

**PROFILES OF SIX HEALTH CARE SYSTEMS: CANADA, AUSTRALIA, THE  
NETHERLANDS, NEW ZEALAND, THE UK, AND THE US**

**30 April 2001**

**by Colleen M. Flood\***

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\* Faculty of Law, University of Toronto, Canada. Email: [colleen.flood@utoronto.ca](mailto:colleen.flood@utoronto.ca) I would like to thank my research assistants Tom Archibald, Andrew Ashenurst and Tracey Epps for their valuable assistance in preparing this paper. I would also like to thank Pauline Allen, Andre den Exter, David Hughes, Jeremiah Hurley, Lynne McKenzie, Mark Stabile and Carolyn Tuohy for their comments. All errors and omissions remain mine.

## **INTRODUCTION**

Canadians are very proud of their health care system ("Medicare") and it is unique amongst developed countries in prohibiting a two-tier system so that those with private resources cannot jump ahead of needier patients queuing in the public system. However, there is great concern about the future sustainability of Medicare. Increasingly the following kinds of questions are being asked:

1. Should Canada allow a greater role for private financing (both private insurance and out-of-pocket payments) in order to reduce the burden on the public sector of growing health care costs?;
2. Should Canada allow for-profit providers to compete with public providers?;
3. Can Medicare be modernized such that it is flexible enough to rapidly respond to changes in technology and demographics and ensures equitable access across the country not only to hospital and physician services but also to drugs, home care, medical equipment, gene therapy, etc?

Canada is not alone in struggling with the complexities of managing and ensuring the sustainability of an equitable health care system. In this paper we take a snapshot look at the health systems in six different countries. We have selected for review the US, the UK, New Zealand, Australia, and the Netherlands in addition to Canada, as being countries of roughly similar wealth who, with the notable exception of the US, attempt to ensure coverage for all their citizens to some range of health care. However, notwithstanding this general commitment to universal access, across these countries there are notably different approaches to the mix of public and private financing. We also have selected these countries as in recent times they have all experimented with different health reform initiatives that may be of relevance in Canada. The profiles have been written with a view to describing how these six different systems function in terms of financing, controlling costs, ensuring access, and paying providers and briefly explaining recent health reform initiatives. The goal is to identify the salient lessons for Canada in terms of its own health reform agenda and where further research and study would prove fruitful for Canadian policymakers.

## COUNTRY PROFILE: US

### FINANCING AND COSTS

The US records the highest private share of total health care spending amongst OECD countries. The average amount of private financing of health care across OECD countries is 25.5% (1998). By comparison in the US private financing accounted for 55.8% of total health care spending in 1999.<sup>1</sup> The US spends more than any country on health care. As the following table indicates the US leads the world in per capita health care spending (calculated on a Purchasing Power Parity (PPP) Basis) in 1998.<sup>2</sup>

COUNTRY	RANK IN OECD	\$ PER CAPITA (PPP)
USA	1	4178
CANADA	5	2312
NETHERLANDS	11	2070
AUSTRALIA	12	2043
UK	18	1461
NEW ZEALAND	20	1424

After 25 years of double-digit annual growth, the rate of growth of health spending did slow during the 1990s.<sup>34</sup> The percentage of GDP devoted to health spending was 13.5% in 1998, roughly the same as the previous decade, but is projected to increase to 16.2% of GDP by 2008.<sup>5</sup> Factors predicted to restrain growth in health care spending are the projected implementation of federal “balanced budget” legislation, the continued impact of managed care, and the effect of projected excess capacity among health providers.<sup>6</sup>

### HEALTH OUTCOMES

Despite its very high levels of spending the US does not perform well with regard to health care outcomes. The World Health Organization (WHO) ranked the US in terms of life expectancy in 1999 17<sup>th</sup> (men) and 18<sup>th</sup> (women) of the 28 OECD countries.<sup>7</sup> In terms of infant mortality, in 1997 the U.S. ranked 22<sup>nd</sup> of 27 OECD countries.<sup>8</sup> There are sharp inequalities in health care outcomes. For example, infant mortality rates are significantly higher among infants of black, Hawaiian, and American-Indian mothers (13.7, 9.0, and 8.7 deaths per 1,000 live births)<sup>9</sup> and life expectancy is 6.9 years shorter for black males than for white males.<sup>10</sup> In 1998, 22.2% of persons living below the poverty threshold reported fair or poor health compared to 5.7% of those with a family income of at least twice the poverty threshold.<sup>11</sup>

### COVERAGE AND ACCESS ISSUES

The overarching philosophy with respect to allocating health care is best described as a minimalist approach. The US is the only developed country to leave a significant proportion of its population (16.3%)<sup>12</sup> without any health insurance. Most people have private insurance through their workplace and uninsured persons are concentrated in the under 65 population and often comprise the working poor.

There are two significant public programs, accounting for 45% of total health care spending, Medicare and Medicaid. Medicare is a federally funded health insurance plan available to persons over 65, the disabled and those suffering from permanent kidney failure.<sup>13</sup> All benefits attract a mix of co-payments, co-insurance, user-charges or deductibles.<sup>14</sup> Medicare does not cover some services at all including prescription drugs, dental care, cosmetic surgery, custodial care in the home or nursing home, routine physical examinations, routine eye care, some vaccinations and some preventive screening tests. Medicaid is a federal/state entitlement

program that pays for medical assistance for some of the poor (the cut-off level being determined on a state by state basis). The number of persons enrolled in Medicaid has risen dramatically due to recent expansions to cover more poor children and pregnant women.<sup>15</sup> The scope of coverage under the Medicaid plan varies considerably from state to state. But each plan *must* offer certain *basic* services to most categorically needy populations<sup>16</sup> and certain recipients (e.g. pregnant women, children under 18) *must* be excluded from having to pay user charges and all are exempt from co-payments for emergency services and family planning services.

The US, unlike Canada, New Zealand and the UK, does not seem to have the same problems with people queuing for care.<sup>17</sup> However, of course waiting time measures primarily only pick up waiting times on the part of those who have insurance coverage and not the 16.3% who have no coverage at all. Do those US citizens who have insurance receive any more care given their higher rates of spending? A study published in 1996 of physicians services for the elderly in the US and Canada found that Canadians receive more basic care but 25% fewer surgical procedures such as cataract extractions and knee replacements.<sup>18</sup> A study published in 1998, comparing back and neck hospitalizations in the province of Ontario and Washington State, found that surgical back and neck hospitalizations were three times as common in Washington. However, medical hospitalizations were twice as common in Ontario and people in Ontario were hospitalized longer for both surgical and non-surgical hospitalizations.<sup>19</sup> Thus the evidence tends to suggest that Americans receive higher volumes of surgical and intensive kinds of care but that Canadians receive higher volumes of primary and preventive care.

## **SUPPLY**

### **Hospitals**

About 15% of community hospitals are for-profit, 60% not for-profit, and about 25% are state-local government hospitals. Given how high health care spending is the US it may be surprising for some to find that the US records a very low number of hospital beds (3.7 in-patient hospital beds per 1000 people compared to an OECD average of 7.4 beds per 1000 people.) The OECD also records that in 1999 the US had an average number of 0.9 in-patient bed days per capita which is around the OECD average but significantly lower than the Netherlands (3.6), Australia (2.4), and the UK (1.5).<sup>20</sup>

Increasingly both public and private insurers are shifting from paying hospitals on a retrospective basis to paying them on a prospective basis. Since 1983, the Medicare scheme has paid hospitals on a "Prospective Payment System" for in-patient hospital services and hospitals are now paid according to a schedule of rates based on the average costs of producing services nation-wide for product lines defined by five hundred Diagnosis Related Groups ("DRGs"). Thus hospitals are not paid for the charges or costs actually incurred in a particular case. This was intended to provide an incentive for hospitals to operate more efficiently, as they are able to keep as profit any difference between their actual costs and the DRG payment. Some states also used this method to fund hospitals delivering Medicaid services.

### **Providers**

What distinguishes the US from the rest of the world is the high ratio of specialists to general or family practitioners. In 1997 there were 51.2 family doctors for every specialist,<sup>21</sup> just over half the OECD average of 101.7, and well below the figure of 103.6 family doctors for every specialist recorded in Canada. Most U.S. physicians are still paid on a fee-for-service basis. However, since the managed care revolution (discussed further below) other payment methods like capitation (a flat fee per patient to cover a broad range of health care needs for a year or some other time period) have become more popular. Despite these recent changes, on average US physicians are still paid at a much higher rate than physicians in other OECD countries. In 1996,

US physicians earned over three times as much as the average of the 10 OECD countries (Canada was not among them) for which income data were available.<sup>22</sup> In recent years, American nurses have seen their rate of pay decline and this trend is more pronounced in states where managed care is prevalent.<sup>23</sup>

## **HEALTH REFORM**

### **Managed Care**

In response to spiraling costs and the threat of the 1993 Clinton reform proposals, a “managed care revolution” has occurred in the private sector.<sup>24</sup> In 1988, only 29% of full-time employees were enrolled in managed care organizations (MCOs) but by 1997 this has increased to 85%.<sup>25</sup> Managed care has also spread to the public sector and in 1999 55.59% of all Medicaid recipients were enrolled in a MCO.<sup>26</sup> There are a variety of MCOs but all subject the delivery of health “to some kind of intense utilization review that is more or less contemporaneous with the provision of the service.”<sup>27</sup> It is generally accepted that managed care has worked to curb the rate of growth in health care spending in the US. However, there has been acute public concern about limitations on access to care and the quality of care supplied by managed care plans. Consequently there has been a flurry of federal and state legislation aimed at protecting those who have private insurance from limitations on access to and diminishment in quality of health care. There are a variety of different managed care initiatives occurring in the US. Canada can use the US as a laboratory of initiatives, analyzing experiments with integrated network providers (particularly the traditional group or staff-model health maintenance organizations) capitation, utilization reviews, selective contracting, etc and adopt those successful initiatives that accord with Canadian values of equity and universal access.

### **Lessons for Canada?**

1. Increased private financing does not equate with reduced health care spending.
2. Increased health care spending does not necessarily equate with better health care outcomes or necessarily a higher volume of services (Canadian seem to receive more every-day or basic health care services whilst Americans may receive more invasive, expensive surgical services). Increased health care spending does seem to be associated with higher prices for physician and hospital services.
3. The managed care revolution in the US has caused concerns about access and quality; however, some of these experiences are worthy of consideration if Canada can adopt these initiatives in a manner that is consistent with its values of equity and universal access.

## **COUNTRY PROFILE: CANADA**

### **FINANCING AND COSTS**

In 1998 Canada ranked fifth in the OECD in total health care spending per capita (calculated on a PPP basis<sup>28</sup>), at \$2,312, well ahead of the 1998 OECD average of \$1,795<sup>29</sup> and higher than the Netherlands, Australia, the UK and New Zealand but behind the US (see the table under "Costs" in the US profile). Looking at the last decade, since 1990 growth in per capita spending has leveled off once adjusted for inflation.<sup>30</sup> However, recent announcements of funding injections by the Federal government may lift the rate of growth in health spending.<sup>31</sup>

The private share of total health care spending in Canada has been steadily increasing over time and is now around 30%<sup>32</sup> and the public share of health care spending in Canada is under 70%. The importance of private financing varies depending on the particular health service or good under discussion with, for example, private financing of drugs accounting for 64.8% of the total spent thereon.<sup>33</sup> Compared to other OECD countries, there has been a sharp decline in Canada's public share of total health spending and real per capita public spending began to decline in 1993 and continued to decline until 1997.<sup>34</sup> In 1990 Canadian public health expenditures per capita were 34% above the OECD mean; in 1997 Canada's public expenditures exceeded the OECD mean by 20%. This degree of fiscal constraint came as a dramatic shock to a system accustomed to generous levels of public spending on health care.

Constitutional responsibility for funding and regulating health care lies with the Canadian provinces. The Federal government assists provinces with health care funding through a combination of cash and tax points under the Canada Health and Social Transfer. As the federal government has sought to restrict growth in its spending on health services, its cash contribution has dropped significantly.<sup>35</sup> There has been a concern that as a result the federal government would have correspondingly less power to enforce the Canada Health Act (CHA) vis-à-vis those provinces that allow user charges or extra-billing. However, with recent announcements of new Federal funding commitments the hope is that these concerns have dissipated.

### **HEALTH OUTCOMES**

Canadians record comparatively good health outcomes and rank high in measures such as life expectancy, infant mortality and percentage of low birth weight babies. For example, in 1997 the Canadian infant mortality rate of 5.5 per 1,000 total births in Canada was significantly better than the OECD average of 7.3 (the average falls to 5.8 if Turkey is excluded), and that of the US at 7.2.<sup>36</sup> However, looking at average figures alone can hide large disparities within a country. Of great concern is the relatively poor health status of aboriginal populations.<sup>37</sup> Inequities in health outcomes and high rates of private financing for drugs, home care and other services may explain why the WHO in its 2000 Report ranked Canada a distant 35<sup>th</sup> in "overall health system performance" and 30<sup>th</sup> in "level of health".<sup>38</sup>

### **COVERAGE AND ACCESS ISSUES**

In terms of philosophical approaches to health care, the guiding principle is that health care should be allocated on the basis of need and not ability to pay. However, the Canadian system, through the CHA, primarily protects and ensures public funding for hospital and physician services. There is significantly more private financing for prescription drugs (64.8% privately financed), home care etc. In particular, with respect to prescription drugs, only 45% of Canadians are publicly insured for drugs, (well below the OECD average for 12 countries of 89.7%<sup>39</sup>) and 12% of the population are without any kind of coverage for drugs administered outside of hospital.<sup>40</sup> The difficulty is that with changing technology and the shift of care out of institutions drug therapies and home care play a much more important role in the health care system than

when the fundamentals of the system were set down in the 1960s. This has contributed to a process of “passive privatization” as care is shifted from sites where it is 100% publicly funded to sites where there is much more of a mixture of private and public funding.

The translation of the CHA prohibitions on user charges and extra-billing into provincial plans has varied from province to province, but the effect has been to foreclose private insurance firms from covering the vast bulk of physician and hospital services.<sup>41</sup> Nonetheless 22 million Canadians, or approximately 72% of the population, has some form of private health insurance coverage (either purchased directly from a private insurer or as part of an employee benefit plan). This insurance covers costs for things like prescription drugs, home care, etc<sup>42</sup> that are only partly subsidized or not subsidized at all by the public sector.

An access issue that has received considerable public attention is growing waiting lists and times for non-emergency services. However, compared to other countries with universal publicly funded systems, Canada has a significantly smaller proportion of its population on waiting lists; 0.7% compared to Australia (0.8%), New Zealand (1.65%) and the U.K. (2.26%) but higher than the 0.51% recorded in the Netherlands.<sup>43</sup>

## **SUPPLY**

The Canadian system is often generically described as publicly funded yet privately delivered. There is nothing within the CHA preventing the supply of health services by private firms, even if they are for-profit organizations.

### **Hospitals**

Canadian hospitals are primarily non-profit private institutions (despite being generally described as “public”) that are dependent on public funding and are heavily regulated.<sup>44</sup> Until recently, provincial ministries of health paid hospitals by way of annual global budgets. With the process of devolution, which has occurred in every province except Ontario, regional health authorities now often control most or all of hospital budgets and negotiate block or global budgets with hospitals.

### **Providers**

As of 1998, Canada had 2.1 physicians per 1,000 people, slightly below the OECD average of 2.7. Although publicly funded, most Canadian physicians are generally private for-profit independent contractors. They contract with provincial governments through their provincial medical associations to supply publicly funded health services to Canadians.<sup>45</sup> Generally, medical associations negotiate overall increases to the total amount of government funding for physician services and the medical associations determine how to allocate this increase between different physician services.

Like many countries, Canada relies upon family doctors to act as gatekeepers or filters to the rest of the health care system – patients must see a family doctor before they can get referred to a specialist, be admitted to hospital (except for an emergency), get a prescription, etc. Most physicians are paid on a fee-for-service basis, although concerns about the efficiency of this payment method have prompted many calls for reform. Since 1990, all provincial governments have sought to cap individual physicians' billings, clawing back amounts paid over an annual billing limit.<sup>46</sup> There also have been trial experiments with paying physicians on a capitation basis (a lump sum per annum per individual enrolled with the physician irrespective of how many times the individual visits the physician), a salary basis, or some combination of these.<sup>47</sup>

Nurses are generally employees of public hospitals and are paid by way of a salary. Provincial governments have been successful in controlling growth in hospital spending; however, this success has adversely affected nurses as many nursing positions have been lost or reduced to part-time.<sup>48</sup> Many argue that this trend to reduce the number of nurses has reduced the quality of care received in hospitals and imposed burdens on family members who may feel required to provide nursing care to family members themselves or retain private nurses to do so - even in the hospital setting. Still, while the ratio of nurses to population has declined from 11.1 in 1990 to 7.5 in 1998, Canada is still ahead of the OECD average of 6.85 per 1000 people in this category.<sup>49</sup>

Canadians are concerned about physician and nurse shortages. In 1999, 584 physicians left Canada and 343 physicians returned. The Canadian Nurses Association predicts there will be a shortage of 59,000 to 113,000 nurses by 2011.<sup>50</sup> However, health policy scholars tend to characterize these problems not as a shortage of health care providers but rather problems of maldistribution both in terms of utilization of skill and geography. Canada's geography means that it is often costly to ensure access to even basic health care services in remote locations. Part of the difficulty lies in attracting and keeping physicians in remote areas when physicians are still able to make reasonable incomes in urban areas (because of the fee-for-service payment system).<sup>51</sup> Another factor is the lure of higher salaries in the US.

### **HEALTH REFORM**

On a province-by-province basis Canada has experimented with a number of initiatives like devolution and shifting to home care. Devolution of responsibilities from central health ministries to regional authorities for planning, priority setting, allocating funds and managing health care services has occurred in every province except Ontario. Even in Ontario, there has been devolution of funding for home care services to "Community Care Access Centres." In no province, however, has responsibility for funding physician services been devolved to regional authorities, thus significantly hampering the capacity of regional authorities to make cost-effective resource allocation decisions. The benefit of devolution is often said to be that decision-making is shifted closer to those most affected by the decisions and thus the process becomes more reflective of local needs but it is not clear that devolving authority to smaller agencies will alone improve responsiveness and accountability.<sup>52</sup> What is required is attention to the incentives that regional health authorities have to make good decisions.

Since 1990, provincial governments have sought to shift the site of care from hospitals and institutions and into the community and home care sectors. As a result, the proportion of total health spending on hospitals has declined in the last 20 years from 42.5% in 1979 to (an estimated) 31.6% in 1999.<sup>53</sup> As well, the ratio of inpatient care beds to population (beds per 1,000 people) declined from 6.2 in 1990 to 4.7 in 1997, much lower than the 1997 OECD average of 7.4 beds per 1000 people.<sup>54</sup> Spending on home care has increased considerably<sup>55</sup> but as home care is not protected by the CHA (even when a direct substitution for hospital care) public funding of home care varies significantly from province to province as does the extent to which quality is regulated.<sup>56</sup> There have been calls to establish a national home care program but as yet no national plan has been implemented.<sup>57</sup> Many home care services are now delivered in the home by a mix of for-profit and non-profit firms competing for contracts with both public and private insurers. The Ontario government has moved to a system of competitive contracting out for home care services and concerns have been raised about whether this initiative will result in a drop in quality and an increase in costs.<sup>58</sup> In analyzing these reforms there is much to be learnt from the experiences with contracting out implemented as part of internal market reform in both the UK and New Zealand and this is discussed further in the Management section of this report.

## **COUNTRY PROFILE: AUSTRALIA**

### **FINANCING AND COSTS**

Relative to the economy, Australia's expenditures on health have remained stable throughout the 1990s, rising from 8.2% of total GDP in 1990 to 8.5 per cent in 1998.<sup>59</sup> The average annual growth rate in total health services expenditures (using constant price estimating method) between 1960-61 and 1997-98 was 5%.<sup>60</sup> In recent years the growth rate seems to have increased slightly from 3.7% in 1992-93 to 4.9% in 1997-98, although still below growth rates in the 1970s and 1980s.

As in Canada approximately 70% of health care spending comes from the public sector and 30% from the private sector. However, the Australian Commonwealth government funds a far greater proportion of health care than the Canadian Federal government. In 1997-98, the Commonwealth government directly funded 45.2% of total health care spending<sup>61</sup> whereas the Canadian Federal government only directly funded 3.8%.<sup>62</sup> Unlike Canada's Federal government, the Commonwealth government takes direct responsibility for certain sectors. It is the primary public insurer of prescription drugs and physician services. It also funds approximately 50% of spending on public hospitals.<sup>63</sup> This funding takes the form of annual block grants, the amounts being negotiated in five-year agreements between the Commonwealth government and the various states, and the states agree not to allow user charges for public hospital services.<sup>64</sup> The main role of state governments is to fund the capital and operating costs of hospitals: approximately 69% of state outlays are used for that purpose.<sup>65</sup>

Of particular interest in the Canadian context given some recent calls for the Federal government to manage a national pharmaceutical plan<sup>66</sup> is that the Commonwealth government operates a national Pharmaceutical Benefits Scheme (PBS). One of the impediments to putting in place a national prescription drug plan in Canada is a concern about the potential for skyrocketing costs. Lessons could be taken from Australia in this regard where the Commonwealth government considers itself to have a good record in containing the prices of drugs.<sup>67</sup> The PBS will not subsidize a drug under the scheme unless it receives a positive assessment with respect to safety, quality, effectiveness and cost-effectiveness criteria.<sup>68</sup> The PBS subsidizes approximately 75% of all prescriptions in Australia, and the average subsidy is 57% of the prescription cost.<sup>69</sup> Thus there is still significant cost sharing but this is in the context of a coherent national system that ensures access for those to whom cost would be a barrier.

### **HEALTH OUTCOMES**

Australia performs very well on what aggregate measures there are of health outcomes with an infant mortality rate and life expectancy rates similar to that recorded in Canada.<sup>70</sup> As in Canada, although Australia's population on *average* enjoys relatively good health, certain segments of the population such as Aboriginal people and the disadvantaged do not. For example, infant mortality rates among Aboriginal children are 3.1 to 3.5 times higher than for the rest of the population.<sup>71</sup> There is a 3.6-year difference between the life expectancy of a male in the lowest socioeconomic group and a male in the top group and a 1.9-year difference for females.<sup>72</sup>

### **COVERAGE AND ACCESS ISSUES**

The guiding philosophical principle is that health care should be allocated on the basis of need and not ability to pay. However, as in Canada there are limitations on the extent to which this principle is applied. In particular, the Australian system is guided by a commitment to encourage funding of the system from private sources.<sup>73</sup> In order to reconcile this aspiration together with a commitment to ensuring access for those who need it, Australia has a complicated system of

safety-nets and exceptions to its requirements for out-of-pocket payments (user charges) and there are also many direct and indirect public subsidies of the private insurance sector.

General patients must pay out-of-pocket any fee charged by a doctor (outside of a hospital) above and beyond 85% of the fee prescribed in the Commonwealth government's Medicare Benefits Schedule ("MBS") of fees.<sup>74</sup> Australian physicians may extra-bill;<sup>75</sup> however, the fact that private insurers are prohibited from providing coverage for additional charges beyond the 85% subsidy is viewed as a mechanism to restrain unnecessary fee increases.<sup>76</sup> In any event, once a general patient pays more than A\$276 in physician fees in a year, they are exempt from further charges.<sup>77</sup> Moreover, the "bulk-billing" scheme instituted by the Commonwealth government (discussed below under Physicians) means there are relatively few physicians who bill patients more than 85% of the MBS schedule.<sup>78</sup> Concessional patients (people who receive certain pensions, benefits or cards administered by the Departments of Family and Children's Services or Veterans' Affairs, or who meet certain criteria for being declared to be disadvantaged) are not required to pay any user fees at all. With respect to pharmaceuticals, general patients are required to pay up to A\$20.60 per prescription item up to a total of A\$612 per year after which they are required to only pay A\$3.30 per prescription item. Concessional patients are only required to pay A\$3.20 per prescription item up to an annual cap of A\$166.40, beyond which prescriptions are free. Care in public hospitals is free. However, if an individual chooses to be a private patient in a public hospital (thus allowing the patient to choose their own doctor) or goes to a private hospital, the Commonwealth government pays only 75% of the fee prescribed in the MBS towards the physician's fees. All other costs (including facility fees, etc) are the responsibility of the patient (and, if applicable, his/her private insurer). For community care, clients pay different fees for services depending on the type of service and the client's capacity to pay.<sup>79</sup>

Australians buy private insurance so that they can choose their own doctor in public hospitals,<sup>80</sup> avoid waiting for elective surgery in public hospitals, and cover the cost of ancillary goods and services such as dental care. By the end of March 2000, 32.7% of Australians had private insurance.<sup>81</sup> Private insurers must "community-rate" their premiums and are not allowed to charge higher rates to high-risk individuals (the elderly, the chronically ill, etc.)

In terms of timeliness of care, there are concerns with regard to waiting times for specialists and surgery in the public sector. The Australians have a two-tier system as those with private insurance or with sufficient resources can buy care in private hospitals rather than queuing in the public sector. Tuohy, Flood and Stabile calculate that in 1997, 0.8 per cent of the Australian population was on a waiting list which is not as low as the figures of 0.51% and 0.62% recorded, respectively, in the Netherlands and Canada. It is, however, significantly better than the 2.48% and the 2.56% recorded, respectively, in New Zealand and England.<sup>82</sup>

## **SUPPLY**

### **Hospitals**

In 1997, 61% of hospitals were publicly owned and accounted for 71% of hospital beds and 74% of bed-days.<sup>83</sup> Public hospitals are usually larger and treat more complex cases than private hospitals. As in Canada, Australia is slowly shifting away from institutional care. Public spending in the hospital sector grew by only 3.1% between 1976 and 1998. By comparison spending on private hospital services, medical services and pharmaceuticals increased, respectively, by 6.8%, 4.3% and 4.3%.<sup>84</sup> Still, Australians are among the highest hospital users in the world, averaging 2.4 in-patient bed-days per capita in 1997, in comparison with 0.9 in the United States, 1.6 in the United Kingdom and 0.9 in New Zealand.<sup>85</sup> How states reimburse public hospitals varies from state-to-state, but it is a mixture of global budgets and "casemix" or "DRGs" (Diagnostic Related Groups) where hospitals receive a fee for treatment of a particular

episode of care. Where implemented, the casemix system has led to a drop in the average length of stay in hospitals.<sup>86</sup>

### **Providers**

Australia had 2.5 physicians per 1000 people in 1997, a figure similar to Canada and the United States.<sup>87</sup> As in Canada, Australia's physicians are private entrepreneurs and paid on a fee-for-service basis. The price for a service (and whether or not Medicare covers it) is set out by the MBS. The Medical Services Advisory Committee determines whether or not a new procedure should be added to the list of publicly funded physician services on the basis of, "safety, cost-effectiveness and benefit to patients."<sup>88</sup>

Australian physicians are able to extra-bill; however, technically patients must pay out-of-pocket for physicians' services and then claim reimbursement from Medicare or alternatively obtain from Medicare a cheque made out to the physician. This provides a strong incentive for both physicians and patients to voluntarily participate in what is known as the "bulk-billing" scheme. In this scheme government pays physicians directly for all services up to 85% of the tariffs set in the MBS but physicians agree not to extra-bill (i.e. charge patients any additional fees.) Patients are attracted to physicians who have entered into the bulk-billing scheme as they avoid paying user charges and physicians like bulk billing as the government is a reliable source of funding and having one payer avoids administrative costs. Bulk billing is used for approximately 70% of services for which Medicare benefits are paid.<sup>89</sup>

Australian nurses have pressured governments in an attempt to gain new prerogatives, such as the ability to refer patients to specialists, prescribe certain medications and perform diagnostic procedures.<sup>90</sup> As in Canada, Australia faces the challenge of providing care in remote areas. The provision for nurse practitioners is seen as particularly necessary in rural areas where doctors are not always available to treat patients and nurses have had to act beyond their normal range of responsibilities in order to treat patients properly.<sup>91</sup> As in Canada, Australia faces a shortage of nurses.<sup>92</sup>

### **HEALTH REFORM**

Australia's health care system has been described as unstable:<sup>93</sup> oscillating "backward and forward between systems of public and private insurance and between systems of free, fee-based and means-tested hospital care."<sup>94</sup> While the system continues to be universal, the Commonwealth government is trying to encourage more individuals to purchase private insurance. To date, the Australian system prevents those who purchase private insurance from opting out of the public system (because those with private insurance still have to support the public system through taxes), but there are concerns this may change.<sup>95</sup>

There has been some movement towards contracting out and there are provisions for provider and service agreements in both the public and private sectors.<sup>96</sup> Shifting from paying public hospitals on a global budget basis to a casemix basis is another example of a move that signals a possibly increased role for contracting out. Once state governments can compare the cost of a service in one hospital with the same service performed in another hospital, they may begin to contract with the lowest cost facility (which may include private hospitals). The rise of provider agreements between hospitals and private insurers, and service agreements between states and public hospitals may result in public hospitals becoming more entrepreneurial as they are forced to compete for contracts from the state and private insurers. Another "new" funding method has been to allow Commonwealth health funding to "follow the patient", so that practitioners have some flexibility in where they treat the patient (at home or in the hospital).<sup>97</sup>

**LESSONS FOR CANADA**

1. Australia has similar health care outcomes, similar geography, etc. yet manages to spend less on health care than Canada does.
2. Australia has a national drug plan, managed and funded by the Commonwealth government, that whilst still providing for a significant amount of cost-sharing is a coherent national system that ensures access for those to whom cost would be a barrier.
3. Australia unlike Canada does not outright prohibit extra-billing for physician services but in response to financial incentives contained in contracts most physicians give up the right to extra-bill in exchange for a single pipe of public funding.

## **COUNTRY PROFILE: THE NETHERLANDS**

### **FINANCING AND COSTS**

The percentage of GDP expended on health care in the Netherlands has remained stable throughout the 1990s, increasing slightly from 8.4% of GDP in 1990 to 8.6% of GDP in 1998.<sup>98</sup> However, total spending on health care per capita increased each year from 1990-1997; in constant \$1995 there was close to a 20% increase in per capita spending,<sup>99</sup> which tends to suggest that growth in the Dutch economy has been able to keep pace with growth in health care spending. The OECD records the percentage of public spending of total health care spending at 70.4% for 1998.<sup>100</sup> This figure suggests that the Dutch system is a “single-payer” system similar to Canada, Australia, the United Kingdom and New Zealand. However, this figure misrepresents the Dutch government’s role for the figure includes within it the mandatory Sickness Fund Scheme, which is financed by employer and employee contributions and not through general taxation revenues. The government has only a very minor role in directly financing the system – directly funding less than 5% of total health care spending.<sup>101</sup> Indirectly the government does have a significant role in the system by requiring certain groups to buy insurance and by regulating insurers.

### **HEALTH OUTCOMES**

In terms of health outcomes, the Dutch fare relatively well, above the OECD average for infant mortality and life expectancy and just slightly below Canada on most indicators.<sup>102</sup> Notwithstanding a good performance with respect to health indicators, there do appear to be some inequalities in health outcomes particularly for more recent immigrant groups like the Surinamese, Antilleans, Turks and Moroccans.<sup>103</sup>

### **COVERAGE AND ACCESS ISSUES**

The philosophical approach of the Dutch system is best described as “solidarity” and there is a strong commitment to ensuring access to health care on the basis of need and not ability to pay. However, the Dutch are much more open to using regulation of private insurance to ensure the goal of solidarity and whilst committed to progressive funding are not committed to public funding for its own sake. Despite the absence of universal insurance covering all citizens for basic hospital and physician services (as in Canada), nearly 100% of the population of the Netherlands has health insurance. Not only is health insurance coverage practically universal, it is also relatively free of user charges; only 7% of total health financing is attributable to out-of-pocket payments.<sup>104</sup>

There are three important government-mandated insurance schemes:

1. the "Exceptional" or "Catastrophic" medical expenses scheme, which covers the entire population for long-term care and mental health care. The premium is set as a percentage of employees’ wages and is paid by the employer.<sup>105</sup> Patients may be required to make co-payments for certain services such as psychotherapy, nursing home care and home care.<sup>106</sup>
2. the Sickness Fund scheme, covering hospital and physician services, drugs, and home care.<sup>107</sup> The scheme ensures coverage for about 64% of the population by mandating that all those earning less than 64,600 Guilders in 1999 have an insurance policy with a Sickness Fund. There are 25 non-profit, regionally based, Sickness Funds. Employers and employees share the cost of this plan and the maximum premium levels are fixed by regulation. Since 1991 patients incur user charges if the drugs they purchase cost more than a reference price set by government regulation (which will cover the cost of the cheapest drug that is clinically effective). In 1997, a system of user charges was introduced but the annual amount of user

charges payable is capped at the low figure of 200 Dutch guilders per annum (100 Dutch guilders for the elderly) and there are exceptions for the chronically ill.<sup>108</sup>

3. the Civil servant scheme which is mandatory for all civil servants (approximately 6% of the population).<sup>109</sup> This scheme is administered by twelve special private insurance arrangements, which covers all medicines and related products and hospital treatment and pays 80 to 90% of other health care costs.<sup>110</sup>

Approximately 30% of the population (being those on the highest incomes) are free to purchase their own private insurance plan for hospital and physicians services and nearly all choose to do so. The main advantage of private insurance is that individuals have somewhat more choice about their premium and deductible levels but the benefit package is similar to that offered by Sickness Funds.<sup>111</sup> Rather than implementing a mandatory universal scheme (as Canada has) for hospital and physician services the Dutch have chosen to deal with the problem of ensuring access by tightly regulating the private insurance market. Thus there is legislation requiring insurers to offer high-risk groups coverage and stipulating a maximum premium.<sup>112</sup> The government also operates a system that spreads the cost of subsidizing premiums for the elderly and high-risk groups amongst all the privately insured.<sup>113</sup> More recently legislation has been passed which sets the maximum premium for private insurance for an individual below the age of 65 at \$200.90 Dutch Guilders per month. For an individual aged over 65, the maximum contribution is \$251 Dutch Guilders per month.<sup>114</sup>

The Dutch system appears to be a two-tier system; the same sort of system much-feared in Canada. However, it is not truly a two-tier system as those who purchase private insurance cannot fall back on the public system – the private system has to cover all needs and not just skim off the easier kinds of care like elective surgery as happens in the UK and New Zealand. Also, it is not two-tier as having private insurance or private financing does not enable Dutch citizens to jump queues in the public system. It is seen as against a physician's ethical code to prefer a patient with private insurance to a patient without and both kinds of patients are treated side-by-side in the same hospitals.<sup>115</sup>

Although there are concerns in the Netherlands with regard to growing waiting times for care, the Netherlands performs very well compared to other countries. Tuohy, Flood and Stabile found that 0.51% of the Dutch population are recorded as being on waiting lists compared to 0.62% in Canada, 0.8% in Australia, and 2.48% and 2.56% recorded, respectively, in New Zealand and England.<sup>116</sup>

## **SUPPLY**

### **Hospitals**

Most hospitals are privately owned and all operate on a non-profit basis. Many are affiliated with Protestant, Catholic or non-denominational religious orders. Relative to the average for OECD countries the Netherlands devotes a high proportion of health care spending to institutional care (hospitals, psychiatric facilities, nursing homes and other institutions).<sup>117</sup> Spending on hospitals has remained steady in the period 1990-1998, falling slightly from 30.9% to 30.6%.<sup>118</sup> The average length of stay in Dutch hospitals of 33.8 days is over twice as much as the OECD average of 12.2 days.<sup>119</sup> The magnitude of this difference leads one to believe that it is as a result of the Dutch commitment to financing long-term care and its *Exceptional Medical Expenses* scheme rather than an excessive propensity to keep general patients in hospital.<sup>120</sup>

Prices for hospital and other institutional services and fees for health care professionals are set during centralized negotiations between representatives of insurers and providers.<sup>121</sup> Since 1983, Dutch hospitals have been funded pursuant to prospective annual global budgets negotiated with

representatives of private insurers and the Sickness Funds. These budgets cover both public and private patients and cover nearly all costs incurred by a hospital apart from specialists' fees.<sup>122</sup> There are two steps involved in fixing a hospital's budget. First, an estimate is made of what should be the operating costs of a hospital if it were efficient. Secondly, an allowance is made for changes in the population served by the hospitals and in the volume of operations performed.<sup>123</sup> If a hospital's budget is exceeded in any particular year then the budget is reduced by that amount in the following year.<sup>124</sup> Since 1996, the Dutch government has introduced measures such as "flex-funding" in an attempt to encourage hospitals to invest in projects that would shorten the length of stay for patients and to give them more flexibility in spending their budgets.<sup>125</sup> Hospitals are now allowed to keep some or all of the profits they make in a particular year.<sup>126</sup>

### **Providers**

The number of physicians in the Netherlands is around the OECD average.<sup>127</sup> Family doctors are gatekeepers to the rest of the system and this gate-keeping role is credited with helping to restrain growth in total health expenditures. Sickness Funds pay family doctors on a capitation basis (an annual fee per person), the fee being uniformly set for the whole of the Netherlands by regulated negotiations between representatives of practitioners and insurers.<sup>128</sup> Each Sickness Fund patient must choose a family doctor to register with from the list of those that the Fund has contracted with. Private insurers pay physicians on a fee-for-service basis. An important element of cost-control mechanisms in the Dutch system is the centralized process of negotiation of fees between insurers (the Sickness Funds Council and private insurers) with physicians. The Central Agency on Health Care Tariffs oversees and regulates these negotiations, which occur at a national level.<sup>129</sup>

Sickness Funds pay specialists a fee per out-patient consultation that entitles the patient in question to one full month of treatment for the particular complaint or condition and if continuation of treatment is required beyond a month, then the specialist receives an additional fee.<sup>130</sup> Also if in any year a specialist bills above an annual sum (agreed by the Sickness Funds and the National Specialists Association) then increasing amounts are clawed back.<sup>131</sup> Private insurers reimburse specialists on a pure fee-for-service basis. Specialists who are employed by university hospitals and by psychiatric institutions are compensated on a salary basis.<sup>132</sup> In 1997, the government introduced a proposal to fully integrate specialists into hospitals by abolishing their ability to directly charge Sickness Funds and patients for their services.<sup>133</sup>

### **HEALTH REFORM**

The Netherlands has been slowly implementing a version of managed competition reform since 1987 with a view to stimulating competition between Sickness Funds and private insurers, and injecting more competition into the system. A fuller discussion of the managed competition proposals is in the Management section of this Report.

Some important features of the managed competition proposals have been implemented but many have not. A new government assumed office in 1994 and in March 1995 yet another version of a managed care reform plan was published. Earlier versions of the managed competition reform proposals had provided for the integration of acute and long-term care and proposed extending the Exceptional Medical Expenses scheme so that it covered all general medical expenses. However, there was concern about how to assess accurately the risk of the need for long-term care as it requires a projection many years into the future.<sup>134</sup> It seems to be accepted that it may be better for these sorts of services to be provided independently of a competition-oriented scheme.<sup>135</sup> As a consequence, the 1995 reforms provide for the retention of a separate Exceptional Medical Expenses scheme, albeit restricted to long-term care and mental health care.

With respect to services considered "curative basic care" the government is proceeding with earlier proposals for managed competition at least with regard to Sickness Funds but as yet has made no inroads with regard to private insurers.<sup>136</sup> The government plans to increase the level of risk taken on by Sickness Funds. The Netherlands' work on risk-adjusting premiums for Sickness Funds is of particular relevance to Canada in considering how to fund Health Authorities or budget-holding groups of physicians and other health care providers.

#### **LESSONS FOR CANADA**

1. In contrast to Canada, the universal compulsory scheme in the Netherlands covers long term care and mental health care. This "Exceptional Medical Expenses" scheme deserves special consideration as Canada struggles with structuring long term and home care programs.
2. As Canada considers the reality that there is resistance to increase taxes in order to create national Pharmacare and Home Care programs the experience of the Netherlands is of particular interest. Through mandatory insurance programs, with contributions from employers and employees, the Dutch manage to have a system that is largely progressively financed but not publicly financed from general taxation revenues.
3. The Netherlands' work on risk-adjusting premiums for Sickness Funds is of particular relevance to Canada in considering how to fund Health Authorities or budget-holding groups of physicians and other health care providers.

## **COUNTRY PROFILE: NEW ZEALAND**

### **FINANCING AND COSTS**

Relative to Canada, New Zealand has always spent less on health care both in real terms and as a percentage of GDP. New Zealand's total health care spending absorbed 8.1% of GDP in 1998,<sup>137</sup> slightly below the OECD average of 8.2%.<sup>138</sup> Of the six countries under study New Zealand also records the lowest figure for per capita health care spending measured in PPPs (see the Table in the US Profile). However, in recent times the rate of growth in spending has increased and between 1988 and 1998, the average growth rate in per capita spending was 6.1% per annum compared to an OECD average of 4.8%.<sup>139</sup> Health care spending is budgeted to increase by 4.4% in 2000/2001.<sup>140</sup>

The New Zealand system is predominantly publicly funded but the share of public funding has fallen from 88% in 1980<sup>141</sup> to 77.1% in 1998.<sup>142</sup> Amongst the OECD countries, the fall in public funding in New Zealand was the most dramatic.<sup>143</sup> This can be largely attributed to the fact that public spending has been historically more concentrated in the hospital sector than in other nations. The contraction of this sector (due to technological change and a deliberate policy of fiscal constraint) thus resulted in sharp decline.<sup>144</sup> As in Canada, there is variation in the public/private mix depending on the type of health care service. For example, in 1998/99, the government paid for almost 100% of public hospital costs but only 61% of community care (personal care including family doctor visits).<sup>145</sup> Private insurance accounted for 6.2% of total health care spending in 1998/99.<sup>146</sup> Although overall still a small proportion, private insurance is much more important in the funding of particular health care services such as non-emergency surgical services, specialist services, and family doctor charges.<sup>147</sup>

### **HEALTH OUTCOMES**

New Zealand has not performed as well as Canada (and many other developed countries) on health outcome measures.<sup>148</sup> For example, New Zealand's infant mortality rate of 7.4 per 1000 live births in 1996 was significantly higher than the 5.8, 6.0 and 6.1 deaths per 1000 recorded respectively in Australia, Canada, and the UK. However, this rate fell to 6.8 per 1000 live births in 1997 and again to 5.7 per 1000 live births in 1998<sup>149</sup> bringing New Zealand into line with the other countries referred to.<sup>150</sup> New Zealand performs relatively poorly in terms of years of potential life lost. New Zealand's figure of 5155.6 potential years of life lost per 100,000 in 1996 was significantly higher than the figures of 4454.8, 4274.1, and 4122.7 recorded respectively in the UK, Canada and the Netherlands.<sup>151</sup> Despite overall improvements in New Zealand's mortality rates over the course of the last century there have been different rates of change between social groups.<sup>152</sup> Also, the Maori have much higher mortality and morbidity rates compared to the rest of the population.<sup>153</sup>

### **COVERAGE AND ACCESS ISSUES**

The philosophical approach is that care should be allocated on the basis of need and not ability to pay. However, there are limitations to how far this principle is applied -- there are significant user charges for family doctor care and a two-tier system is allowed so that people with private insurance or resources can buy care in private hospitals and avoid queuing in the public sector.

In New Zealand, most people have to pay the full cost of a visit to their family doctor (although 37% have private insurance to help cover these costs.)<sup>154</sup> There are government subsidies for those on lower incomes and those with chronic illness but they still only cover about half of the fee charged by family doctors. In the period 1980 to 1998/9, the percentage of total health care spending paid out-of-pocket by patients increased from 10.4%<sup>155</sup> to 15.9%.<sup>156</sup> The amount paid for out-of-pocket health care expenses varies considerably depending on the type of service in

question. Out-of-pocket payments amounted to 10% of total spending on public institutional care, 28% of drug spending, 30% of spending on family doctor services and 58% of specialists' visits.<sup>157</sup> Approximately 37% of New Zealanders purchase private insurance in order to avoid long queues for non-emergency surgery in public hospitals and to cover the cost of user charges.<sup>158</sup> However, although 59% of households with incomes in the top fifth purchased private insurance, only 13% of those in the bottom fifth did so.<sup>159</sup>

What has been the impact on user charges to access to care? In a 2000 study, it was found that New Zealanders perceived inequities in access to care, with significantly more problems reported by those with below-average incomes. The rate of not getting needed care was 2.5 times higher among below-average income groups than high-income groups (17% compared to seven percent). Waiting times and scarcity of resources were cited as presenting the most serious barriers to care for below-average income groups.<sup>160</sup> Grant *et al.* found that user charges act as a barrier to access for some sectors of the population and that New Zealanders are less able to access basic primary care than people in the UK, Canada, and Australia.<sup>161</sup> Some targeted measures have been taken to address these concerns and since 1996, visits to family doctors have been free for children under 6.

The growth of waiting lists has been of significant concern in New Zealand, particularly for non-emergency surgical services. Relative to other countries, New Zealand records a very high rate of its population on waiting lists in the public sector.<sup>162</sup>

## **SUPPLY**

### **Hospitals**

New Zealand's public hospitals are truly "public" in that they are owned by the government. New Zealand has historically devoted a relatively high proportion of total health expenditures to hospital services but this has fallen over time. In 1991, funding for hospitals and other institutions comprised nearly 73% of central government health spending<sup>163</sup> but by 1997/98 this had declined to 60.2%.<sup>164</sup> There are 10,934 beds in private hospitals compared to 12,469 beds in public hospitals.<sup>165</sup> Private hospitals tend to concentrate most heavily on elective surgery, leaving the public sector to deal with acute and emergency care.<sup>166</sup>

### **Providers**

Specialists working within public hospitals are paid on a salary basis and cannot charge patients additional fees. There are no such restrictions on specialists working outside of public hospitals. Many specialists work in both the public hospitals (where they are paid a salary) and in the private sector (where they are paid on a fee-for-service basis). Since spending additional effort in the private sector will directly translate into additional income specialists may have little incentive to reduce waiting lists in the public hospitals.<sup>167</sup>

Family doctors are private contractors and are predominantly paid on a fee-for-service basis. Unlike Canada, physicians are entitled to extra-bill. The government pays a subsidy to family doctors, which is meant to reduce what patients have to pay out-of-pocket. The real value of the government's subsidy has fallen from around 75% of the total fee when it was first introduced in 1941 to an average of less than 20%.<sup>168</sup> Not all patients are subsidized, so family doctors charge patients for part, or all, of a consultation.<sup>169</sup> The government's subsidy of family doctor care was increased in October 1988 and again in September 1990 for children, the elderly, and the chronically ill. Since internal market reform in 1993, about 80% of family doctors have become members of Independent Practitioner Associations or "Budget-holders".<sup>170</sup> These are physician

groups of varying size paid on a capitated basis by the government and expected to fund the cost of specified services for their patients such as drugs, diagnostic tests, x-rays etc.

New Zealand has a 'no-fault' accident compensation scheme<sup>171</sup> that compensates for the full medical costs of accident victims and up to 80 percent of lost earnings.<sup>172</sup> "As a result of the no-fault accident compensation scheme physicians are protected from civil claims for damages that arise directly or indirectly from medical misadventure."<sup>173</sup>

### **HEALTH REFORM**

In 1993, following on the heels of similar reforms in the UK, New Zealand embarked on what is known as "internal market reform." The goal was to split the purchaser and provider roles of Health Authorities so that the Authorities no longer had an incentive to prefer financing services from the public hospitals they managed rather than other potentially more efficient providers. Internal market reform required government-appointed purchasers (initially four Regional Health Authorities and subsequently one central Health Funding Authority) to bargain and enter into contracts with competing public and private health service providers. The Health Funding Authority was the sole purchaser of publicly funded health services and was required to buy a comprehensive range of health and disability services on behalf of all New Zealand citizens. A split was created between the purchasing and provision of hospital and other health services so that the Health Funding Authority was not permitted to provide health services directly. On the other side of the split were public hospitals which were managed by crown corporations called "Crown Health Enterprises" or "CHEs". These "CHEs" were meant to act much more like private firms and compete with each other and private providers for supply contracts with the Health Funding Authority. In addition 'Budget-holders' or 'Independent Practice Associations' were established (discussed above).

November 1999 saw the election of Labour/Alliance coalition government and yet another round of major reforms. The 1999/2000 reforms mark a move away from the competitive and market-driven approach. The Minister of Health has said that the latest reforms mark the beginning of a return to a "genuine public health service" for New Zealand.<sup>174</sup> The latest reforms largely return the New Zealand system to the pre-1993 configuration with District Health Boards (DHBs) performing the dual functions of managing public hospitals and managing government funds with which to purchase most hospital and other secondary services in their respective areas. Thus, the provider and purchaser functions are to be recombined in one entity for each of the districts. Unlike the old Area Health Boards, however, the new DHBs will also have responsibility for funding primary care, which is a very important step in terms of integration of care. The latest reforms continue to place a heavy emphasis on governance and accountability mechanisms including performance expectations, incentives and sanctions, and mechanisms to ensure delivery of government's goals, targets and service standards.

New Zealand's experience with internal market reform has been very mixed and merits close analysis as Canadian provinces like Ontario and Alberta experiment with competitive contracting out. The reforms certainly did not achieve the efficiency gains originally hoped for. Nonetheless some benefits were achieved particularly in terms of the generation of information and the integration of funding in one purchasing agent in a region. Moreover, mistakes were made in the implementation of health reform in New Zealand, which Canadian provinces should endeavor to avoid. For example, very little attention was paid to the incentives that managers within Health Authorities would have to change the status quo and engage in hard bargaining with competing public and private providers. Also insufficient attention was paid to ensuring that Health Authorities would have the necessary cost and quality information needed to engage in effective bargaining and to monitor performance.

**LESSONS FOR CANADA**

1. User charges for family doctor care seem to be correlated with inequitable access and possibly with poor health care outcomes.
2. Allowing a two-tier system does not seem to reduce pressure or waiting lists in the public sector as waiting lists in New Zealand's public system are much longer than in Canada's.
3. New Zealand's experiment with internal market reform bears close examination as the provinces of Ontario and Alberta consider experimenting with competitive contracting out *within* a publicly funded system. In particular it is important to consider what incentives and information purchasers of care (be they Health Authorities or Ministries of Health or groups of providers) have.

## **COUNTRY PROFILE: UNITED KINGDOM**

### **FINANCING AND COSTS**

The UK exemplifies a "command and control" system, which is one in which government not only finances most care but is also heavily involved in managing the delivery of services. Health scholars often associate "command and control" systems with the capacity to control costs and the UK has consistently spent less on health care than many other developed countries. In 1998, the UK spent 6.7% of GDP on health care services compared to an OECD average of 8.2%.<sup>175</sup> However, in March 2000 the New Labour government announced that spending would increase to bring it into line with the European average of 8% of GDP.<sup>176</sup> New Labour anticipates that the National Health Service ("NHS") will grow by a third in real terms over five years.<sup>177</sup>

Although the percentage of health care paid for by the public sector has declined the UK still has one of the higher percentages of public funding in the OECD. In 1999, government funded 84.2% of total health care spending.<sup>178</sup> In introducing the new NHS Plan in July 2000, Tony Blair said that the government had examined alternative methods of funding but had concluded that alternatives would be inefficient and that modernization of the NHS was what was required, not its dismantling.<sup>179</sup> Expenditures by private-for-profit insurers as a proportion of total health care expenditures is small at 3.2% in 1990, rising to 3.5% by 1998.<sup>180</sup>

### **HEALTH OUTCOMES**

Although the UK spends a lot less on health care as a percentage of GDP than countries of similar wealth it nonetheless performs around the OECD average with regard to health outcomes. This suggests that it is a very efficient system although on certain health indicators it does not perform as well as its European neighbours.<sup>181</sup> For example, there are concerns about the relatively poor outcomes for various forms of cancer in the UK compared to other European countries.<sup>182</sup>

### **ACCESS AND COVERAGE ISSUES**

The basic philosophical principle of the NHS is that care should be allocated on the basis of need and not ability to pay.<sup>183</sup> There are fewer explicit limitations on this principle than in other countries. Unlike New Zealand, there are no user charges for family doctor care. Also unlike Canada, the NHS provides coverage for the cost of prescription drugs although there is a flat rate user charge (6.00 pounds per item) but 60% of the population are exempt from these charges and 80% of prescriptions are in fact dispensed to those who are exempt.<sup>184</sup> User charges (out-of-pocket payments) by patients accounted for a mere 3.4% of total health care expenditures in 1990 and declined to 2.7% in 1995. By comparison, in 1998, user charges accounted for 17.7% of total health care expenditures in the US, 22.9% in New Zealand and 5.9% in the Netherlands.<sup>185</sup> The 1998 figures are not available for Canada, however, the 1997 figure was 17.1%. Unlike Canada, the UK does allow a two-tier system where those who have private resources can buy care (mainly elective surgery) in private hospitals and jump long queues in the public hospitals. The proportion of the population with private health insurance has historically been small but has steadily grown in recent years to 11.5% in 1999.<sup>186</sup> The percentages of professionals, employers and managers with private insurance is significantly higher than the rest of the population.<sup>187</sup>

Although the UK seems to perform reasonably well with regard to aggregate health outcomes, there are significant concerns with regard to the timelines within which care is delivered. In particular, the growth and management of waiting lists for elective (non-emergency) surgery continues to be an issue of huge public concern.<sup>188</sup> Compared to other countries, the UK records a very high percentage of its population on waiting lists -- 2.56%.<sup>189</sup>

## **SUPPLY**

What distinguishes the UK from most other systems is government's obligation to supply health care services and not simply to insure citizens. The direct line of hierarchy between the government and regional and district authorities has resulted in government being held accountable at the highest level for small difficulties within the system and has politicized decisions such as the rationalization of the hospital sector.<sup>190</sup>

### **Hospitals**

The government owns public hospitals in the UK. Prior to internal market reform in the 1990s public hospitals were funded by way of block budgets based on historical expenditures. Consequently, there was a perverse incentive against improving efficiency as this may have resulted in a reduction in funding in the following financial year and/or resulted in more referrals but with no more resources to deal with these new patients.<sup>191</sup> Capped hospital budgets also provided incentives for cost shifting. For example, specialists based in public hospitals referred patients back to their family doctors who were not subject to the same budget limitations for either the cost of their own services or for the pharmaceuticals they prescribed.<sup>192</sup> Long and growing waiting lists for elective surgery can also be viewed as a form of cost shifting on to patients. Internal market reform implemented in 1991 sought to address these difficulties and provided for the establishment of public hospitals as self-governing "NHS Trusts" (which are not trusts in the legal sense but crown companies). These NHS Trusts had to compete with each other and private hospitals for contracts with Regional Health Authorities. The 1989 reforms also saw the abolition of District Health Authorities and Family Practitioner Committees. (See further the discussion under Health Reform Initiatives below.)

Between 1990 and 1998 the number of private hospitals increased from 200<sup>193</sup> to 248.<sup>194</sup> As in New Zealand, private hospitals only provide elective surgery leaving public hospitals total responsibility for the provision of acute and emergency care.

### **Providers**

Specialists in the public sector are paid on a salary basis and also may receive "distinction awards" that can result in an increase of their salary of between 40 to 95%.<sup>195</sup> Specialists may work part-time in private hospitals (generally on a fee-for-service basis) although their primary employer remains the NHS. As in New Zealand, since spending additional effort in the private sector will directly translate into additional income specialists may have little incentive to reduce waiting lists in the public hospitals.

Family doctors are treated as independent private contractors even although they are publicly financed. Every individual in the UK is enrolled with a family doctor. Patients are free to select a family doctor from the NHS list subject to the doctor's consent. Historically, family doctors have been paid using a mixture of three methods. First, practitioners received a basic practice allowance or salary (which was larger for practitioners locating in those areas viewed as being under-serviced). Second, they received a capitation payment per registered patient (with three levels of payment depending on the age of the patient). And, finally, they received specific fee-for-service payments for particular preventive services.<sup>196</sup>

Pursuant to internal market reform and the implementation of General Practitioner (GP) Fundholding there was a significant shift in the role and responsibilities of family doctors as they become purchasers of care and had financial incentives to consider the costs and benefits of the care they recommended or prescribed. The New Labour Reforms, although dismantling GP Fundholding, still seek to enhance the role of family doctors as commissioners (purchasers) of care but extend this role to include practice nurses.

## HEALTH REFORM

Most of the policy changes in the 1990s in Britain focused on re-organization *within* the public sector rather than on the public/private balance. The key part of internal market reform in the UK, as in New Zealand, was splitting the purchaser and provider roles of the District Health Authorities which had formerly been responsible for purchasing all hospital care *and* managing all the public hospitals in their district.<sup>197</sup> In the reformed system 100 health authorities were expected to be transformed into proactive purchasers and contract out to competing public and private providers. On the supply side, public hospitals were transformed into crown corporations ("NHS trusts") with the power to vary salary packages for employees and to borrow capital within annual financing limits. Public hospitals no longer received a more or less automatic operating budget and were expected to compete with each other and private providers for contracts with the Health Authorities to supply services. An initially small component of the reforms, but one that gained increasing importance was GP Fundholding where groups of family doctors received capitated budgets and funding responsibility for a range of care (drugs, diagnostic tests, elective surgery, etc.) for all the patients enrolled with them. By 1997, there were 3,500 GP Fundholders, involving around 15,000 family doctors, acting as purchasers for approximately 50% of the population for a limited range of health care services.<sup>198</sup> GP Fundholding gave family doctors a financial incentive to consider the costs and benefits of the different services they prescribed or recommended.

With the exception of the GP Fundholding scheme, the internal market reforms proved to be less transformative of the system than might have been expected from the boldness of the new design.<sup>199</sup> The New Labour government elected in 1997 announced yet further reforms, the most significant of which was the abolishment of GP Fundholders from 1 April 1999 and the creation of "Primary Care Groups" (PCGs). The latter are large groups of family doctors (50-60 family doctors from 20 or so different practices) and practice nurses. On 1 April 1999, 481 PCGs began life in England, with a patient population ranging from 46,000 to 257,000 but with the average being 100,000. Each PCG has available their population's share of funding for hospital and community health care services, the budget for prescribing by family doctors and nurses, and the budget which reimburses family doctors for the cost of their practice staff premises and computers. Thus, the PCGs do not control payments to family doctors for the services they provide and family doctors retain their 'independent contractor status'. However, the New Labour government has expressed enthusiasm about extending a pilot project under which family doctors cease to be independent contractors and become employees.

## LESSONS FOR CANADA

1. The UK has a very low percentage of health care spending coming from private sources, it manages to include prescription drugs with minimal user charges in its publicly funded plan, and it spends a lot less on health care than Canada does.
2. Although the UK has a two-tier system allowing those with private resources to jump queues in the public system, the existence of a two-tier option does not seem to reduce pressure on the public system where there are very long waiting lists for care.
3. As in New Zealand, the experience with internal market reform in the UK has been very mixed. The reform initiative that has had the most impact was the creation of GP Fundholding. This initiative, which gave family doctors a financial incentive to consider the costs and benefits of the different services they prescribed or recommended is worthy of careful attention as Canada considers how best to engage in primary health care reform.

## CONCLUSION

Canada is unique in the developed world as it prevents a "two-tier" system in which people can buy privately hospital and physician services that are covered in the public system. Consequently there is almost 100% public funding for hospital and physician services; however as technology has advanced and the site of care has increasingly shifted from hospitals and into communities and homes other kinds of care, like drug therapy and home care, have become increasingly important. The latter kinds of care have high rates of private financing and are not protected by the provisions of the Canada Health Act thus allowing varying standards across provinces in terms of access and quality. Increasingly questions are asked about the sustainability of Medicare and whether it is possible to modernize and reform the system without a cost explosion. What can Canada learn from other countries in this regard?

The US is the only developed country to leave a significant proportion of the population (16.3%) without any health insurance yet it spends more on health care than any other country. The US system demonstrates that increased private financing does not equate with reduced health care spending. Thus any argument made in Canada that increased private financing is needed because of growing health care spending must take account of the fact that increased private spending may mean increases in total health care spending. The US system also shows that increased health care spending does not necessarily equate with better health care outcomes or necessarily a higher volume of services (Canadians seem to receive more every-day or basic health care services whilst Americans may receive more invasive, expensive surgical services). Increased health care spending does, however, seem to be associated with higher prices for physician and hospital services. On a more positive note, the managed care revolution in the US has caused concerns about access and quality; however, some of these experiences are worthy of consideration if Canada can adopt these initiatives in a manner that is consistent with its values of equity and universal access. Canada should view the US system as a laboratory of different reform initiatives from which it can select the best.

Given the geographic and constitutional similarities of Canada and Australia, the Australian health care system merits close scrutiny. The ratio of public to private spending is similar to Canada's but there is more private financing of hospital and physician services and greater public financing of drugs than in Canada. There are an array of safety nets in place designed to ensure that user charges do not deter access to care for the disadvantaged and chronically ill. Of particular interest, is the voluntary bulk-billing arrangements with physicians, which effectively eliminate user charges for physician care for most Australians. Also of particular interest is the fact that Australia spends less on health care than Canada but has a national drug plan (managed and funded by the Commonwealth government). The drug plan requires significant out-of-pocket payments but with a system of safety nets so that it is a coherent national system that ensures access for those to whom cost may be a barrier.

The Dutch system relies to a significant degree on private insurance yet nonetheless manages to achieve near universal coverage. In contrast to Canada, the universal compulsory scheme in the Netherlands covers long term care and mental health care. This "Exceptional Medical Expenses" scheme deserves special consideration as Canada struggles with structuring long term and home care programs. If there is resistance to increased taxes or government spending, even in order to fund national pharmacare and home care programs, then the experience of the Netherlands is of particular interest. Through mandatory insurance programs, with contributions from employers and employees, the Dutch manage to have a system that is largely progressively financed but not publicly financed from general taxation revenues. The Netherlands' work on risk-adjusting

premiums for Sickness Funds is also of particular relevance to Canada in considering how to fund Health Authorities or budget-holding groups of physicians and other health care providers.

The New Zealand system has a higher level of public funding than in Canada and has historically been a cheaper system. However, it imposes user charges for family doctor services resulting in inequitable access to the system. 37% of New Zealanders have private insurance allowing them to jump long public sector queues and to cover user fees. Allowing a two-tier system does not seem to reduce waiting lists in the public sector, as waiting lists in New Zealand's public system are much longer than in Canada's. New Zealand's experiment with internal market reform bears close examination as the provinces of Ontario and Alberta consider experimenting with competitive contracting out *within* a publicly funded system. In particular it is important to consider what incentives and information purchasers of care (be they Health Authorities or Ministries of Health or groups of providers) have.

The UK system relies very heavily on public financing and is, relatively, an inexpensive system and records good health care outcomes but has had great difficulty in ensuring access to timely care and records long waiting lists. Unlike Canada the UK includes prescription drugs with minimal user charges in its publicly funded plan. Although the UK relies much more on public financing than Canada, approximately 10% of the population has private insurance allowing those people to avoid long public sector queues for elective surgery. The existence of a two-tier option does not seem to reduce pressure on the public system where there are very long waiting lists for care. As in New Zealand, the experience with internal market reform in the UK has been very mixed. The reform initiative that has had the most impact was the creation of GP Fundholding. This initiative, which gives family doctors a financial incentive to consider the costs and benefits of the different services they prescribe or recommend is worthy of careful attention as Canada considers how best to engage in primary health care reform.

Canada is at an important crossroad in deciding how best to reform its publicly funded health care system. Medicare has served Canadians well, meeting Canadian values of fairness and equity. However, its sustainability is increasingly being tested by changes in technology and demographics and the system needs to be modernized and reformed so that it is able to respond to health care needs regardless of the site of care or the nature of the provider. There is much to be learnt from close consideration of other countries' experiences with reform, both the failures and the successes. Although some will argue that the Canadian context is unique such that one cannot transplant international experiences, it is striking that many of the calls for reform in Canada (e.g. competitive contracting out, greater use of private for-profit providers, primary care reform, user charges), mimic reform initiatives that have already occurred or are underway in other countries. Rather than repeating the same mistakes, Canadian policy-makers should keep in mind the words of Publius Syrus, from 42 B.C., and "learn to see in another's calamity the ills which you should avoid."<sup>200</sup> This will require a much more detailed analysis of the reforms that have occurred than is possible here but it is hoped that this paper has served to identify what are likely to be the most fruitful areas of study.

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<sup>1</sup> Center for Disease Control and Prevention and National Center for Health Statistics, *Health, United States, 2000*, (Hyattsville, Maryland: National Center for Health Statistics, 2000) [hereinafter called “Health 2000”] at table 118: “National health expenditures, average annual percent change, and percent distribution, according to type of expenditure: United States, selected years 1960–98”.

<sup>2</sup> OECD, *OECD Health Data 2000: A Comparative Analysis of 29 Countries* (Paris: OECD, 2001) [hereinafter OECD Data 2000]; Tables generated on file with authors. The OECD makes cross-national comparisons of cost possible by converting national amounts into a consistent standard called Purchasing Power Parity (PPP) units. PPPs are the rates of currency conversion that allow the purchasing power of different currencies to be expressed in a common unit. In other words, they compute the sum required to buy the same basket of goods and services in each country if everyone had to pay the same prices as the United States. PPPs eliminate all differences in price levels among countries so that international variations reflect only differences in the volume of goods and services purchased. As such, they are the preferred approach for many international comparisons. Information accessed online: [http://www.oecd.org/els/health/sources/monetary\\_conversion\\_rates.htm](http://www.oecd.org/els/health/sources/monetary_conversion_rates.htm).

<sup>3</sup> See figures from Health 2000, *supra* note 1: Table 115, “Gross domestic product, national health expenditures, Federal and State and local government expenditures, and average annual percent change: United States, selected years 1960–98” and Table 116: “Consumer Price Index and average annual percent change for all items, selected items, and medical care components: United States, selected years 1960–99”.

<sup>4</sup> By comparison, for all non-medical goods and services, the annual change in CPI was 4.7% in 1990 and 2.2% in 1999 – Health 2000, *ibid* at table 116: “Consumer Price Index and average annual percent change for all items, selected items, and medical care components: United States, selected years 1960–99”.

<sup>5</sup> Office of the Actuary, Health Care Financing Administration, *National Health Expenditures Projections: 1998-2008*, online: <http://www.hcfa.gov/stats/>.

<sup>6</sup> *Ibid.*

<sup>7</sup> World Health Organization, “The World Health Report 2000” (Geneva: WHO, 2000) [hereinafter World Health Report 2000] at table 2: basic indicators.

<sup>8</sup> While this was close to the 1997 OECD average of 7.3, it must be noted that the five countries with a worse rate were those whose rates departed the most from the average: Hungary (9.9), Poland (10.2), Mexico (16.4), and Turkey (39.5). Were it not for these countries’ figures, the OECD average would be much lower, and the US’s infant mortality rate comparatively thus even poorer.

<sup>9</sup> Health 2000, *supra* note 1 at table 20: “Infant, neonatal, and post neonatal mortality rates, according to detailed race of mother and Hispanic origin of mother: United States, selected birth cohorts 1983–97”.

<sup>10</sup> *Ibid.* at table 28: “Life expectancy at birth, at 65 years of age, and at 75 years of age, according to race and sex: United States, selected years 1900–98”.

<sup>11</sup> *Ibid.* at table 58: “Respondent-assessed health status according to selected characteristics: United States, 1991, 1995, 1997, and 1998”.

<sup>12</sup> *Ibid.* at table 146: “Persons without health care coverage by geographic division and State: United States, selected years 1987–98”.

<sup>13</sup> Part A of Title XVIII of the Social Security Act, 42 U.S.C. 1395.

<sup>14</sup> Co-payments are user charges levied on patients per use (e.g. a \$10 fee). Deductibles and co-insurance refer to amounts the user must pay privately to share the cost of the service with Medicare. Deductibles are one-time charges, whereas co-insurance charges are sometimes made in addition to deductibles on a periodic basis to shift ongoing costs to the patient.

<sup>15</sup> Although some of the increase can be attributed to changes in how Medicaid recipients are defined statistically -- Health 2000, *supra* note 1 at Glossary "Health Expenditures".

<sup>16</sup> These services generally include the following: inpatient hospital services; outpatient hospital services; prenatal care; vaccines for children; physician services; nursing facility services for persons aged 21 or older; family planning services and supplies; rural health clinic services; home health care for persons eligible for skilled-nursing services; laboratory and x-ray services; paediatric and family nurse practitioner services and nurse-midwife services.

<sup>17</sup> G. Anderson et al., "Health Spending and Outcomes: Trends in OECD Countries, 1960-1998" (2000) 19:3 Health Affairs 150 at 155.

<sup>18</sup> W. P. Welch, D. Verrilli, S.J. Katz, & E. Latimer, "A Detailed Comparison of Physician Services for the Elderly in the US and Canada" (1996) 275(18) JAMA 1410.

<sup>19</sup> V.M. Taylor *et al.*, "Hospitalization for Back and Neck Problems: A Comparison between the Province of Ontario and Washington State" (1998) 33 Health Services Res 929-45.

<sup>20</sup> Figure for 1998 calculated over 19 countries -- OECD Health Data 2000, *supra* note 2. The figure for Australia is from 1997.

<sup>21</sup> Health 2000, *supra* note 1 at table 102: "Physicians, according to activity and place of medical education: United States and outlying U.S. areas, selected years 1975-98".

<sup>22</sup> OECD Data 2000, *supra* note 2.

<sup>23</sup> P. Buerhaus & D. Staiger, "Trouble in the nurse labor market? Recent trends and future outlook" (1999) 18:1 Health Affairs 214-22.

<sup>24</sup> For review of the evolution of managed care, see J. Spidle, "The Historical Roots of Managed Care", in D.A. Bannahum, ed., *Managed Care: Financial, Legal and Ethical Issues* (Cleveland: Pilgrim Press, 1999) at 22.

<sup>25</sup> Figures from Iglehart, 'Health Policy Report: Physicians and the Growth of Managed Care', at 1168 and Mercer/Foster Higgins, "National Survey of Employer-Sponsored Health Plans" (New York: William M. Mercer, Inc., 1997) at 9 as quoted by Smith *et al.*, Enrolment in health maintenance organizations (HMOs) (the traditional vehicle of managed care) increased from 19.4% of the U.S. population (50.9 million) in 1995 to 30.1% (81.3 million) by 1999 -- Health 2000, *supra* note 1 at table 131: "Health maintenance organizations (HMO's) and enrollment, according to model type, geographic region, and federal program: United States, selected years 1976-99".

<sup>26</sup> Health Care Funding Association, "National Summary of Medicaid Managed Care Programs and Enrollment, June 30, 1999", online: <http://www.hcfa.gov/medicaid/trends99.htm> (date accessed: January 29, 2001).

<sup>27</sup> R.L. Schwartz, "How Law and Regulation Shape Managed Care" in D.A. Bannahum ed., *supra* note 24 at 22. Schwartz predicted that all insurance plans would be MCOs before much longer.

<sup>28</sup> The OECD makes cross-national comparisons of cost possible by converting national amounts into a consistent standard called Purchasing Power Parity (PPP) units. *Supra* note 2.

<sup>29</sup> OECD Data 2000, *supra* note 2.

<sup>30</sup> Canadian Institute for Health Information, "Health Care in Canada 2000: A First Annual Report" - Table 7: "Growth in Health Spending" (Ottawa: CIHI, 2000), online: [http://www.cihi.ca/Roadmap/Health\\_Rep/healthreport2000/toc.shtml](http://www.cihi.ca/Roadmap/Health_Rep/healthreport2000/toc.shtml) (date accessed: 29 January 2001).

<sup>31</sup> At the time of the September 2000 First Ministers' agreement on Health, the Government of Canada committed \$21.1 billion in new cash to the Canadian Health and Social Transfer (general transfer payment to the provinces). This additional funding consists of an \$18.9 billion general increase to the CHST in support of health and \$2.2 billion in targeted funds to the Early Childhood Development initiative.

<sup>32</sup> Canadian Institute for Health Information, *supra* note 30 at table 14: "The Private Share".

<sup>33</sup> Health Canada, Table 8: "Public and Private Share of Health Expenditures Canada 1975-1996" at [http://www.hc\\_sc.gc.ca/datapcb/datahesa/hex97/table8.jpg](http://www.hc_sc.gc.ca/datapcb/datahesa/hex97/table8.jpg) accessed 13 June 1998. See also National Forum on Health, "The Public and Private Financing of Canada's Health System: A Discussion Paper", (Ottawa: National Forum on Health, 1995) at 6-7.

<sup>34</sup> C.H. Tuohy, C.M. Flood & M. Stabile, *The Impact of Private Finance on Public Health Care Systems: Evidence from OECD Nations* (University of Toronto, 2001) [unpublished].

<sup>35</sup> A Renewed Vision for Canada's Health System: Conference of Provincial/Territorial Ministers of Health at 7.

<sup>36</sup> OECD Data 2000 *supra* note 2. Again, it must be noted that the five countries with a worse rate were those whose rates departed the most from the average: Hungary (9.9), Poland (10.2), Mexico (16.4), and Turkey (39.5). Were it not for these countries' figures, the OECD average would be much lower. If Turkey is excluded, the average rate is 5.8.

<sup>37</sup> Royal Commission on Aboriginal Peoples, "Report of the Royal Commission on Aboriginal Peoples, vol. 3", (Ottawa: Supply & Services Canada, 1996) at 127.

<sup>38</sup> World Health Report 2000, *supra* note 7.

<sup>39</sup> OECD Data 2000, *supra* note 2. Figures for 1998 are only available for three countries making it impossible to calculate an OECD average.

<sup>40</sup> National Forum on Health, *supra* note 33 at 3.

<sup>41</sup> C.M. Flood & T. Archibald, "Legal Constraints on Privately-Financed Health Care in Canada: A Review of the Ten Provinces", (Forthcoming Canadian Medical Association Journal, March 2001).

<sup>42</sup> Canadian Life and Health Insurance Association, "Facts & Figures: Canada and Out of Country", online: <http://www.clhia.ca/e4.htm> (date accessed: 11 February 2001).

<sup>43</sup> C.H. Tuohy, C.M. Flood & M. Stabile, *supra* note 34 at 15.

<sup>44</sup> A. Blomqvist, "Conclusion: Themes in Health Care Reform" in A. Blomqvist & D. M. Brown, eds., *Limits to Care: Reforming Canada's Health System in an Age of Restraint* (Toronto: C.D. Howe Institute, 1994) 399 at 416.

<sup>45</sup> Provincial medical associations are generally charged with representing physicians and promoting their professional interest. A separate body in each province, the College of Physicians and Surgeons, is charged with regulating the profession in order to protect and serve the public interest and has powers to discipline individuals who fall short of professional standards.

<sup>46</sup> J. Hurley et al., "The Madcappers: A Case Study of Physician Expenditure Caps as Financial Incentives" in M. Giacomini et al., eds., *Financial Incentives in the Canadian Health System: Executive Summary* (Ottawa: NHRDP, 1996) at 31.

<sup>47</sup> Canadian Institute for Health Information, *supra* note 30 at table 7: "Growth in Health Spending", Table 29: "How Doctors are Paid".

<sup>48</sup> Canadian Institute for Health Information, "More Registered Nurses Working Part-time and in Community-Based Care: 1997 Figures", online: <http://www.cihi.ca/facts/rn.htm> (date accessed: 23 June 1998).

<sup>49</sup> OECD Data 2000, *supra* note 2.

<sup>50</sup> CNA, Press Release, "Major Registered Nursing Shortage Looming" (4 November 1997), online: <http://www.english/whatnew/whatsnew/majshortage.html> (date accessed: 24 June 1998).

<sup>51</sup> M. Barer & L. Wood, "Common Problems, Different "Solutions": Learning from International Approaches to Improving Medical Services Access for Underserved Populations" (1997) 20: 2 Dalhousie L. J. 321-359.

<sup>52</sup> J. Lomas, J. Woods, & G. Veenstra, "Devolving Authority for Health Care in Canada's Provinces: An Introduction to the Issues" (1996) 156:3 CMAJ 371.

<sup>53</sup> Canadian Institute for Health Information, *supra* note 30 at table 9: "Where Health Care Dollars Are Spent"

<sup>54</sup> OECD Health Data 2000, *supra* note 2.

<sup>55</sup> P.C. Coyte, "Home Care in Canada: Passing the Buck", prepared for the National Leadership Roundtable on Health Reform (June 2000).

<sup>56</sup> See for example, L. Soderstrom et al. "The health and cost effects of substituting home care for inpatient acute care: a review of the evidence" (1999), 160:8 CMAJ 1151; J. Lavis et al., "Free-standing health care facilities: financial arrangements, quality assurance and a pilot study" (1998), 158:3 CMAJ 359; and K. Parr, Saskatchewan Health Services Utilization and Research Commission, *The Cost-Effectiveness of Home Care: A Rigorous Review of the Literature* (Saskatoon: HSURC, 1996).

<sup>57</sup> National Forum on Health, "Canada Health Action: Building on the Legacy: Synthesis Reports and Issues Papers" (Ottawa: National Forum on Health, 1997) at 19.

<sup>58</sup> A. P. Williams et al., "Long-term Care Goes to Market: Managed Competition and Ontario's Reform of Community-Based Services" (1999) 18:2 Canadian Journal on Aging 125; R. Deber et al., "The Public-Private Mix in Health Care", Report to the 1997 National Forum on Health (Toronto: Department of Health Administration, University of Toronto, 1996).

<sup>59</sup> Australian Institute of Health and Welfare 2000, *Australia's Health 2000* (Canberra: AIHW, 2000) [hereinafter *Australia's Health 2000*] at 234.

<sup>60</sup> Fluctuating from a high of 14.5% in 1975-76 (coinciding with the Commonwealth government taking over funding half the operating costs of the states' public hospitals and assuming most of the responsibility for funding medical services) to a low of 2.8% in both 1983-84 and 1984-85 -- *Australia's Health 2000, ibid.* at 236 (Table 5.3).

<sup>61</sup> *The Australian Health Care System: An Outline*, online: Commonwealth Department of Health and Aged Care, <[www.health.gov.au/haf/pubs/ozhealth/ozsys299.html](http://www.health.gov.au/haf/pubs/ozhealth/ozsys299.html)> (date accessed: 20 January 2001) [hereinafter *Australian Health Care System Outline*] at 235.

<sup>62</sup> Canadian Institute for Health Information, *Health Expenditures Data 2000*, (Ottawa: CIHI, 2001), available at: <http://www.cihi.ca/facts/nhex/hexdata.shtml>.

<sup>63</sup> Australian Health Care System Outline, *supra* at note 61 and J. S. Deeble, "Medicare's maturity: shaping the future from the past" (2000) 173 Medical Journal of Australia 44 at 46.

<sup>64</sup> A. Podger & P. Hagan, "Reforming the Australian Health Care System: The Role of Government" (Canberra: Department of Health and Aged Care, 1999) at 22.

<sup>65</sup> B. Ross et al., "Health Financing in Australia: The Objectives and Players", Occasional Papers: Health Financing Series, vol. 1" (Canberra: Department of Health and Aged Care, 1999) at 32.

<sup>66</sup> See IRPP Taskforce on Health Policy, "Recommendations to First Ministers" (Institute for Research on Public Policy: Montreal, 2000).

<sup>67</sup> A. Podger & P. Hagan, *supra* note 64 at 22.

<sup>68</sup> Australian Health Care System Outline, *supra* note 61.

<sup>69</sup> *Ibid.* at 94.

<sup>70</sup> OECD Data 2000, *supra* note 2.

<sup>71</sup> Australia's Health 2000, *supra* note 59 at 210.

<sup>72</sup> *Ibid.* at 221.

<sup>73</sup> John Deeble, "Unscrambling the Omelette: Public and Private Health Financing in Australia," in G. McLachlan and A. Maynard (eds.) *The Public/Private Mix in Health: the Myth and the Reality* (London: Nuffield Provincial Hospitals Trust, 1982).

<sup>74</sup> G. Gray, "Reform and Reaction in Australian Health Policy" (1996) 21 *Journal of Health Politics, Policy and Law* 3 587 at 592.

<sup>75</sup> Australian Health Care System Outline *supra* note 61.

<sup>76</sup> *Ibid.*

<sup>77</sup> *Ibid.*

<sup>78</sup> J. Deeble, "Medicare: Where have We Been? Where are We Going?" The Gordon Oration, National Centre for Epidemiology and Population Health, The Australian National University, 1999, 4.

<sup>79</sup> Australian Health Care System Outline, *supra* note 61.

<sup>80</sup> *Ibid.*

<sup>81</sup> Australia's Health 2000, *supra* note 59 at 252.

<sup>82</sup> C.H. Tuohy, C.M. Flood & M. Stabile, *supra* note 34.

<sup>83</sup> S. Duckett and T. Jackson, "The New Health Insurance Rebate", (2000) *Medical Journal of Australia* 172 (5 January 2000) 439 at 442.

<sup>84</sup> Australia's Health 2000, *supra* note 59 at 234.

<sup>85</sup> OECD Data 2000, *supra* at note 2.

<sup>86</sup> A. Podger & P. Hagan, *supra* note 64 at 23.

<sup>87</sup> OECD Data 2000 *supra* note 2 and J. White, *Competing Solutions* (Washington Brookings Institution Press, 1995) at 96.

<sup>88</sup> Australian Health Care System Outline, *supra* note 61.

<sup>89</sup> *Ibid.*

<sup>90</sup> "Nurses in Australia: their role today and tomorrow" (1996) 164 *Medical Journal of Australia* at 520.

<sup>91</sup> C. Zinn, "Role of nurses to expand in Australia" (1998) 317 *BMJ* at 617.

<sup>92</sup> Australian Nursing Federation, "Nursing numbers falling", online: Australian Nursing Federation [http://www.anf.org.au/news/news\\_professional\\_9910.html](http://www.anf.org.au/news/news_professional_9910.html) (date accessed: 29 January 2001).

<sup>93</sup> See G. Gray, "Reform and Reaction in Australian Health Policy" (1996) 21 *Journal of Health Politics, Policy and Law* 3 587.

<sup>94</sup> *Ibid.* at 587-88.

<sup>95</sup> J. S. Deeble, "Medicare's maturity: shaping the future from the past" (2000) 173 *Medical Journal of Australia* 44 at 47.

<sup>96</sup> A. Podger & P. Hagan, *supra* note 64 at 20.

<sup>97</sup> B. Ross, et al., *supra* note 65 at 39.

<sup>98</sup> OECD Data 2000, *supra* note 2.

<sup>99</sup> OECD Data 2000, *supra* note 2.

<sup>100</sup> OECD Data 2000, *supra* note 2. The OECD records government spending as a percentage of total health expenditure for 1998 as being 4.2. This is to be distinguished from the figure cited in the text which is public spending as a percentage of total health expenditure.

<sup>101</sup> P. Huijbers and A. Martin, "Health Care Insurance in the Netherlands", online: Netherlands Institute of Gerontology, <[www.nig.nl/facts&figures/healthcareinsurance\\_en.html](http://www.nig.nl/facts&figures/healthcareinsurance_en.html)> (date accessed: 12 February 2001).

<sup>102</sup> *Ibid.* 1999 Statistics for the Netherlands are from World Health Report 2000 *supra* note 7 at 176.

<sup>103</sup> The figures in this paragraph are from H. P. Uniken Venema, H. F. L. Garretsen & P. J. Van Der Maas, "Health Of Migrants and Migrant Health Policy, The Netherlands As An Example", (1995) 41(6) *Soc. Sci. Med.* 809 at 811. Despite these poorer health outcomes, the authors of the study note at 815 that qualitative and quantitative studies show, however, that Turks, Moroccans, and Surinamese are able with little impediment to access needed health care services.

<sup>104</sup> Ministerie van Volksgezondheid, Welzijn en Sport (Ministry of Health, Welfare and Sport), *Health Insurance in the Netherlands* (The Hague: Ministerie van Volksgezondheid, Welzijn en Sport, 2000) [hereinafter Health Insurance in the Netherlands] at 7.

<sup>105</sup> *Ibid.* at 21.

<sup>106</sup> *Ibid.* at 13.

<sup>107</sup> *Ibid.* at 14-19.

<sup>108</sup> F. T. Schut & H. E. G. M. Hermans, "Managed Competition Reform in the Netherlands and its Lessons for Canada", (1997) 20:2 *Dalhousie Law Journal* 437 at 451.

<sup>109</sup> Health Insurance in the Netherlands, *supra* note 104 at 56.

<sup>110</sup> *Ibid.* at 56.

- <sup>111</sup> R.L.J.M. Scheerder, "The Financing of the Dutch Health Care System" in *Health and Health Care in the Netherlands* at 165.
- <sup>112</sup> F.T. Schut, *Health Care Reform In the Netherlands: Balancing Corporatism, Etatism, and Market Mechanisms* (Den Haag: 1995) at 633.
- <sup>113</sup> *Ibid.* at 633.
- <sup>114</sup> Health Insurance in the Netherlands, *supra* note 104 at 51.
- <sup>115</sup> See W. B. F. Bouwer & F. T. Schut, "Priority Care for Employees: A Blessing in Disguise?" (1999) 8 *Health Economics* 65. See also W. Brouwer & H. E.G.M. Hermans, "Private Clinics for Employees as a Dutch Solution for Waiting Lists: Economic and Legal Arguments" (1999) 47 *Health Policy* at 7.
- <sup>116</sup> C.H. Tuohy, C.M. Flood & M. Stabile, *supra* note 34.
- <sup>117</sup> Statistics Netherlands, "Cost and financing of health care", online: Statistics Netherlands, [www.cbs.nl/en/figures/keyfigures/kgw0640z.htm](http://www.cbs.nl/en/figures/keyfigures/kgw0640z.htm) (date accessed: 2 February 2001).
- <sup>118</sup> *Ibid.*
- <sup>119</sup> OECD Data 2000, *supra* note 2.
- <sup>120</sup> This has been confirmed by E. Schut, health economist at Erasmus University, Rotterdam, the Netherlands.
- <sup>121</sup> Akved & H.E.G.M. Hermans, "The Netherlands" in *Medical Law - Suppl.* (Deventer and Boston: Kluwer Law and Taxation Publishers, 1995) at 25.
- <sup>122</sup> OECD, *Health Policy Studies No. 2, the Reform of Health Care: A Comparative Analysis of Seven OECD Countries* (Paris: OECD, 1992) at 92.
- <sup>123</sup> *Ibid.* and Akved and Hermans, *supra* note 121 at 25. See also M. M. van den Berg & J. Stevens, "Dutch hospitals: More and better cure for less money?" (undated, unpublished, archived with Colleen Flood). The authors note that hospital budgets are composed of three external functions – fixed costs (known as availability), semi-fixed costs (capacity) and variable costs (production). The budget is "filled...through a system of reimbursements per provision (at the national uniform tariffs) and reimbursements per inpatient day." J. A. M. Maarse, "Hospital Budgeting in Holland: Aspects, Trends and Effects" (1989) 11 *Health Policy* at 257, notes that about 35 percent of the budget is determined by the number of beds and the specialists in the hospital, 25 percent relates to the size of the population in the hospital's catchment area, and the balance is calculated by costing the number of admissions, patient days, out-patient surgeries, and specialist visits that have agreed to have been provided by the institution in question.
- <sup>124</sup> F.T. Schut, *supra* note 112 at 189.
- <sup>125</sup> M. van den Berg & J. Stevens, "Dutch Hospitals: More and better cure for less money?" [undated, unpublished, archived with Colleen Flood].
- <sup>126</sup> Standing Committee of the Hospitals of the European Union, "Trends in hospital financing in the European Union", online: <http://www.hope.be/07publi/leaflet/financ/fintre.htm> (date accessed: 12 February 2001).
- <sup>127</sup> OECD Data 2000, *supra* note 2.
- <sup>128</sup> C.M. Flood, *International Health Care Reform: A Legal, Economic and Political Analysis* (London: Routledge, 2000) at 107.
- <sup>129</sup> OECD, *supra* note 122 at 91.
- <sup>130</sup> F. Rutten & A. Van Der Werff, "Health Policy in the Netherlands: At the Crossroads" in G. McLachlin & A. Maynard, *The Public/Private Mix For Health: The Relevance and Effects of Change* (London: Nuffield Provincial Hospitals Trust, 1982) at 175.
- <sup>131</sup> B. L. Kirkman-Liff, "Cost Containment and Physician Payment Methods in the Netherlands" *Inquiry* (1989) 26 468 at 473.
- <sup>132</sup> A. J. P. Schrijvers, "Letter from Utrecht: The Netherlands Introduces Some Competition Into the Health Services" (1991) 266:16 *JAMA* 2215 at 2217.
- <sup>133</sup> F. T. Schut & H. E. G. M. Hermans, "Managed Competition Reform in the Netherlands and its Lessons for Canada", (1997) 20(2) *Dalhousie L.J.* 437 at 454.
- <sup>134</sup> OECD, *supra* note 122 at 99.
- <sup>135</sup> W. P. M. M. Van De Ven & F. T. Schut, "Should Catastrophic Risks Be Included In A Regulated Competitive Health Insurance Market" (1994) 39:10 *Soc. Sci. Med.* at 1468.
- <sup>136</sup> F.T. Schut & H.E.G.M. Hermans, *supra* note 133 at 452.
- <sup>137</sup> OECD Data 2000, *supra* note 2.
- <sup>138</sup> *Ibid.*
- <sup>139</sup> New Zealand Ministry of Health, "Health Expenditure Trends in New Zealand 1980-99" (Wellington: August 2000) at 47, online: <http://www.moh.govt.nz> [hereinafter Health Expenditure Trends].
- <sup>140</sup> This figure relates to non-departmental outputs excluding capital funding. The Treasury, "Budget 2000" (Wellington, 15 June 2000), online: <http://www.treasury.govt.nz/budgets>.
- <sup>141</sup> OECD Data 2000, *supra* note 2.
- <sup>142</sup> Health Expenditure Trends, *supra* note 139 at 44.
- <sup>143</sup> OECD Data 2000, *supra* note 2.
- <sup>144</sup> C.H. Tuohy, C.M. Flood & M. Stabile, *supra* note 34 at 41.
- <sup>145</sup> Health Expenditure Trends, *supra* note 139 at 60 (Appendix 6A).

<sup>146</sup> Health Expenditure Trends, *supra* note 139 at 54 (Appendix 4A).

<sup>147</sup> In the year ended June 1999, private insurers funded 10% of family doctor services, 25% of diagnostics, 17% of miscellaneous specialist services and 44.5% of private institution treatments excluding disability support services. Health Expenditure Trends, *supra* note 139 at 56 (Appendix 5A).

<sup>148</sup> For a full discussion see C.M. Flood, *supra* note 128 at 74-88.

<sup>149</sup> Ministry of Health, "Our Health Our Future – Hauora Pakari, Koiora Roa – The Health of New Zealanders 1999" (Wellington: Ministry of Health, 1999) at 83, online: <http://www.moh.govt.nz>.

<sup>150</sup> In 1997, Canada recorded an infant mortality rate of 5.5 per 1000 births [Statistics Canada, Catalogue no. 82F0075XCB, online: <http://www.statcan.ca>]; while Australia recorded a rate of 5.3 per 1000 births (OECD Data 2000, *supra* note 2).

<sup>151</sup> OECD Data 2000, *supra* note 2. These figures are the most recent that are available for all the countries cited.

<sup>152</sup> Ministry of Health, "Healthy New Zealanders: Briefing Papers for the Minister of Health 1996, vol 2, The Health and Disability Sector" (Wellington: Ministry of Health, 1996) notes, "In the 1992/93 Household Health Survey, people with a family income of \$20,000 or less were more than three times as likely as people with an income of over \$30,000 to report their health as 'not so good' or 'poor'."

<sup>153</sup> Ministry of Health, "Briefing for Incoming Minister: Facts About Health and Disability in New Zealand" (Wellington: Ministry of Health, 2000) at 33 [hereinafter 2000 Briefing].

<sup>154</sup> Health Expenditure Trends, *supra* note 139 at 37. (The figures cited are the most recent available.)

<sup>155</sup> *Ibid.* at 54 (Appendix 4A).

<sup>156</sup> *Ibid.* at 42.

<sup>157</sup> *Ibid.* at 57 (Appendix 5A).

<sup>158</sup> *Ibid.* at 23.

<sup>159</sup> Excerpts from "Health Expenditure Trends in household expenditure on health and health insurance" (NZ Institute of Economics Research Inc: Report to Health Funds Association of New Zealand, June 2000) – provided by Faye Pulley of Health Funds Association of New Zealand, by email dated 31 January 2001.

<sup>160</sup> C. Schoen *et al.*, "Equity in Health Care Across Five Nations: Summary Findings From an International Health Policy Survey" (New York: The Commonwealth Fund, May 2000) at 6.

<sup>161</sup> C. C. Grant, C. B. Forrest & B. Starfield, "Primary Care and Health Reform in New Zealand" (1997) 110 *New Zealand Med. Jnl* at 35. See C. Schoen *et al.*, *ibid.* at 6.

<sup>162</sup> C.H. Tuohy, C.M. Flood & M. Stabile, *supra* note 66.

<sup>163</sup> Health Expenditure Trends in New Zealand, *supra* note 139 at 55 (Appendix 4J).

<sup>164</sup> *Ibid.* at 22.

<sup>165</sup> Figures for 1958 from New Zealand Board of Health, Clinical and Public Health Laboratory Services, (1974) 22 Report Series, at 14 as cited by I. Hay, *The Caring Commodity -- The Provision of Health Care in New Zealand* (Auckland: Oxford University Press, 1989) at 163 and 2000 figures provided by Nicola Waugh of the New Zealand Private Hospital Association, via email on 2 February 2001.

<sup>166</sup> I. Hay, *ibid.* at 152.

<sup>167</sup> T. Ashton, A. Beasley, P. Alley & G. Taylor, "Reforming the New Zealand Health System: Lessons From Other Countries -- Report of A Study Tour Sponsored By Health Boards New Zealand" (April 1991) at 19.

<sup>168</sup> 2000 Briefing, *supra* note 153 at 25. See also T. Ashton, A. Beasley, P. Alley & G. Taylor, *ibid.*

<sup>169</sup> In general, people aged 16 years and over are required to pay the full cost of a consultation. However, higher subsidies are available to beneficiaries and people on low incomes. In addition, the government provides a substantial subsidy to family doctors for all consultations with children. For children under six the family doctor receives a subsidy of \$32.50, which means most family doctors do not need to set a part charge. (See also, 2000 Briefing, *supra* note 139 at 23-25.

<sup>170</sup> 2000 Briefing, *ibid.* at 23.

<sup>171</sup> For a description of the history of the scheme and a critique of the 1992 amendments see Rt. Hon. Sir G. Palmer, "New Zealand's Accident Compensation Scheme: Twenty Years On" (1994) 44(3) *University of Toronto Law Journal* 223.

<sup>172</sup> Since 1 July 1992 a "disability allowance" is paid in lieu of lump sum payments. Payments for pain and suffering and loss of enjoyment of life are no longer made.

<sup>173</sup> The Accident Compensation Amendment Act 1974 amended the term "personal injury by accident" to include "medical, surgical, dental or first aid misadventure". Patients suffering medical misadventure are still able to initiate common law claims for exemplary damages -- *Donselaar v. Donselaar* [1982] NZLR 97. The 1992 changes to the scheme have revived some private tort actions, such as the tort of emotional shock.

<sup>174</sup> Hon. A. King as reported in Hansard, New Zealand Public Health and Disability Bill – Introduction, 17 August 2000, online: [http://rangi.knowledge-basket.co.nz/hansard/han/text/2000/08/17\\_025.html](http://rangi.knowledge-basket.co.nz/hansard/han/text/2000/08/17_025.html) (date accessed: 19 January 2001).

<sup>175</sup> OECD Data 2000, *supra* note 2.

<sup>176</sup> Department of Health, Press Release, "Milburn insists front line NHS services must benefit from new money" (28 March 2000), online: <http://www.doh.gov.uk>.

<sup>177</sup> 10 Downing Street Newsroom, "Prime Minister's Statement on the National Health Service Plan" (27 July 2000), online: <http://www.number-10.gov.uk> [hereinafter Prime Minister's Statement].

<sup>178</sup> OECD Data 2000, *supra* note 2.

<sup>179</sup> Prime Minister's Statement, *supra* note 177.

<sup>180</sup> OECD Data 2000, *supra* note 2.

<sup>181</sup> For example, it has significantly higher death rates for ischemic heart disease than the former-West Germany or France. "Ischemic" is a condition where there is an inadequate amount of blood reaching the heart resulting in inadequate oxygen supply. J. Spiby, 'Health Care Technology In The United Kingdom', (1994) 30(1) Health Policy 295 at 296.

<sup>182</sup> See the recent National Service Framework on Cancer Services. HSC 2000/021, online: <http://tap.ccta.gov.uk/doh>.

<sup>183</sup> In introducing the National Health Service Plan in July 2000, Prime Minister Tony Blair stated that "the NHS was the greatest achievement of the post-war Labour Government. It was based on one solid founding principle: that health care should be given on the basis of a person's need not their wealth ... this side of the House will never abandon what one of the greatest civilizing acts of emancipation this century has ever known." Prime Minister's Statement, *supra* note 177.

<sup>184</sup> M. Ryan & B. Yule, "The Way to Economic Prescribing" (1993) 25 Health Policy 25 at 31.

<sup>185</sup> Figures are from the OECD Data 2000, *supra* note 2.

<sup>186</sup> C. H. Tuohy, C.M. Flood & M. Stabile, *supra* note 34.

<sup>187</sup> T. Besley, J. Hall & I. Preston, "Private Health Insurance and the State of the NHS" (London: The Institute for Fiscal Studies, 1996) at 16-17.

<sup>188</sup> See S. Lyall, "Britain's Prescription for Health Care: Take a Seat", *New York Times* (18 April 2000) at 3.

<sup>189</sup> C.H. Tuohy, C.M. Flood & M. Stabile, *supra* note 34.

<sup>190</sup> A.C. Enthoven, "NHS Market Reform" (1991) 10:3 Health Affairs 60 at 63.

<sup>191</sup> *Ibid.* at 62.

<sup>192</sup> J. Cairns & C. Donaldson, "Introduction to Economics In The New NHS", (1993) 25 Health Policy 1.

<sup>193</sup> A.J. Culyer & A. Meads, "The United Kingdom: Effective, Efficient, Equitable?", (1992) 17 J. Health Polit Policy Law 667 at 675.

<sup>194</sup> Laing & Busisson, "The Private Healthcare Industry in the UK – Private Medical Insurance – Key Statistics (1998/99)", online: <http://www.privatehealth.co.uk/laing/pmi.htm>.

<sup>195</sup> See Department of Health Newsletter 98/079, 'Fifth Annual Distinction Awards Report Published', 3 March 1998, online: <http://www.coi.gov.uk/coi/depts/GCH/coi8431d.ok> (date accessed: 30 March 1999).

<sup>196</sup> J. Culyer & A. Meads, *supra* note 195 at 674.

<sup>197</sup> For a full discussion see C.H. Tuohy, *Accidental Logics*, (New York: Oxford University Press, 1999) at 169-202 and also C.M. Flood, *supra* note 128 at 95-103.

<sup>198</sup> A. Harrison, ed., "Health Care UK 1994/95: An Annual Review Of Health Care Policy" (Bristol: J. W. Arrowsmith Limited, 1995), noted at this time there were 2,500 Fundholders. "The New NHS: Modern Dependable, A White Paper" CM 3807, 8 Dec. 1997, records the number of Fundholders at 3,500.

<sup>199</sup> C. H. Tuohy, C.M. Flood & M. Stabile, *supra* note 34. See also P. Allen, "A socio-legal and Economic Analysis of Contracting in the NHS Internal Market Using a Case Study of Contracting for District Nursing" (In press, 2001), Social Science and Medicine and A. Enthoven, "In Pursuit of an Improving National Health Service" (Nuffield Trust: London, 1999).

<sup>200</sup> J. Bartlett, comp., *Familiar Quotations*, 10th ed, rev. & enl. by N. Haskell Dole (Boston: Little, Brown & Company, 1919), online: [www.Bartleby.com/quotations/](http://www.Bartleby.com/quotations/).