amounts of money in the very short term, its stipulations ensure that British patients are kept in a kind of medical time warp. Using old technologies costs the NHS greater amounts of money over time, by increasing the pressure on hospital beds and costly inpatient care. It also results in British patients receiving care that is demonstrably substandard – which hardly fits in with ministers’ claims to be running a “world-class” health service.

The lessons of NICE are clear. The pursuit of social solidarity via state health care provision is incompatible with the demands of today’s increasingly savvy patient. British politicians are somewhat belatedly beginning to recognise this, and are starting to think about how to inject more competition and choice into health care, in an equitable way. Having seen firsthand over many years just how inhumane this system can be, it is remarkable that other countries would even consider emulating it.

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Lessons from Abroad for Health Reform in the U.S.

Comparative effectiveness review and therapeutic substitution in Canada: lessons about centrally planning the allocation of health care resources

By Brett J. Skinner

Canada’s federal government certifies both the safety and effectiveness of all new drugs before they can be legally sold. As a result of the various government approval regimes through which all new drugs must pass, Canadians have very low rates of access to innovative medicines via the public health system, with wide variations amongst different provinces. Canadians spend a higher proportion of their post-tax incomes on prescription drugs than Americans, and the Canadian government spends more on health care as a result of increased but avoidable hospitalization.

Comparative effectiveness review in Canada

Once certified by Health Canada (Canada’s counterpart to the U.S. FDA), new drugs must receive additional approvals from federal, provincial and territorial (FPT) governments before they become eligible for reimbursement under publicly funded drug insurance programs. In 2003, FPT governments created a quasi-governmental process for assessing the comparative effectiveness of new medicines, called the Common Drug Review (CDR). The CDR “uses Clinical and Pharmacoeconomic Drug Reviews to evaluate the comparative benefits and costs of the drugs under consideration and make common formulary listing recommendations” to public drug plans (CADTH, 2008:1). CDR recommendations are non-binding, and FPT governments make separate jurisdictional decisions about final reimbursement. All FPT jurisdictions participate except the province of Quebec.

In practice, FPT governments have not eliminated their own separate reimbursement approval processes, and so the CDR has added another hurdle to patients who need access to new drugs. The CDR also does not publish the details of its methodology for assessing the comparative effectiveness of new drugs. The lack of transparency means there is no way to replicate, verify or challenge CDR decisions, or to raise questions about the assumptions that influence how it measures the value of new medicines.

Under Canada’s comparative effectiveness regime, access to new medicines is very limited. Canadians already wait more than a year on average (380 days) for Health Canada to reach a decision on the safety and effectiveness of new bio-pharmaceuticals. Then on top of this, comparative effectiveness and public reimbursement review adds another year on average (323 days) to the wait for access to new medicines (Skinner, Rovere and Glen, 2007). Only a small percentage of the new drugs previously certified as safe and effective by Health Canada actually end up being recommended for reimbursement by the CDR. As of May 2006, the CDR had recommended for reimbursement only 48% of the new pharmaceuticals and only about 30% of the new biologics that it reviewed during 2004 and 2005 (Skinner, Rovere and Glen, 2007). Even fewer new drugs are finally approved for reimbursement by public drug plans. On average, only 42% of all drugs that Health Canada approved as

"Government interference in drug markets has not delivered the savings on overall drug spending promised by its advocates in Canada."

* The process is not officially part of government and is therefore not accountable to the public. CDR is structured like a non-profit corporation owned by each of the Ministers of Health.
safe and effective in 2004, 2005 and 2006 had actually been reimbursed\(^*\) as of October 2007 (Skinner and Rovere, 2008a).

Importantly, there is also wide variation in the final reimbursement decisions made by the FPT governments (Skinner and Rovere, 2008a; Skinner, Rovere and Glen, 2007). If the FPT reimbursements were actually based on objective scientific considerations of comparative effectiveness, and not on rationing, then there should not be such variation.

It is noteworthy that unlike its public drug plans, Canada’s private-sector drug insurance market does not use centralized comparative effectiveness review, and access to new medicines is much better for privately insured Canadians.\(^†\) All new drugs are usually eligible for private-sector insurance reimbursement in Canada as soon as they are certified by Health Canada (Skinner, Rovere and Glen, 2007). This means that due to the comparative effectiveness review used by governments in Canada, recipients of publicly funded drug plans receive access to less than half as many new drugs as privately insured people, and they must wait up to a year longer to get access to the few new medicines that are finally covered by governments.

**Therapeutic substitution in Canada**

Comparative effectiveness review is based on a flawed assumption that only one drug treatment among all the choices available to treat a particular health condition is adequate or best for all patients, all of the time. Following the faulty premise that “one-size-fits-all,” one provincial government in Canada experimented unsuccessfully with government-imposed Therapeutic Substitution. The policy required patients to switch from their existing prescription to a drug that government authorities deemed equivalent, even though it was composed of an entirely different chemical molecule. A recent study published in the journal *Alimentary Pharmacology and Therapeutics* (Skinner, Gray and Attara, 2009) strongly suggests that while advocates of Therapeutic Substitution argued that the policy would save money, it actually ended up causing increased health care utilization, resulting in significant net avoidable overall health expenditures.

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**Due to the comparative effectiveness review used by governments in Canada, recipients of publicly funded drug plans receive access to less than half as many new drugs as privately insured people, and they must wait up to a year longer to get access to the few new medicines that are finally covered by governments.**
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**Cost burden of prescription drug spending in the United States and Canada**

Government interference in Canadian drug markets is apparent in a variety of policies including: price controls on patented drugs; restrictive public formularies; comparative effectiveness review; therapeutic substitution; and direct provision of drug insurance. Yet, if one examines overall spending on prescription drugs in Canada versus the United States it becomes clear that Canada’s approach to drug policy is not producing lower costs for Canadians. In 2007, per capita spending on prescription drugs was 1.5% of per capita GDP\(^‡\) for Canadians compared to 1.7% for Americans. Per capita prescription drug expenditures were a slightly higher percentage of after-tax income in Canada than in the United States: Canadians spent 2.5% of their personal income after taxes on prescription drugs compared to only 2.3% for Americans (Skinner and Rovere, 2008b).\(^§\)

**Conclusions**

Actual Canadian experience suggests that centralized comparative effectiveness review will likely be abused by

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\(^*\) Many reimbursement approvals by FPT governments are extremely limited in terms of providing full access because they are often restricted to particular circumstances requiring case-by-case approval by government authorities.

\(^†\) In Canada, publicly funded drug programs cover about one-third of the population and account for about 48% of total (public and private) spending on prescription drugs. The rest of the Canadian population obtains drug insurance from the private sector, or pays cash. The eligibility rules for public coverage vary by jurisdiction. Politicians have publicly funded drug insurance plans that are separate from the general public plans, and contain much richer benefits.

\(^‡\) Gross Domestic Product or national income.

\(^§\) The number of prescriptions dispensed per capita in both countries is also roughly equal (13.7 in Canada; 12.6 in the US).
Lessons from Abroad for Health Reform in the U.S.

insurance payers to avoid accountability for rationing decisions that restrict access to new medicines. Experts have observed that the centralization of comparative effectiveness review has facilitated rationing not only in Canada, but also with the Pharmaceutical Benefits Scheme in Australia, the Pharmaceutical Management Agency in New Zealand, and the National Institute for Health and Clinical Excellence in the United Kingdom (Pollard, 2006; Sundakov, 2005).

Government interference in drug markets has not delivered the savings on overall drug spending promised by its advocates in Canada. One-size-fits-all drug policies can also produce significant net additional health care expenditures that could have been avoided, if governments had not interfered in the private decisions made by patients in conjunction with the expert advice of their physicians.

Recommendations

Comparative effectiveness is used to centrally plan the allocation of health care resources. The limitations and failures of central planning are well known in the science of economics (e.g. Hayek, 1945). Alternatively, payers could simply expose health care consumers to price signals through partial percentage insurance reimbursement, deductibles, and premiums linked to pre-determined expenditure limits. This would be expected to produce a more efficient and sustainable allocation of health technologies.

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