Cornell University

International Comparisons, Part 2

PUBPOL 2350

November 28, 2023

The State of

THE AMERICAN DREAM

Thursday, Nov. 30 | 4:30 – 6:00 PM

Physical Sciences Building 401

Julián Castro

Cornell Brooks School Distinguished Policy Fellow

Former Secretary of Housing and Urban Development

Cornell Brooks Public Policy

BROOKS SCHOOL JOHN W. NIXON '53
DISTINGUISHED POLICY FELLOWS PROGRAM

Cornell University

YOU CAN SAVE A LIFE!

Thursday, November 30
6 - 7:30 PM
Location: MVR 1153

LIVE Narcan Education+Training!

In partnership with:

ADC Alcohol & Drug Council of Tompkins County, Inc.

SIGN UP!

Today's Topics

1. **Structure:** Describe how the health care system is structured in 4 other high-income countries that spend much less than the U.S.

2. **Lessons Learned:** Do these countries offer lessons for how the United States could provide universal coverage, improve quality, and/or reduce medical costs

1. Canada Has a Single-Payer, Universal Health Insurance System

- Entire population is covered by the same health insurance plan, with some small differences across the 13 provinces.
- Benefits and covered services of the federal plan are uniform within a province (i.e., no ability to choose a different federal health plan).
- People cannot “opt out” and purchase private insurance as a replacement (although 67% have supplemental insurance, such as for prescription drugs, dental care, vision care, home care; this accounts for 12% of total national spending).
- Patients required to pay little (e.g., small drug co-payment) or nothing out-of-pocket, which creates substantial moral hazard (i.e., demand for medical care is high).
- Patients can choose any physician/hospital.

This Seems Too Good to be True

How does Canada control medical expenditures if everybody has coverage, there is little patient cost sharing, and no restrictions on which physicians and hospitals a patient can see?

Controlling Costs in Canada

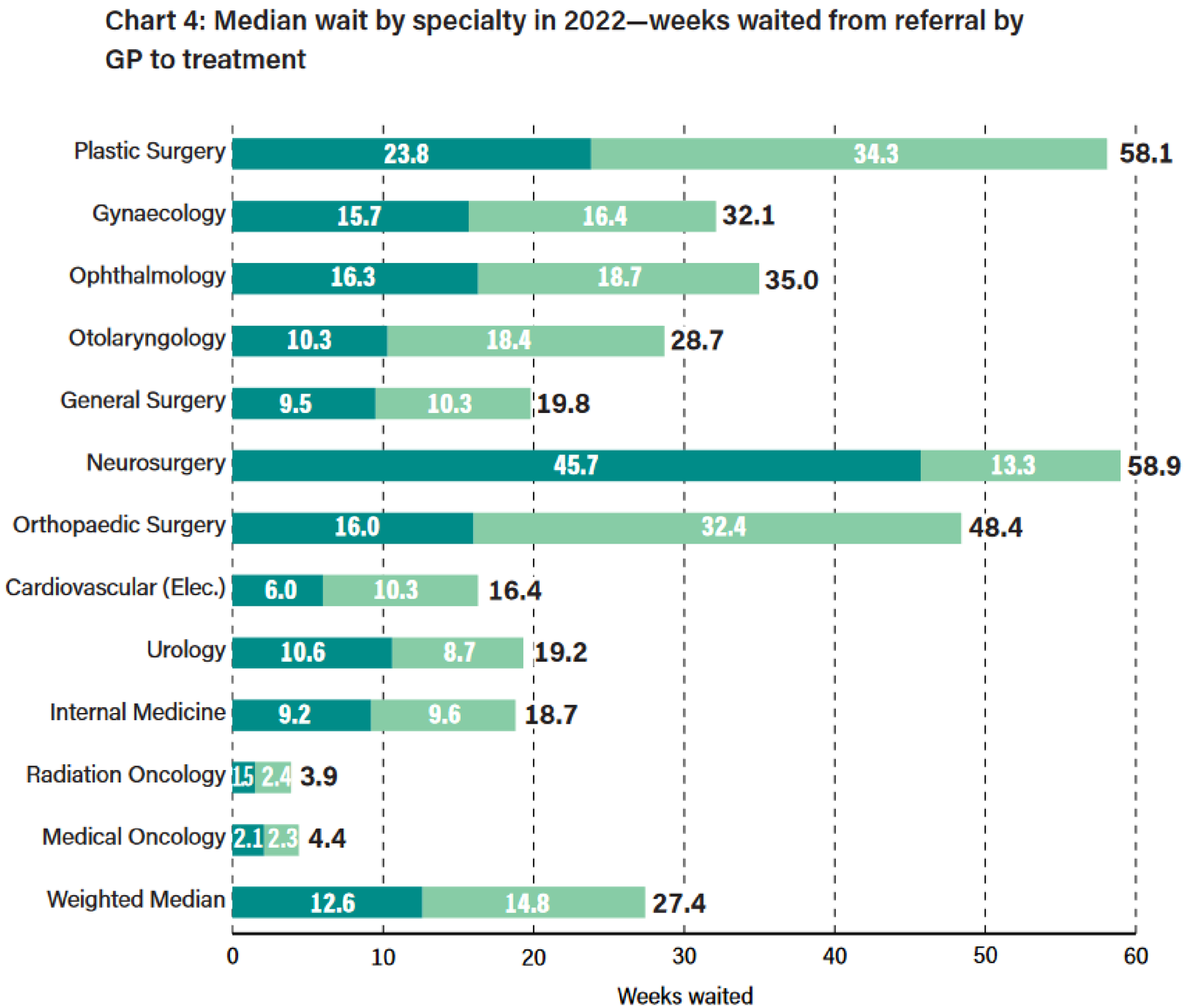
- Federal government provides each province with some funds (from federal taxes); remainder is financed by provincial income taxes.
- Provinces set a budget, which cannot be exceeded, for each hospital. Amount of hospital spending is a political decision made in advance, with resolve.
- Cost control requires rationing services, paying low fees/prices.
- Most MD are independent, not employees of government or a hospital.
- Provinces set MD fees and pay fee-for-service. MDs must accept fee as final payment. There is no negotiation.
- MD income is controlled; once a MD's practice revenue exceeds a threshold, he/she is paid 25% of the original fee per visit/procedure. One implication of price control: see next slide.
- Because costs to patients are zero/low and payments to providers are low (and set by government), demand for medical care exceeds supply (see slide 9).
- Administrative costs are low because there is only 1 payer; easy for providers to follow the rules of a single, national health insurer. (See later slide).
- 67% of people have complementary private insurance for prescription drugs and dental care, which are not included in the universal insurance benefits.

One Consequence of Price Controls: Physicians Earn Much Less in Canada Than the U.S. ($000s)

	Primary care MDs	Specialist Physicians
United States	$218	$316
Canada	$146	$188
France	$112	$153
Germany	$154	$181
UK	$135	$172
Japan	$125	N/A

Source: Papanicolas et al., JAMA, March 13, 2018.

Canada Has Long Waiting Lists (or Queues)



Canadian government pays for some citizens to receive treatment in the U.S. to keep queues from getting too long

U.S. Rations Medical Care Via Patient Cost Sharing; Other Countries (Canada and UK) Tend to Use Supply Restrictions

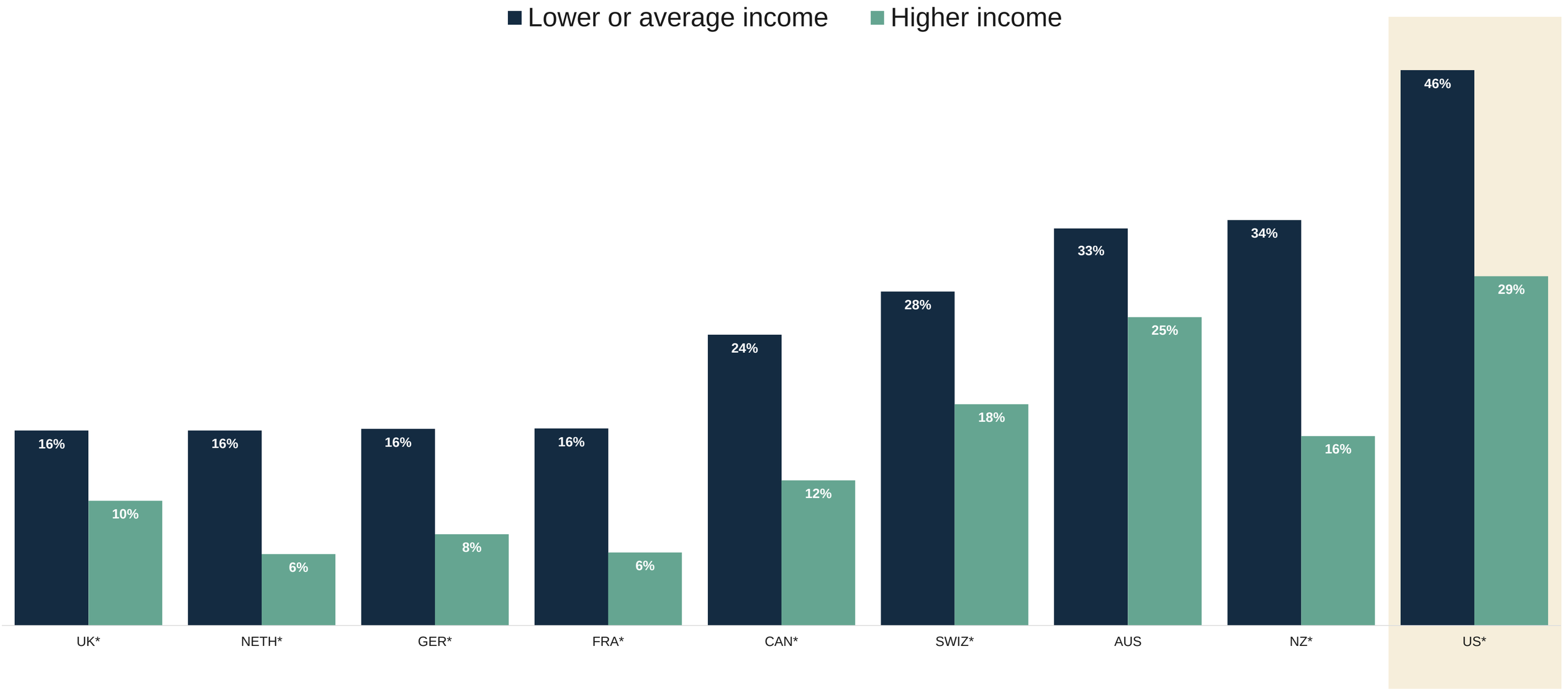
Adults' Access to Medical Care Based on Surveys, 2016

	Waited 6+ days to see an MD	Waited 2+ months to see a specialist	Elective surgery wait	
			< 1 month	4+ months
US	18%	6%	86%	4%
UK	24%	19%	60%	12%
Germany	34%	3%	61%	0%
Canada	29%	30%	46%	18%

Source: Commonwealth Fund, "Mirror, Mirror: 2017."

U.S. Rations Medical Care Via Patient Cost Sharing; Other Countries (especially Canada) Tend to Use Supply Restrictions

Percentage of adults who had a cost-related access problem in the past 12 months



^ Cost-related access problem includes responding “yes” to at least one of the following because of the cost: had a medical problem but did not visit a doctor; skipped a medical test, treatment, or follow-up that was recommended by a doctor; did not fill a prescription for medicine; or skipped doses of medicine. * Indicates the difference between lower or average income group and higher income group within country is statistically significant at p<.05 level; in Australia, that difference is statistically significant at p<.01 level.

Data: Commonwealth Fund International Health Policy Survey (2023).

Source: Munira Z. Gunja et al., *The Cost of Not Getting Care: Income Disparities in the Affordability of Health Services Across High-Income Countries — Findings from the Commonwealth Fund’s 2023 International Health Policy Survey* (Commonwealth Fund, Nov. 2023). https://doi.org/10.26099/jbe9-c870

The Commonwealth Fund

There Are 2 General Methods of Limiting Growth in Medical Spending Without Reducing Quality Too Much (i.e., reducing low VALUE medical care)

Demand-Side (patient)

- Ask patients to pay a substantial amount of the price of medical care (e.g., high deductible)
- Let patients choose which technologies/treatments are worth it (almost all technologies are available)
- "Self-rationing"
- US-favored method

Supply-Side (provider)

- Government/insurer chooses which technologies to pay for and promote
- Sets low prices, and/or restricts access to technologies (e.g., queues)
- "Payer-rationing"
- European-favored method.
  Also Canada and U.S. managed care companies tried this in 1990s.

Discussion

What would happen if the U.S. substantially reduced physician fees, hospital payments, and required long queues for elective procedures?

2. United Kingdom: Government Pays For (via taxes) AND Provides Medical Care

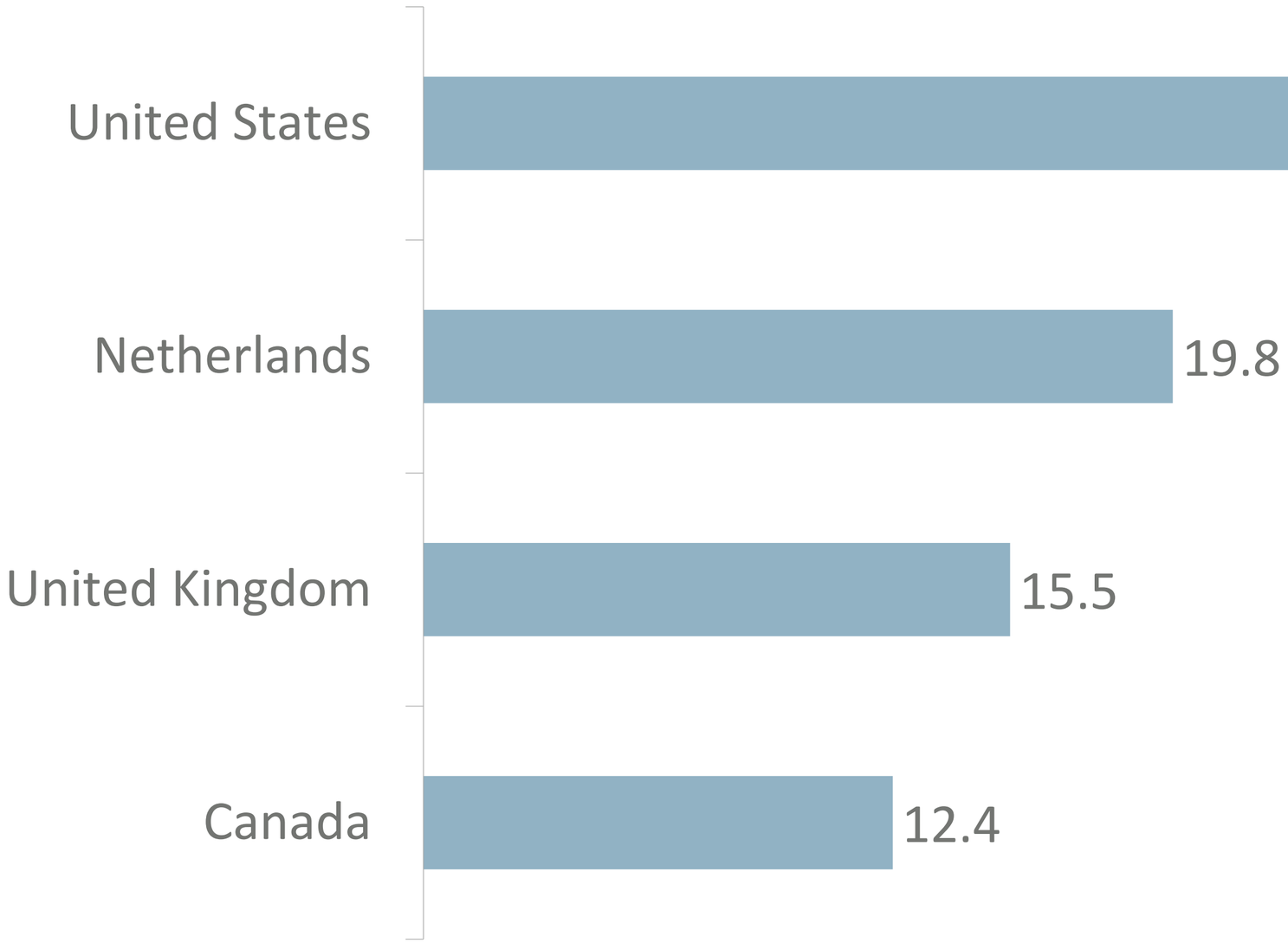
- All citizens entitled to receive medical care from the National Health Service (NHS). No insurance involved at all.
- Paid for with progressive income taxes (i.e., those with higher incomes pay higher taxes). No insurance premiums.
- Most hospitals owned by government. Hospital-based physicians (i.e., specialists) are government employees and are paid a salary.
- Most primary care MDs are private contractors w/ govt. Paid capitation with some fee-for-service payments and (potentially) large bonuses.
- 11% of people purchase private insurance that supplements but does not replace the basic NHS services: can receive elective care at private hospitals that have shorter waits/queues.

NHS Advantages (Apply to Canada as Well)

- Effectively a single (dominant) payer system that allows NHS to negotiate low prescription drug prices, limit MD income, and limit hospital spending.
- Less spent per capita on medical services because:
  - Government uses negotiating power and political will to drive down prices, MD fees/salary, hospital budgets.
  - Restrict use of expensive goods/services due to cost effectiveness threshold requirement (e.g., only approve and promote cost-effective drugs).
  - Low administrative costs due to single payer.

Multiple Health Insurers in U.S. Creates Greater Complexity and Higher Administrative Costs

Administrative costs as a % of hospital costs, 2010



Annual cost <u>per physician</u> to interact with health insurers:

- **Canada: $22,000**
- **U.S.: $83,000**

Cornell University

Source: Himmelstein et al., *Health Affairs*, September 2014; Morra et al., Health Affairs, 2011.

The United Kingdom Keeps Its Spending Low, In Part, By Requiring People to Wait for Non-Emergent Elective Care

2:25 – 5:00

https://www.pbs.org/video/the-best-health-care-1598993655/

Please watch the entire 9-minute UK video for this lecture

Source: PBS, “The Best Health Care? America and the World,” 2020.

NHS Disadvantages

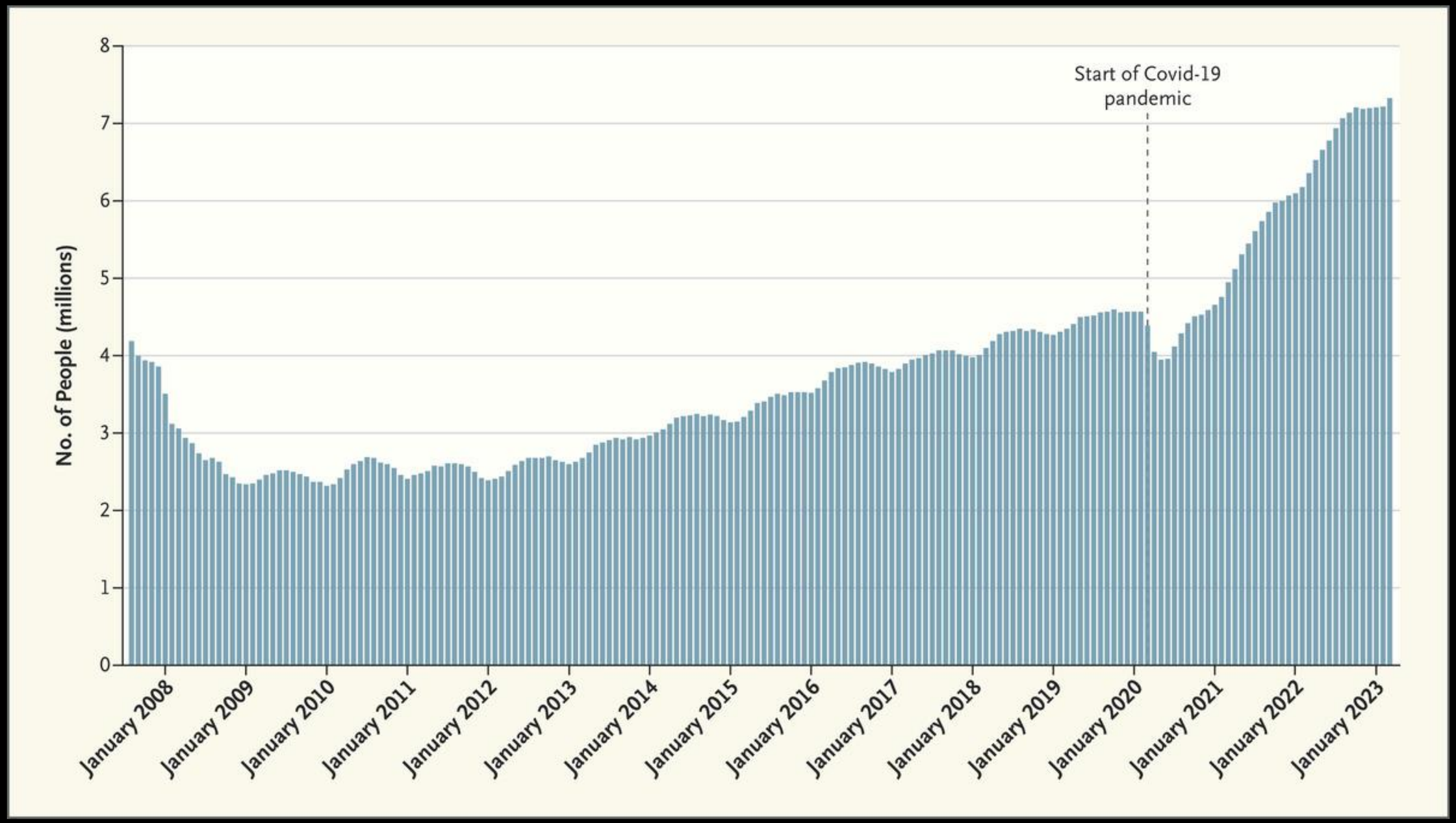
- Low budget levels limit in advance the amount of medical care people can receive. Explicit, planned rationing.

- Rationing and queuing, as with Canada. 7 million people (in a country with a population of 66 million) are now on a waiting list for an elective procedure (see next slide). Over 300,000 of these people have been waiting for over 1 year.

- Weaker incentives for innovation and efficiency (i.e., “civil service mentality”) because physicians and hospitals are not subject to as much competition as in the U.S.

Source: Hunter, 2023; Butini, Wall Street Journal, December 2021; Yeginsu, New York Times, July 19, 2020.

Number of People on National Health Service Waiting Lists for Consultant-Led Elective Care, August 2007 to March 2023.



DJ Hunter. N Engl J Med 2023;389:100-103.

The NEW ENGLAND JOURNAL of MEDICINE

UK Implemented Several Reforms to Promote Competition and Higher Quality

- Pay-For-Performance program: primary care physicians can now receive large (e.g., $60,000 per year!) bonus payments if they provide high-quality care.

- Decentralization: primary care physicians have been given more authority over how the NHS money is spent.

- Competition: encouraging more competition between hospitals and between other medical providers (to improve quality) by allowing non-NHS facilities to receive some government funding.

Source: Black, *New England Journal of Medicine*, 2013; Doran et al., *New England Journal of Medicine*, 2006

Videos of German Health Care System

26:40 – 29:25

32:10 – 34:10

Cornell University

Source: PBS, “Sick Around the World.”

3. Germany: Closest to U.S. System

- Individual mandate: people must belong to an approved sickness fund (i.e., insurance plan). 90% choose a statutory/ social insurance plan and 10% (high-income) a private insurance plan. Statutory plans do not differ much from one another.
- Employers and unions offer sickness funds; employers and workers contribute to sickness funds about 50-50 (about 15% of wages, split between employer and worker).
- All sickness funds are non-profit.
- Government pays insurance premiums for unemployed or low-income. The individual mandate is enforced/binding.
- Sickness funds pay primary care physicians with capitation, which encourages physician-led rationing of their time.
- Hospitals pay specialist physicians a salary.

Source: Gusmano et al., Health Affairs, November 2020.

Videos of Japanese Health Care System

13:55 – 15:50

16:45 – 18:45

19:05 – 20:15

Cornell University

Source: PBS, “Sick Around the World.”

4. Japan: Like Germany, Has Multiple Payers

- Explicitly modeled after German system.
- Employers mandated to offer private health insurance to employees.
- Workers must choose the plan their employer offers.
- National health insurance plan available for non-workers.
- Employees split health insurance premium with their employer and contribute about 10% of their salary, on average.
- Private health insurance premiums are adjusted only by a person's age, not their health status – (slightly) modified community rating.
- Co-insurance rates are 30% – substantial patient cost sharing.
- Non-profit health insurers are very similar: they all cover the same services, use the national fee schedule to pay providers, and allow patients to see all eligible providers.

Source: Gusmano et al., Health Affairs, November 2020.

More Details on the Japanese Health Care System

- Patients often bypass primary care MDs, who are in short supply, and start their care by seeing a specialist.

- National price controls on provider fees and drugs. Physician fees are about 25% of Medicare's! Major cost control mechanism. All insurance plans use the same fee schedule.

- Citizens receive a relatively large # of physician visits and prescription drugs. Physicians prescribe and sell drugs.

- Hospitals pay specialists a salary.

Discussion

What feature(s) of these other 4 health care systems has the greatest chance to be implemented in the United States?

International Comparison Conclusions

- Some countries achieve universal coverage by providing coverage or medical care to everyone; others by truly mandating it.
- Universal coverage in and of itself does not control costs.
- Other countries control costs through combination of: rationing via supply controls and capitation; price controls; employing MDs/hospitals (and controlling their pay); setting hospital budgets.
- Private markets (U.S.) good at allowing choice/variety for consumers; allowing prices to increase the provision of medical services when patients demand it (i.e., less rationing and queues); incentives for innovation; and more technology (when patients are willing and able to pay for it).
- Government-run or regulated markets better at providing universal coverage (and access?), equity, and controlling spending.