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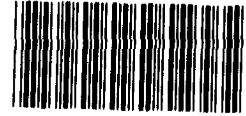

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CANADIAN HEALTH INSURANCE:

Lessons for the United States

Statement of
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Before the
Committee on Government Operations
House of Representatives

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SUMMARY OF STATEMENT OF COMPTROLLER GENERAL CHARLES A. BOWSHER ON LESSONS OF THE CANADIAN HEALTH INSURANCE SYSTEM

Canada's health financing system is instructive because it incorporates three principles that GAO believes should guide U.S. health care reform: universal health insurance, uniform reimbursement rules, and systemwide spending controls.

Canada has been more successful than the United States in constraining the growth in health care spending, even while providing health insurance to all its residents. Measured either on a per capita basis or as a share of the gross national product, health care costs in Canada have risen at a slower pace than in the United States. GAO believes that Canada's lower spending is the result of its streamlined administration of health insurance and controlled reimbursements to physicians and hospitals.

In 1987, Canada's per capita spending on insurance administration was only one-fifth that of the United States. Canada spends less because its publicly financed single-payer system eliminates the costs associated with marketing competitive health insurance policies, billing for and collecting premiums, and evaluating risks.

For physician services, Canada spent 34 percent less per person in 1987 than did the United States. This difference is largely the result of Canada's controls on physician fees. In addition, Canadian physicians have lower practice expenses for billing and malpractice premiums.

For hospital services Canada spent 18 percent less per person in 1987 than the United States. GAO attributes the difference to Canada's system of allocating budgets to hospitals in lump sums, limiting hospitals' acquisition of high technology, and hospitals' lower administrative costs under a simplified reimbursement system.

However, tight hospital operating budgets and restraints on acquiring expensive medical technology have resulted in waiting lines, called "queues," for some high technology and specialty procedures. Emergency patients rarely wait for services, but queues for elective surgery and diagnostic procedures may result in delays that are several months long.

If the Canadian system's key features--universal coverage, a single payer, and systemwide spending controls--were applied in the United States, the savings in administrative costs alone would be more than enough to finance insurance coverage for the millions of Americans who are uninsured. But any reform should retain the strengths of the current U.S. health care system, like the continuing development of advanced medical technology, detailed management information systems, and the flexibility to incorporate alternative service delivery mechanisms, such as health maintenance organizations.

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss the implications of the Canadian health insurance system for U.S. health care reform. The health care system in the United States is in crisis. Rapidly rising expenditures now account for more than 12 percent of the gross national product (GNP). Even though these costs are the highest in the industrialized world, over 32 million Americans, many of whom are working adults, lack health insurance, and many American businesses are being impaired financially under the weight of providing costly employee health benefits.

In light of these problems, leaders of Congress are examining a variety of health financing reform options. You asked us to report on whether the Canadian health care system had useful lessons for the United States, and today we are releasing that report. Canada's health financing system is instructive because it incorporates three principles that we believe should guide our own health care reform efforts. They are: universal health insurance, uniform reimbursement rules, and systemwide spending controls.

In brief, we found that if the United States were to adopt the key features of the Canadian approach, it could offer health insurance to all residents without adding to national health expenditures.

The key features of the Canadian health care system are:

-- Universal access to care through full health insurance coverage of medically necessary services.

-- Health insurance administered in each province by a single government agency that is the sole source of payment to almost all providers of medical care.

-- Systemwide policies for controlling health expenditures, including global budgets for hospitals and uniform fee schedules for physicians.

Canada's health system also has important features in common with the U.S. system. Canadians choose their own private physicians. Most physicians are compensated on a fee-for-service, rather than salaried, basis. And most hospitals are private, nonprofit institutions.

KEY FEATURES HELP CANADA CONTAIN SPENDING GROWTH

Canada has a better record than the United States in controlling the growth of health care spending even while providing full health insurance coverage for all residents. In 1971, when Canada fully implemented its system for financing medical services, the two

countries spent the same share of GNP--about 7.5 percent--on health care. By 1989, the U.S. share was 11.6 percent, whereas Canada's was 8.9 percent. In that same year, Canada spent roughly $1,700 per person on health care whereas the United States spent over $2,300 per person. The differences--some $600 per person per year--reflect Canada's lower spending on insurance administration and physician and hospital reimbursement.

Canada spends less on insurance because its publicly financed single-payer system eliminates the costs associated with marketing competitive health insurance policies, billing for and collecting premiums, and evaluating insurance risks. As a result, in 1987, the latest year for which comparable data are available, Canada's per capita spending on insurance administration was only one-fifth that of the United States.

In that same year, Canada also spent 34 percent less per capita on physician services than did the United States. We attribute the difference in large measure to Canada's controls on physicians' fees. In Canada, physician associations in each province set reimbursement rates for each service. The associations negotiate rate increases with the provincial government each year. The provincial government uses its power as the single payer to restrain growth in costs. Between 1971 and 1985, after adjusting for inflation, Canadian physician fees decreased 18 percent, while those of U.S. physicians rose 22 percent. In addition, Canada

prohibits physicians from charging fees that are additional to the fixed reimbursement rate; this is a common practice in the United States known as "balance billing."

We also attribute Canada's lower spending for physicians to lower practice expenses. Unlike their U.S. counterparts, Canadian physicians need not maintain an extensive office staff for insurance record keeping, direct billing of patients, or collecting bad debts. In 1987, Canadian physicians spent an average of 36 percent of their gross income on professional expenses, compared with 48 percent for U.S. physicians. In addition, in the same year, malpractice insurance premiums for U.S. physicians averaged 10 times those of their Canadian counterparts. This is more a reflection of differences in the tort systems, however, than in the health insurance systems.

In 1987, Canada spent 18 percent less per person for hospital services than did the United States. We believe that this difference is chiefly attributable to Canada's system of global, or lump-sum, budgeting and its limits on the acquisition of high technology. In Ontario, for example, the Ministry of Health sets each hospital's annual operating budget prospectively. The Ministry also decides which hospitals may acquire expensive high-technology equipment and which may provide expensive specialized services. To stay within budget, hospitals have an incentive to

manage with smaller hospital staffs and to avoid buying expensive equipment, except when authorized by the Ministry.

As with physicians, Canada's streamlined payment system permits hospitals to have far lower administrative costs than their U.S. counterparts. A Canadian hospital has virtually no billing department and a minimal accounting structure to assign costs and charges to patients and physicians. However, Canadian hospitals have substantially less detailed information on the cost of particular services than is available in a well-administered U.S. hospital.

OTHER CONSEQUENCES OF CANADIAN COST-CONTAINMENT POLICIES

An oft-cited consequence of Canada's regulated supply of high technology is limited access to a few important services. Canada's ample supply of physicians, including primary caregivers, allows ready access to most medical services. In fact, Canadians make more physician visits and have longer hospital stays than Americans. However, for high technology and specialty services, tight hospital operating budgets and restraints on the diffusion of expensive medical technology require Canadians to wait in line, or "queue." These treatments include open-heart surgery, magnetic resonance imaging, cataract surgery, and hip replacements. Patients with immediate or life-threatening needs rarely wait for

services but queues for elective surgery and diagnostic procedures may results in delays of several months. To some degree, hospital capacity in the United States is a safety valve if Canadian queues become a problem, but such "border jumping," at least in Ontario, is not extensive.

In addition, attempts to control spending for physician and hospital services have encouraged provider practices that may be inefficient. For example, controls on physician fees have been accompanied by substantial increases in the provision of physician services, partially eroding the effectiveness of the fee schedule. Also, fixed budgets provide hospitals the incentive to retain low-cost patients for long stays while offering no incentive to collect detailed patient data for utilization review or other management purposes.

POTENTIAL SAVINGS OFFSET COSTS OF PROVIDING UNIVERSAL ACCESS

The key lesson of the Canadian experience is that it is possible to have universal coverage of health care without incurring additional costs, if reform also includes simplification of the payment system and more effective expenditure control. We estimate that the administrative savings achievable through the introduction of a Canadian-style payment mechanism are sufficient to finance the extra services associated with a system of universal access modeled

after Canada's. The cost of serving the newly insured could be about $18 billion, and the cost of providing additional services for those currently insured--stemming from the elimination of copayments and deductibles--could be about $46 billion. In the short run, these costs could be offset by $34 billion in savings in insurance overhead and by another possible $33 billion in savings in hospital and physician administrative costs.

In the long run, effective limitations on provider payments through global budgeting and negotiated physician fees, as well as controls on future expensive technology, could significantly constrain the growth of U.S. health spending, leading to substantial future savings.

CONCLUSION

Canada's 20-year experience with universal health insurance reveals a system that, on the whole, has much merit but is not without some flaws. On the positive side, Canada has demonstrated the ability to expand health insurance to all residents while retaining a greater degree of control over costs than has the United States. On the negative side, Canada has developed queues for selected services.

Our work over the last several years has convinced us that the United States needs to develop a comprehensive approach to health

care reform if it is to bring costs under control and achieve equitable access for all. That approach should build on lessons learned from Canada and other countries while preserving the unique features of the American health care system. It should borrow from Canada those concepts that work, such as universal access, a uniform payment system, and expenditure controls for physicians and hospitals. But it should retain the strengths of the current U.S. health care system, for example the continuing development of advanced medical technology, detailed management information systems, and the flexibility to incorporate alternative service delivery mechanisms, such as health maintenance organizations.

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Mr. Chairman, this concludes my statement. I would be happy to answer any questions.