INSTITUT C.D. HOWE INSTITUTE

COMMENTARY
NO. 621

Going Dutch: Choice, Competition and Equity in Healthcare

The Netherlands provides a good example of how managed competition can promote efficiency while preserving the principles of universal insurance and an equitable sharing of the cost.

Åke Blomqvist

About The Author

Åke Blomqvist
is Adjunct Research Professor, Carleton University; Fellow-in-Residence, C.D. Howe Institute.

The C.D. Howe Institute's Commitment to Quality, Independence and Nonpartisanship

The C.D. Howe Institute's reputation for quality, integrity and nonpartisanship is its chief asset.

Its books, Commentaries and E-Briefs undergo a rigorous two-stage review by internal staff, and by outside academics and independent experts. The Institute publishes only studies that meet its standards for analytical soundness, factual accuracy and policy relevance. It subjects its review and publication process to an annual audit by external experts.

As a registered Canadian charity, the C.D. Howe Institute accepts donations to further its mission from individuals, private and public organizations, and charitable foundations. It accepts no donation that stipulates a predetermined result or otherwise inhibits the independence of its staff and authors. The Institute requires that its authors disclose any actual or potential conflicts of interest of which they are aware. Institute staff members are subject to a strict conflict of interest policy.

C.D. Howe Institute staff and authors provide policy research and commentary on a non-exclusive basis. No Institute publication or statement will endorse any political party, elected official or candidate for elected office. The views expressed are those of the author(s). The Institute does not take corporate positions on policy matters.

Commentary No. 621
April 2022

Daniel Schwanen
Vice President, Research

$12.00
ISBN 978-1-989483-86-2
ISSN 0824-8001 (print);
ISSN 1703-0765 (online)

The Study In Brief

While medical and pharmaceutical technologies have changed dramatically over the last 50 years, the basic features of Canada's single-payer system for financing and delivering healthcare have remained largely unchanged. Though there have been many calls for reform, they have been controversial and none have led to significant changes. To break the logjam, Canada should start a serious debate about introducing a model with competing insurance plans among which people can choose. A carefully designed system of managed competition among multiple payers can preserve the principle of universal insurance and access to healthcare, without worsening overall economic inequality, and be more likely to produce urgently needed organizational innovation.

Innovations aimed at making the various professionals and other resources in healthcare work more efficiently together have been undertaken in many countries. In the US, they were central to the "managed care revolution" in the 1990s. In the UK, general practitioners serve as the "medical homes" for patients on their roster, and as gate-keeping managers of the care the patients receive from other providers including specialists. Like Canada, the UK has a single-payer financing system, but it has considerably lower per capita costs, and because its performance usually is ranked above Canada's in international comparisons, many have suggested the UK as a model for reform here. However, in a single-payer system which covers all patients and providers, getting a politically acceptable agreement among all parties for major changes may be very difficult; the divided federal-provincial jurisdiction over healthcare in Canada adds to the problem.

In a system where consumers can choose among competing health plans, in contrast, system change can happen gradually and with less controversy as providers and plans experiment with new methods of funding and organizing production, and consumers gravitate towards those that are most successful. The Netherlands provides a good example of how managed competition can promote efficiency while preserving the principles of universal insurance and an equitable sharing of the cost. Universality is ensured by means of compulsory insurance, and equity is attained through requirements that plans have open enrollment and through a system of government-funded risk-adjusted vouchers that people can use as partial payment of the premiums charged by the plans they choose.

One way of making the proposal to transform Canada's system into a multi-payer model less controversial would be to treat existing provincial health insurance plans as a default option, meaning that everyone would continue to be covered by their provincial plan unless they explicitly chose to opt out and get coverage through an approved substitute plan. To set the process in motion, provinces could introduce a choice for consumers between two alternative public-sector plans. Individuals would be allowed to opt out of the traditional plan and choose an alternative government plan with gate-keeping primary-care practitioners, as in the UK, in which patients would agree to get all their care from the practice that has them on its roster, or through a referral from that practice.

Policy Area: Health Policy.
Related Topics: Access to Care; Healthcare Delivery and Management; Insurance; International Health Comparisons.
To cite this document: Blomqvist, Åke. 2022. *Going Dutch: Choice, Competition and Equity in Healthcare.* Commentary 621. Toronto: C.D. Howe Institute.

C.D. Howe Institute Commentary© is a periodic analysis of, and commentary on, current public policy issues. James Fleming edited the manuscript; Yang Zhao prepared it for publication. As with all Institute publications, the views expressed here are those of the author and do not necessarily reflect the opinions of the Institute's members or Board of Directors. Quotation with appropriate credit is permissible.

To order this publication please contact: the C.D. Howe Institute, 67 Yonge St., Suite 300, Toronto, Ontario M5E 1J8. The full text of this publication is also available on the Institute's website at www.cdhowe.org.

While medical and pharmaceutical technologies have changed dramatically over the last 50 years, the basic features of Canada's single-payer system for financing and delivering healthcare have remained largely unchanged.

Over the years, many reforms to better control costs and improve its performance have been proposed, and many have been tried out in various pilot projects. But none has led to major changes; the Canadian healthcare system's resistance to reform has assumed almost legendary status (Bliss 2010, Lazar et al. 2013, Tuohy 2018).

In this *Commentary*, I argue that once a single-payer financing model has been established, major health system reform becomes very difficult politically. Given this, Canada should start a serious debate about the possibility of replacing ours with a model with several competing payers from which people can choose. Countries like Australia, Israel, and the Netherlands have shown that it is possible to design such a model in a way that preserves the principle of universal access to care and an equitable sharing of the cost. I believe Canada should follow a similar path.

To start with, provinces should eliminate the laws and regulations that currently prevent or discourage the provision of health services outside of the provincial health insurance plans. Later on, they should introduce a new set of rules that would give people a choice between staying with their provincial plan or opting out and enrolling in an approved substitute plan, private or public.

Needless to say, these are controversial proposals. But as I explain below, a carefully designed system with these features would not be incompatible with the principle of universal insurance and access to healthcare, or worsen overall economic inequality. Those who support our current single-payer health-financing model will say that the proposals are contrary to principles that make the Canadian system superior to that in the US, even if they agree that Canada's healthcare system is in need of reform. While I agree that Canada's healthcare system is vastly preferable to that in the US, I do not believe that this is due to the single-payer feature. There are several countries with healthcare systems whose performance has been rated as equal to or better than Canada's, in terms of both efficiency and equity, where consumers can choose among multiple plans. We should draw on the example of these pluralistic systems and try to set up a model in which some degree of regulated public-private competition helps move us away from the expensive and unwieldy healthcare system in which we appear to be currently stuck. In the short term (and perhaps for some time to come), the most pressing concern for health policymakers in Canada is likely to be how to supply the increased number of doctors and nurses that will be needed to deal with the health problems of the aging babyboomers. However, it is not too early to give more attention to longer-term issues of fundamental reform as well.

All high-income countries other than the US have healthcare financing systems with universal coverage because they value equity, but not all of them have a single plan that covers everyone.

The author thanks Rosalie Wyonch, Parisa Mahboubi, Ramisha Asghar, Marcel Boyer, Tom Closson, Janet Davidson, Peter Glossop, Marcel Saulnier and anonymous reviewers for helpful comments on an earlier draft. The author retains responsibility for any errors and the views expressed.

Key Concept Explainer

Universal Healthcare: The Multi-payer Option

In Canada, health insurance coverage is universal. Each province and territory has an insurance plan that gives every resident access to "medically necessary" physician and hospital services at no out-of-pocket cost to the patient. This contrasts with the US, where health insurance coverage is not universal, and a substantial number of people are covered neither by a public nor a private plan and hence may not have access to even urgently needed care if they don't have the means to pay for it. Because doctors and hospitals in Canada get virtually all the revenue they are paid for their services from a single source – the plan in the province or territory where they are located – Canada is often said to have a "single-payer" system of healthcare financing.

But while universal access in Canada's provinces and territories is provided through a single-payer plan that covers everyone, a number of other countries with universal coverage offer consumers a choice among several competing insurance plans – the multi-payer option. Examples are the Netherlands, Germany, Switzerland, and Australia. As the example of the Netherlands shows, a universal system with compulsory insurance and many competing payers can be designed so that the burden of paying for healthcare is shared equitably (in the Dutch case, through a system of risk-adjusted healthcare vouchers for individuals).

Canada's experience with a single-payer system shows that political considerations may make it very difficult to adapt and reform the organization of the healthcare system in response to changing medical and pharmaceutical technology. In a universal model of managed competition among several payers, adapting the system to changing circumstances may be easier to accomplish, as patients and providers can switch to plans that meet their needs most successfully. Canada could move gradually toward such a system by designating the existing provincial-territorial plans as the default option, and allowing residents to opt out of the provincial plans and use a risk-adjusted voucher to pay all or part of the cost of an approved substitute plan instead.

After providing the background to the discussion in Section 1, in Section 2, I consider the origins of the Canadian single-payer model,[1] and compare it with that in the UK, whose single-payer National Health Service was established in 1948 and served as an example when the Canadian system was formed. Although single-payer models may be equitable, they are difficult to manage and less able to adapt to changing medical technology than models with multiple competing plans from which consumers can choose. Section 3 discusses one such model of "managed competition," that of

1 I follow convention here and disregard the fact that the Canadian system still would not meet a strict legalistic definition of "single-payer": Our provincial plans don't have universal coverage against items like pharmaceuticals or long-term care, and some population categories (e.g., those in the Armed Forces) are covered by separate plans.

the Netherlands, in some detail and considers the possibility of reforming Canada's healthcare system along the lines of the Dutch one. Section 4 provides concluding thoughts.

SECTION 1: THE BACKGROUND

Universal Access to Healthcare: How it Promotes Equity

Universal access to healthcare must reasonably be seen as one aspect of a broader societal objective: that of reducing inequality by redistributing material resources toward those whose standard of living or welfare would otherwise, through no fault of their own, be below a tolerable level. With the exception of the US, all rich countries in the world today have programs that guarantee universal access to healthcare.

In designing healthcare policy, governments must pay attention to two kinds of inequality and redistribution. The first and most obvious is between those who are sick and those who are well: a well-functioning system of healthcare financing must ensure that everyone in society has enough resources to access care when they are sick and need it. A single-payer financing model in which there is one government insurance plan that pays the full cost of everyone's healthcare obviously accomplishes this.

The second dimension of health-related inequality and redistribution is more subtle. While private insurance can be used as a tool to create access to care for everyone when they need it, the cost at which it does so can vary greatly from person to person. In unregulated private insurance markets, the terms on which individuals can get coverage would depend on the expected cost of the care they are likely to need over the period that the plan covers.[2] This expected cost can be highly variable depending on factors such as age and sex, the illness histories of the individuals and their families, diagnosed pre-existing conditions, and so on. A single-payer financing model in which universal health insurance is supplied under a tax-financed government plan eliminates this form of inequality as well. It redistributes resources not only between the sick and the well, but also between high-risk individuals with high expected healthcare costs and healthier ones with lower risk of illness (Blomqvist and Horn 1984).[3]

Because the US does not have universal health insurance, health-related inequality still exists there to a substantial extent, both with respect to access to care and with respect to the cost of insurance.[4] A large number of Americans still have little or no insurance, and hence may have major access issues when they are sick. Among those who are privately insured, those with high expected costs because of factors such as previous illness history often must pay much higher premiums than others, if they can get insurance at all. Not surprisingly, therefore, when comparing our single-payer model of health financing with the mixed public-private, multiple-payer system in the US, most Canadians strongly

2 In real-world insurance markets, the consequences of this issue are mitigated to some extent by the fact that most private health insurance is supplied via employment-related group plans, and by regulatory rules that real-world plans must obey.

3 While it is clear that a tax-financed single-payer system contributes to reduced *health-related* inequality, whether or not it contributes to reduced overall inequality (in net income after taxes and transfers) also depends on the extent to which the tax system is progressive. I return to this issue in a later section.

4 The US does, however, have public plans for specific population groups; see Box 3 below.

prefer ours.[5] In addition to being inequitable in those dimensions, the US system is also much more expensive than Canada's (Table 1). When health policy issues are discussed in the media, the focus usually is on Canada-US comparisons. Proposals for reform to expand the role of private medicine and insurance in Canada tend to be resisted on the grounds that we don't want to introduce anything that would make our system more like the American one.

Why We Shouldn't Just Compare Ourselves with the US

The Canadian view that our model is much better than that in the US has been reinforced by a number of studies that have ranked the performance of healthcare systems in a collection of high-income countries (for example, Commonwealth Fund 2014, 2017, 2021). But while Canada's system has been ranked above the US in terms of equity and efficiency, it has often been ranked below those in a number of developed countries that can reasonably be considered Canada's peers, like the UK, the Netherlands, and Australia. Data on per capita healthcare costs suggest that while Canada spends much less than the US, our costs are similar or higher in comparison with other peers such as the UK and Australia, Further, our performance on criteria such as waiting times for elective procedures or access to care after hours is spotty at best, with some provinces having recurring problems (Busby et al. 2018). In the view of some domestic critics, our medicare model has been slow to adapt to changing technology, and resistant to change (Government of Canada 2015, Lazar et al. 2013, Tuohy 2018). The opinion that the Canadian system needs reform is widely shared, even among those who believe that what we should strive for should be a less costly and more efficient version of the single-payer model.

Like Canada, the United Kingdom also has a health financing system that comes close to

Table 1: Healthcare Spending in 2019 (Various Countries)

	Percent of GDP Spent on Healthcare	Per Capita Healthcare Spending in $US PPP
Australia	9.4	4,919.2
Canada	10.8	5,370.4
France	11.1	5,274.3
Germany	11.7	6,518.0
Israel	7.5	2,903.4
Netherlands	10.2	5,739.2
New Zealand	9.1	4,211.9
Norway	10.5	6,744.6
Sweden	10.9	5,551.9
Switzerland	11.3	7,138.1
United Kingdom	10.2	4,500.1
United States	16.8	10,948.5

Note: PPP=purchasing power parity.

Source: OECD Health expenditure and financing dataset, 2019.

5 A detailed survey of Canadian attitudes toward the healthcare system in the early 2000s is in a report to the Health Council of Canada (Soroka 2007), in which it is stated that for many Canadians, "publicly funded universal health care is one of the foremost policy features of the Canadian state."

being a single-payer model (Cylus et al. 2015).[6] The example of the UK suggests that it is indeed possible to design a single-payer model that is less expensive than Canada's and delivers care that is as good or better than what currently is available here (Commonwealth Fund 2014, 2017, 2021, Shaw 2022). Reforming Canada's healthcare system so that it operates more like that in the UK could go a long way toward improving its performance.

But a critical characteristic of a single-payer financing system is that it must be collectively managed, through the political process. Once it is in place, it can be very difficult to change. Major reform of a single-payer model that covers every consumer and provides the livelihood for a wide range of health professionals and other workers is a daunting task for governments. In Canada, the task is further complicated by the way we do politics in the federation. As a consequence, the chances that we would be able to negotiate the changes necessary to make the Canadian system operate more like the UK's, are not very good. In contrast, a strategy of allowing a pluralistic model with both public and private insurance offering competing plans to consumers could produce a gradual transformation into a more efficient system without the need for long and fractious debates about ideology, vested interests, and federal-provincial relations.[7]

Contrary to what US-Canada comparisons might suggest, a single-payer model with a common plan to which everyone must belong is not a necessary condition for either universal or equitable health insurance coverage. Countries such as Israel, Switzerland, the Netherlands, and Australia, are examples of pluralistic systems in which health insurance coverage is universal because it is compulsory, but residents can choose among several different approved plans, private or public (van de Ven 2013, 2015, Commonwealth Fund 2020). As explained below in Section 3, with proper regulation, such systems can ensure that everyone, regardless of ability to pay, has access to care when they need it. Moreover, as the example of the Netherlands in particular shows, a pluralistic model can also be financed in a way that addresses the second of the two inequality dimensions referred to above, by redistributing resources from relatively healthy low-risk individuals to those with high expected healthcare costs. A pluralistic model in which consumers have a choice among competing health plans can be designed and managed so that it promotes efficiency without being inequitable, and in a way that avoids the very high cost of the US multi-payer model (Box 1). On balance, I believe Canada would be better served by a less restrictive financing system that allows some choice and competition, than by continued adherence to the current single-payer model.

Section 2: Canada's Single-payer System. How We Got It and Why It's Not Working Well

Many of the features of the current Canadian healthcare system date back to the establishment of universal medicare. Health policy in Canada falls primarily under provincial jurisdiction, but the federal *Canada Health Act* (CHA) imposes restrictions on the provinces as a condition for them being eligible for that portion of federal-provincial

6 The United Kingdom is the union of England, Wales, Scotland, and Norther Ireland. While the four constituent countries have somewhat different systems, all of them are versions of the UK National Health Service (NHS) and share the basic single-payer design. While the role of private medicine that is supplied outside the NHS may be relatively small, some analysts believe it nevertheless is important in making the UK system as a whole more efficient (Shaw 2022).

7 Another country that sometimes is classified as having a version of a single-payer system is France (Labrie 2008). However, private insurance plays a major complementary role to the universal public plan that covers all French residents.

Box 1: The High Cost of the US Multi-payer System

The examples of countries like the Netherlands and Australia show that a multi-payer system can function well, at a reasonable cost. However, as the US example shows, a model with multiple competing payers can also end up being very expensive. How can one explain the fact that per capita healthcare costs in the US are so much higher than in the Netherlands, say, even though the US also finances most healthcare through a model in which many payers compete?

Microeconomic theory suggests that an economy functions efficiently when agents (consumers and producers) have good information about the consequences of all actions that are available to them, and there is competition in the sense that there are few restrictions on the options that agents can choose. Multi-payer systems of healthcare financing do not have the restriction on consumers' choice of insurance plans that are inherent in a single-payer system, so the theory would suggest that, other things equal, a multi-payer system would tend to operate more efficiently.

However, other things are not equal. The efficiency of a healthcare system, and hence its cost, depends not just on the extent of competition in the market for health insurance, but also in the markets for physician and hospital services, and pharmaceuticals. It has long been recognized that the per unit costs of various specific kinds of health services are higher in the US than elsewhere (Anderson, Hussey and Petrosyan 2019), and that this is due, to a large extent, to limited price competition, for example among physicians, or between physicians and other health professionals, or in local markets for hospitals services. In part, the lack of price competition may be unavoidable (a small community can only support a single full-service hospital), but it may also be the unintended result of delegating government regulatory powers to professional associations of providers. Better government policies to promote what is known as "managed" competition, or even direct regulation of fees and prices, are the most likely reasons why countries like the Netherlands and Australia are able to operate high-performance healthcare systems that are much cheaper than the one in the US, even though they use multi-payer models of financing. Better government policy (in the form of regulation, or a system of risk-adjusted public subsidies, discussed in the text) also appears to have substantially neutralized the problem of "adverse selection" (the tendency for people with high expected healthcare costs to gravitate toward generous plans) that has greatly impeded the functioning of private health insurance markets in the US over the years.

transfers that is designated as being "for health" (the Canada Health Transfer). The current version of the CHA and Canada's single-payer health financing system dates from 1984 when provisions were introduced that required the provinces to eliminate all patient out-of-pocket charges, including those that some providers still collected when they treated provincially insured patients. Universal publicly administered health insurance dates further back, but when the CHA led to the elimination of all patient charges it created a single-payer system both in the sense that everyone in each province or

territory was covered by the same plan, and because the cost of the services was no longer shared between patients and the plan.[8]

While the CHA requires that provinces not allow any patient charges, it says nothing about provincial policy toward private health insurance, or provision of physician or hospital services outside the provincial plans (Boychuk 2012). That is, although the CHA requires provinces to have public insurance plans that are universally available, its language does not imply that these plans must be the only payers or that doctors should not be allowed to treat patients privately. However, provinces have passed a variety of laws and regulations to rule out or discourage private health insurance that covers services that already are covered under the provincial plans – "duplicative insurance" in the words of the ruling in the recent British Columbia case about private surgical clinics (Supreme Court of British Columbia 2020) – or provision of privately paid-for services outside these plans. In the early days, they did so because they wanted to make sure that enough doctors would agree to treat patients on the terms offered by the newly established provincial plans. Today, these laws and regulations are maintained and defended by those who support the single-payer system, and who are opposed to reforms that would allow more room for private insurance and medicine, but there are also voices calling for them to be changed (Shaw 2022).

Why the Canadian Model Has Become Outdated and Needs to be Changed

Our model of universal health insurance may have worked well at the time when it was introduced, but many of its features have now become outdated.[9] Healthcare has changed dramatically in the past half-century. As medical technology changes, the way production of health services is organized may also need to change. In an earlier era, most health services could be provided by general practitioners who worked in small offices with one or two employees and were paid via fee for service. Healthcare today has a much wider range of highly specialized doctors and other professionals, working with increasingly sophisticated drugs and equipment in hospitals, pharmacies, labs, and imaging clinics. For the system to function efficiently, its different components and specialists must be coordinated and motivated to work closely together. Our model for funding and organizing care was established fifty years ago in a simpler environment and is not well designed for accomplishing this. Most doctors in primary care and specialties continue to be funded independently on the basis of fee for service. Physician services, hospitals, and drugs are budgeted for and managed in separate silos.

Drawing on the literature in Canada and elsewhere, one can identify a number of reforms that could improve the quality of care and reduce healthcare costs by making the various professionals and other resources in the system work more

8 The term "patient charges" refers both to any "user charge" under the insurance plan, or any "extra billing" (over and above what is covered by the plan) that is collected by the provider. Because patients pay nothing at all for physician and hospital services, our single-payer system is sometimes referred to as "deep" (in comparison with others where patients must pay a part of the costs, as a co-payment). It is also, however, described as "narrow", because it doesn't cover certain costs, notably pharmaceuticals and long-term care.

9 See, for example Government of Canada 2015, the report by the Advisory Panel on Healthcare Innovation (chaired by David Naylor). In the introductory chapter, the Panel notes that there was "an extraordinary consistency of resolve that real change in healthcare was greatly overdue" among the many analysts and provider representatives who appeared before it.

efficiently together.[10] Reform proposals that have appeared frequently include strengthening and reorganizing primary care. One idea is that each patient should have a well-defined "medical home" with a provider who is familiar with their medical history and responsible for supervising and managing the pharmaceuticals they use and the care they receive from all providers in the system, including specialist and hospital care (Nielsen et al. 2016). Another idea concerns the potential for supplying a larger share of primary care through multi-disciplinary teams that include not just family doctors but also other professionals such as nurse practitioners, pharmacists, dietitians, physiotherapists, social workers, and others.[11] Other proposals have been about promoting more efficient use of specialist doctors in secondary and tertiary care and their use of hospital facilities and outpatient clinics. There has also been a great deal of discussion about the use of information technology in healthcare (Protti 2015, Bhatia and Falk 2018), both to promote information sharing across providers via electronic medical records, and via increased use of virtual care.[12]

Innovations and experiments with new methods to organize and integrate the resources used in producing healthcare have been undertaken in many countries. In the US, they were central to what became known as the "managed care revolution" that began several decades ago when private health insurers started to take an active role in contracting with the providers that served their clients (Baker 2011). More recently, the Centers for Medicare and Medicaid Services, a federal agency that works with the American public plans that cover retirees and those with low income, has experimented with initiatives in which providers agree to collaborative funding arrangements with incentives to contain costs while supplying care of high quality (in Accountable Care Organizations, or under the model of Acute-Care Episodes; Liao et al. 2020). In the UK, attempts to improve the management of the NHS go back to what was known in the 1990s as the "purchaser-provider split" and GP "budgetholding" (Ham 2010, Tuohy 2018). These experiments later morphed into a bewildering array of organizational forms that included "primary-care trusts," and, most recently "clinical commissioning groups." Attempts to get better integration of the care delivered by different providers have been made elsewhere in Europe as well.

Medical technology in Canada has also undergone major change since our version of medicare was established many decades ago, but the methods we use for managing and paying for healthcare have not responded to the increasing complexity to any great extent. Although there have been many small-scale pilot projects and experiments to at least partially remedy the problems that arise as a result of separate funding streams and lack of coordinated management, these

10 Many of the reform proposals have been reviewed in various contributions to the C. D. Howe Institute's Health Policy Initiative. Blomqvist and Busby (2012b) and Blomqvist and Wyonch (2019) discuss aspects of primary-care reform, while Blomqvist and Busby (2013) and Sutherland et al. (2013, 2017) deal with hospital funding and the payment of specialist doctors; Bhatia and Falk (2018) discuss virtual care. The proposals draw on both the experience of the UK, which has long been a pioneer in the organization of primary care, and on the large literature that deals with the applications of the various innovations in the US.

11 Harris et al. (2016) survey evidence from experiments with team-based primary care in the US (often in managed-care plans), Australia, and some Canadian provinces.

12 A referee has drawn attention to the fact that private insurance plans in Canada that supplement the coverage of the provincial plans had started experimenting with certain forms of virtual care even before the provincial and territorial plans began doing so during the pandemic.

have not been scaled up, and the system remains largely unchanged from its original state.

Improving the Canadian System: The UK NHS as a Model?

In looking for ways in which the Canadian model might be changed, some have suggested looking to the UK as an inspiration (Blomqvist 2002). Like Canada, the UK also has a model of healthcare funding that comes close to being a single-payer model, and like our system of universal health insurance, the NHS was established as part of the strengthening of social policy and the welfare state that took place in many countries after World War II. Today, the UK has a healthcare system where per capita costs are considerably lower than in Canada (Table 1), and whose performance usually is ranked above Canada's in international comparisons.[13] Therefore, the suggestion to pursue reforms that would make our system more similar to that in the UK is a natural one.

The NHS has several features that may explain why it has been somewhat successful in containing costs and tends to be highly ranked in international comparisons (Blomqvist and Busby 2012a, Tuohy 2018). To have access to covered services, everyone must sign up as a "rostered" patient with a local general practitioner who has a gate-keeping role: When they need care, patients must go to their chosen GP practice in the first instance, and the GP's referral is required for access to any covered hospital or specialist services. GPs are paid not through fee for service, but through a mix of salary and capitation; i.e., based on the number of patients in different categories on their roster. Hospital-based specialists also are not paid via fee for service but are salaried employees of the hospitals where they work. The UK NHS, therefore, already incorporates the idea that each patient should have a medical home where their records are kept, as a well as a provider who is familiar with their medical history, oversees their use of pharmaceuticals, and helps manage the care they receive from other providers in the system. It also operates according to the principle that the services of hospitals should be paid for and managed jointly with the services produced by the doctors who treat their patients, in contrast to what applies in Canada and the US where doctors and hospitals are funded separately. That is, the NHS already operates in accordance with several of the principles that have featured in the discussions of, and experiments with, possible reforms in North America.

Converting Canada's provincial health insurance plans into replicas of the NHS would be relatively simple and straightforward from an administrative point of view. Governments would have to introduce a rule that required every resident to register with one, and only one, primary-care provider.[14] When they were sick and needed care, people would then have to get it either from this provider, or through his/her referral to a specialist or for an elective hospital procedure. The primary-care providers would be compensated under a system

13 In its widely quoted health system ranking in 2000, the World Health Organization has the UK in 18th place, with Canada in 30th. More recent examples are Commonwealth Fund (2014, 2017, 2021). Government of Canada (2015) and Shaw (2022) also provide various partial performance measures that place UK ahead of Canada.

14 In the UK, the patient must choose from a list of GPs in the area where they live. A Canadian version of the model might also have that feature. Several referees have pointed out that a system of compulsory registration with a primary-care provider will only work if there are enough doctors (or nurse practitioners) who are willing and able to take on that role. I agree; no healthcare system can function properly unless it has enough trained professionals. This is an issue that Canadian provinces must address as the demand for care rises with an aging population, regardless of how the financing system is organized.

that would include capitation but also could include elements of salary, fee for service, and incentive payments based on the costs of their patients' care and drugs. Another new rule would be that doctors would no longer be paid via fee for service for treating hospitalized patients; only doctors who had accepted employment in the hospital and were paid a salary from the hospital's budget would be allowed to treat inpatients. Ensuring access to services that required hospital facilities, including the services of the treating physicians, would be one of the responsibilities that hospitals would assume in return for continued provincial funding.

While reform along these lines may seem administratively straightforward, implementing it would be a daunting task for the politicians who are ultimately responsible for the provincial insurance plans. Even if the UK system may look like something that Canada could emulate, the reforms that would be required to do so may be politically impossible. The features of the UK model that explain its good performance largely date back to the time when the NHS was established after World War II, and our system might have been more efficient today if we had made similar choices some 50 years ago (Box 2). Over time, however, relations between governments and producer groups in a publicly managed single-payer system become entrenched and change becomes more and more difficult.

Why Reforming a Single-payer Model is So Hard

In a pluralistic system where consumers can choose among competing health plans, adaptation to new technology can happen gradually and in a piecemeal fashion as providers and plans experiment with new methods of funding and organizing the production of health services, and consumers gravitate towards those that are most successful at delivering care that is cost-effective and of good quality.[15]

By contrast, in a single-payer system, any substantive change in the way consumers are covered will affect everyone at the same time, and must happen as a result of political decisions, not decisions by individual consumers. It must be preceded by a full debate in which people are allowed to argue for and against it, no doubt leaving some dissatisfied whether or not a reform proposal is accepted. On the supply side, government must negotiate with the organizations that represent providers before implementing any changes in the way they are compensated, or in the rules under which they provide their services (or supply drugs, in systems where the single-payer plan covers pharmaceuticals). Universal health insurance in Canada was established in the 1960s and '70s after extensive bargaining in which provincial governments agreed to negotiate with the medical associations about fees and other terms; provisions to this effect are part of the *Canada Health Act*.

Proposals for changes that are intended to make the health system more efficient often involve changes in the roles of specific provider groups and the demand for their services. For example, reforms under which primary care would be supplied by nurse practitioners and multi-disciplinary teams would decrease the demand for the services of independent family doctors paid via fee for service. Supplying specialist services in outpatient clinics would reduce the demand for hospital-based surgeons and unionized hospital nurses. Debates about such reforms can be complicated and lead

15 Healthcare, of course, remains heavily regulated in real-world, multi-payer systems, and health policy is highly controversial in countries like Australia and the Netherlands as well. But even so, I strongly believe that allowing some degree of "managed competition" among multiple payers will improve the system's ability to adapt over time.

Box 2: How the British Did It, and Why We Can't Do the Same

Partial reforms that would make our healthcare system more like the UK system have been actively discussed for a long time, and some versions of them have been tried out in Canada as pilot projects or controlled trials. Notable examples have been experiments in Ontario and Alberta with the use of capitation rather than fee for service in primary care, consistent with the idea of strengthening primary-care providers' role as patients' medical home, and introduction of various forms of activity-based funding of hospitals as part of the attempts to shorten waiting lists for certain kinds of specialist care. But while the results have sometimes been encouraging, progress in implementing the reforms has been slow and halting. A frequent complaint has been that even when pilot projects seem to have been successful, they have not been scaled up and applied throughout the provincial systems (Government of Canada 2015). Progress with reforms has also been slowed when an election has taken place and a new health minister and cabinet have had little willingness to carry on with reforms begun by a previous one.

While the UK tends to be highly ranked in international comparisons, government healthcare costs are high and growing there as well, and policies to control costs and deliver care more efficiently have been vigorously debated (Tuohy 2018). But in the UK, too, reforming the single-payer system has proved politically difficult. Efforts have been made to introduce more cost consciousness in the organization of care, through incentives on GPs when exercising their gate-keeping function (for example, through the "fundholding" experiment), or through attempts to create competition among hospitals in "internal markets." Like Canada, the UK has spent large amounts of resources trying to promote the use of electronic health records (Boston Consulting Group 2017). However, it is fair to say that, as in Canada, progress has been slow and the various efforts have not led to major changes in the status quo (Collins 2019). The relatively good performance of the UK single-payer model seems due largely to a number of good (or lucky) decisions at the time the NHS was first established, rather than to a superior ability of the system to adapt to change over time.*

* While she vividly describes the complicated politics of health system reform in the UK, Tuohy thinks of the UK reforms since the 1980s as quite substantial and successful, and as major contributors to the system's relatively good performance over time. An interesting question is to what extent the UK's success in that respect is due to the fact that it doesn't have to deal with the complications that arise as a result of the divided federal-provincial jurisdiction that Canada has to contend with.

to spirited disagreements within and among the organizations that represent the different provider groups, and as these organizations present their arguments to the public and politicians who often have limited knowledge about the issues involved. Perhaps most importantly, the expected benefits of reforms that are intended to make the system more efficient will only occur over a long period of time as producers and consumers get used to them, and the hoped-for advantages, in the form of lower taxes and improved quality of care, will be widely diffused. The disruption and costs of system-wide change, in contrast, will all occur at the time the reforms are undertaken and will have major effects for specific provider groups. For politicians with a time horizon that depends on the election cycle, trading off short-term controversy for widely diffused and uncertain long-term gains does not look like an attractive proposition. Given these considerations, it is perhaps not surprising that studies have found Canada's healthcare system very resistant to meaningful change (Lazar et al. 2013, Tuohy 2018).

In Canada, management of the publicly funded healthcare system is also complicated by the fact that healthcare is under provincial jurisdiction, but provincial governments rely on the federal government for some of the revenue they need to pay for healthcare and other programs. In a publicly funded system, the politicians who ultimately are responsible for managing it must carefully balance the objective of saving money for the taxpayer against that of giving the system enough resources to provide care of high quality. To save taxpayers money, they must try to manage the system so that services are supplied at the lowest possible cost, forcing them into sometimes difficult negotiations with provider groups whose incomes account for the largest share of healthcare spending.

In Canada, it is the provincial politicians who engage in these negotiations, on behalf of provincial taxpayers, but part of the revenue needed comes from federal taxes. As a result, a great deal of energy is devoted to the question how the cost should be divided between the two levels of government.[16] From the point of view of taxpayers, it doesn't matter whether the cost is paid out of the federal or provincial portion of the taxes they pay, but the perception that the costs should be shared between the two governments has an important influence on Canadian health policy. Providers may argue that it reduces the amount of resources available to healthcare because politicians at either level can claim that it is those at the other level that are not contributing their fair share. Or, the shared responsibility may reduce the willingness of provinces to experiment with various reforms because politicians at the federal level want to score points by opposing reforms that might save money but can be perceived as being against the principles of the CHA. Some observers have argued that a lack of clear assignment of political responsibility

16 In comparison with other countries, Canada appears to have been relatively slow in introducing electronic health records and other information technology in the healthcare sector (Protti 2015), perhaps in part because of difficulties in coordinating the efforts that both provincial and federal governments were undertaking in this realm. However, progress in this respect was slow in the UK NHS as well, even though it is centrally managed by the national government (Boston Consulting Group 2017).

to one of the two levels of government is a major reason for the lack of success in creating a more efficient Canadian system (Whatley 2020).[17]

The complications that arise because of the divided federal-provincial jurisdiction only add to the difficulty of accomplishing meaningful reform of our single-payer model, in which every consumer is covered by the same plan, and every provider must supply their services according to the terms set out in that plan. In a model where consumers are allowed to choose among several competing plans, in contrast, change and adaptation to new technology can come about with much less difficulty. In a pluralistic system, the scaling up of successful experiments can occur more or less automatically, as more consumers switch to plans that others seem satisfied with, and as more plans follow in the footsteps of early experiments.

In such a model, reform and change happens gradually as plans can experiment with different coverage features and organizational forms. Successful ones expand when consumers find them more attractive, and providers are allowed to negotiate the terms on which they are willing to treat the patients in their plans. That is, healthcare can adapt as a result of voluntary decisions by consumers and providers, rather than being blocked by the fear of lengthy and contentious negotiations in the political arena that have discouraged most reform initiatives in the past.

Section 3: The Alternative: An Equitable Pluralistic Model like Holland's?

The current provincial rules that discourage providers from supplying care outside the single-payer system and restrict private health insurance have been the subject of highly publicized court challenges. Examples are the Chaoulli case in the province of Québec some 15 years ago and the more recent Cambie case about private surgical clinics in British Columbia (Shaw 2022, Supreme Court of British Columbia 2020). In the debates about these cases, the perception has been that the main beneficiaries of relaxing these rules would be relatively wealthy individuals who then would be able to get care faster than in the public system, while those with low incomes who stayed with the public system would be hurt by longer wait times and reduced quality of care. That is, opponents of private medicine have argued that relaxing these rules would increase economic and social inequality.

But as the example of the Netherlands illustrates, a pluralistic model in which patients and providers can choose among competing plans can be designed to be equitable (Commonwealth Fund 2020a, b, van de Ven 2008). Moreover, if an indirect consequence of allowing more choice and competition is to make the healthcare system more efficient, the savings that are generated by these efficiency gains can, in principle, be redistributed across income groups

17 The divided jurisdiction over health policy makes it harder not just to negotiate reform with respect to physician and hospital services that are part of the single-payer system, but also to accomplish reform such as trying to extend it to universal coverage of the cost of drugs (pharmacare). In the context of the debate over pharmacare, the stakeholders include the private insurance companies that currently participate in the financing of drugs, and hence have an interest in how the pharmacare initiative ultimately plays out. Paradoxically, a multi-payer system may require a stronger federal role in the financing of healthcare. As discussed below, a multi-payer system must be carefully regulated in order to function as intended, and be financed through a system of risk-rated publicly funded subsidies that might be difficult for individual provinces to construct and manage.

in such a way that everyone is better off than they would have been in a single-payer model (see Appendix).

To be considered equitable, a pluralistic model must perform both of the types of redistribution that a single-payer model does. It must ensure that everyone has access to needed care regardless of ability to pay – that is, redistribute resources from the well to the ill – and do so without forcing those with high risk of illness to pay more for this than low-risk people.

In the Netherlands (and in other countries with compulsory insurance but multiple plans), the first of these objectives is addressed by specifying a set of conditions that a plan must meet in order for it to be eligible for a public subsidy. Residents must be covered by a government-approved plan in order to satisfy the insurance requirement. The second objective is addressed through a combination of two measures. First, in order to be approved, any premium that a plan charges enrollees must not differentiate according to factors such as previous illness history or pre-existing conditions, and plans must have a period of "open enrollment" during which they must accept everyone who applies for coverage at the posted premiums. Second, when plans are funded, in whole or in part, by a public subsidy or voucher, the amount of the voucher is "risk-adjusted." It is calculated according to factors that can be used to help determine the expected cost that the plan will incur for a given patient, such as age, sex, pre-existing conditions and previous illness history. The first of these features is what accomplishes the redistribution from low-risk to high-risk population groups, since any premiums that the patients pay out of pocket are the same, regardless of factors that influence their expected healthcare costs. Risk-adjusted subsidies or vouchers, on the other hand, are used for the purpose of reducing the incentive for insurers to design plans that are especially attractive to individuals with low expected costs, or to use selective marketing techniques to attract low-risk clients (van de Ven et al. 2015).[18]

Although the detailed provisions may differ, other countries with compulsory insurance systems that are intended to be equitable use some combination of these regulations and financing tools. They are also used in the US Medicare Advantage plan for retirees, where eligible individuals have a choice between either "Original Medicare" or one among many approved

18 The risk adjustment approach and regulations appear to have been successful in counteracting the adverse selection problem that has figured so prominently in the US health insurance debate over the years (Cutler and Reber 1998). The incentive for insurance plans to engage in risk selection can also be reduced through regulation that requires insurance plans to participate in a risk equalization scheme under which plans pay part of their premium revenue into a fund that subsidizes the premiums of individuals with unusually high expected costs. The insurance exchanges that were established as part of the 2014 *Affordable Care Act* in the US (Obamacare) were required to participate in a risk adjustment scheme of this kind. Besides the Netherlands, other countries with compulsory insurance systems and risk adjustment include Israel, Belgium, Germany, and Switzerland. Van de Ven et al (2015) discusses some of the problems in the European countries that have used it.

and subsidized substitute plans (Kaiser Family Foundation 2020).[19] They would also have been a critical element in the near-universal insurance model that would have been established in the U.S. if the implementation of Obamacare had been allowed to proceed as intended (Box 3). In the next few paragraphs, I consider how one could draw on lessons from these examples and construct an equitable Canadian version of the compulsory insurance model.

How Canada Could Transition to an Equitable Multi-payer Model of Managed Competition

From a purely administrative point of view, reforms inspired by the single-payer system in the UK might seem relatively simple, as noted above. In contrast, transforming Canada's single-payer system into a pluralistic, multi-payer model of managed competition might seem a daunting undertaking, even if one could overcome the resistance that such a proposal would provoke in the political arena. If carefully done, however, it could be accomplished gradually and in a way that would not imply sudden and major disruption of the current system.

One way of making a transition less controversial would be by treating existing provincial health insurance plans as a default option, meaning that at each stage, all residents would continue to be covered by their provincial plan unless they explicitly chose to opt out and get coverage through an approved competing plan.[20] Every resident would have a choice of two options: stay in their existing provincial plan, or receive a voucher that would be used toward paying all or part of the premium for an approved substitute plan. The voucher would not be cashable by the individual, but would be transferred to whichever approved substitute health insurance plan, public or private, the individual had chosen.

Critical elements of a reformed model of this kind would be (i) the criteria to be used for government to approve a substitute plan, and (ii) the methodology to be used for calculating the size of the voucher.

Rules for approval of substitute plans could be relatively simple. Consistent with the principle of universal access to needed care, plans would have to cover medically necessary hospital and physician

19 Wikipedia's entry on the background and organization of the Medicare Advantage program is the most helpful and informative description I have been able to find: https://en.wikipedia.org/wiki/Medicare_Advantage (accessed May 14, 2021). Details about the methodology that have been used in the risk adjustment by the Center for Medicare & Medicaid Services (CMS) are available in a 2016 publication by America's Health Insurance Plans (AHIP 2016). The CMS risk adjustment factors have been used not just by Medicare Advantage but also in designing the Obamacare risk adjustment schemes referred to in the previous footnote; the methodology used in calculating them is still being refined (Healthpayer Intelligence 2020).

20 In existing multi-payer systems such as those in the Netherlands, Israel, or Switzerland, there is no plan that is designated as the "default plan", but insurance is compulsory. None of these systems, however, started out as a single-payer system, as Canada would if we decided to move in this direction, and as long as provincial politicians would agree to competition from substitute plans on equal terms, designating the existing provincial plan as the default plan wouldn't make a big difference. Having a default plan would also protect people and providers in remote and rural areas where private substitute plans might not be willing to operate.

Box 3: Obamacare and the Compulsory Insurance Model

Many Canadian are aware that Bernie Sanders and others in the progressive wing of US Democrats are in favour of adopting a Canadian-style single-payer model of universal publicly funded health insurance. The chances of that actually happening are slim – it would mean replacing the private group insurance plans that currently cover most people of working age with a government plan, something that a majority of Americans (including doctors) would strongly resist. However, the US would have come reasonably close to achieving a form of universal coverage if the reforms that were started during the Obama years had been fully implemented.

Although much US healthcare is privately funded, there are also large public plans. One, referred to as Medicare, covers Americans aged 65 or older, while another, Medicaid, pays for the care of people with low income. While a majority of those of working age have private coverage, a substantial minority remains uninsured. In 2013, before the Obamacare reforms began operating, over 15 percent of the population was uninsured. The reforms under the *Affordable Care Act*, the official name of Obamacare, tried to reduce this percentage through a combination of carrots and a stick.

Among the carrots were subsidies toward the premium costs of approved private individual insurance plans, and new regulations that specified standard requirements on the coverage that these plans must offer. A particularly important regulation was that every approved plan in a given region must agree to cover anyone who wanted to sign up, at a premium rate that was the same as for everyone else in that person's age group. That is, plans were not allowed to discriminate against people with pre-existing medical conditions, or with high expected healthcare costs for any reason. The stick used to encourage reluctant uninsured individuals to sign up was a fine that had to be paid by anyone who could not supply proof of coverage by any plan.

Fines for non-insurance are no longer imposed because that law was deemed unconstitutional when it was challenged in court during the Trump administration. Had the fine provisions remained in force, the US would have come closer to a form of compulsory insurance and hence to attaining the long-sought objective of universal coverage. A fully implemented Obamacare model would have differed in some respects from the Dutch model – for example, the subsidies toward the premium costs were not risk-adjusted, and were not available for individuals whose income was low enough so they were eligible for Medicaid coverage. But in many respects, the two models would have been similar.

services, as well as pharmaceuticals.[21] However, in order to give plans flexibility to experiment with the use of gate-keeping in primary care, and with provision of services through less expensive physician substitutes, the rules should not prohibit restrictions on patients' choice of providers. Based on examples in other countries, plans should be allowed to charge a premium on top of the voucher amount they would receive, but the premium would have to be the same for all enrollees. Moreover, the plans would be required to have a period of open enrollment during which they would have to accept anyone who applied for coverage at the quoted premium.

Although approved plans in other countries with compulsory insurance may require some degree of patient cost-sharing in the form of co-payments for insured services, the concept of "user fees" has been very controversial in the history of Canadian medicare (Barer, Evans and Stoddart 1979). In any case, most of the potential advantages of a pluralistic competitive model could probably be achieved even if it retained the *Canada Health Act*'s prohibition of any patient fees.

Once a person had opted out, the provincial default plan would no longer be responsible for providing, or paying for, any of the care that this person received. A reasonable principle for determining the voucher amount (the opting-out subsidy) would thus be to have it reflect the expected cost that the default public plan would have incurred if the person had remained in it. Setting the subsidy this way would allow substitute plans to compete effectively with the default plan. Under this principle, taxpayers at large would neither gain nor lose when a person opted out, and consumers who opted out could either choose a low-cost plan with a premium less than the subsidy, or pay an additional amount for a plan with features they considered sufficiently superior to that of the default plan.[22]

Producing accurate estimates of the expected costs for different individuals under Canada's current provincial insurance plans would not be an easy task. While existing data on aggregate hospital and physician services can be used to calculate average per capita amounts, meaningful risk adjustment would require more detailed information on the utilization of different services by individuals in different categories. Although existing administrative data can be used for information about individuals' utilization, good data on the per-unit cost of different services

21 That is, I am assuming that provincial plans in a future multi-payer system would cover the cost of outpatient drugs as well as hospital and physician services. It could also incorporate elements of dental care, a topic that has received a great deal of attention in early 2022 as a result of its role in the negotiations about the agreement under which the NDP will support the minority Liberal government until 2025. A possible model of universal dental care is outlined in Blomqvist and Woolley 2018.

22 Recall again that a person could only opt out by enrolling in another *approved* plan (that is, approved by a regulator). Thus, universal coverage would be preserved, and regulations would ensure that any low-cost substitute plans would provide coverage of an acceptable quality. If the size of the voucher is set equal to the expected cost of a patient's care under the default plan, it may be reasonable to allow low-cost plans to attract clients by charging a "negative premium" (i.e., return part of the voucher amount as a cash payment to the enrollee). If the voucher is set below the expected cost in the default plan, that plan would have to require a premium as a condition for coverage. In cases where a premium must be paid for enrollment even in a low-cost plan, specific subsidies toward payment of these premiums may have to be available to individuals with low incomes, so as to guarantee that everyone can afford a plan with an acceptable degree of coverage.

often are not available, especially for the hospital sector.[23] Moreover, risk adjustment to account for factors such as diagnosed chronic conditions and previous illness history requires samples of individuals for whom information is available about both their service utilization and relevant risk factors. Actuarial estimates based on such samples are routinely produced in systems where there is extensive private health insurance, but would have to be newly constructed in Canada.

A set of rules that specified what would have to be covered, and how a patient's voucher would be calculated, would be necessary in a pluralistic model of managed competition. Moreover, in order for it to function as intended, substitute plans would also have to be able to assure potential clients that they could find providers to supply the services they need when they become ill. In other words, substitute plans would only be able to compete effectively with the default plan if they could find doctors and hospitals who would agree to treat their clients on the terms that the plans offered. In the early stages of the development of a multi-payer system, provincial governments could make this easier by allowing doctors and hospitals to treat patients both within and outside the provincial plan.[24] Governments could also enter into agreements with hospitals with respect to how their provincial funding would be affected by the revenue the hospitals would earn under contracts with substitute plans. Governments in some Canadian provinces have already been experimenting with various forms of activity-based funding (Sutherland et al. 2013) under which part of hospitals' annual funding comes in the form of per-unit payments for certain specific procedures that have been performed during the year. In these provinces, government could move to a mixed model in which hospitals would earn part of their revenue in the form of per-procedure payments from either the provincial plan or substitute plans, and receive any additional funding in the form of provincial lump-sum grants.[25]

In the Canadian debate about private health insurance and medicine, it has generally been assumed that the people who would opt out of the public system, if they had the opportunity, would be mostly the rich. This assumption may seem reasonable; reforms that would allow private insurers to offer alternative insurance could lead to the emergence of expensive plans with various features that would appeal to wealthy individuals.

But reforms of this kind could also give entrepreneurs an incentive to develop plans that would be more cost-effective than the current system, and hence could be made attractive to individuals with average and below-average incomes. Suppose it is indeed the case that healthcare of roughly the same quality as in the current system can be produced at significantly lower cost by means of gate-keeping primary-care providers, more use of less expensive health professionals and virtual care, and offering surgery in free-standing outpatient clinics with salaried

23 Meaningful cost data have, however, become more easily available over time as governments are asking hospitals to file reports in formats that facilitate patient-specific costing calculations.

24 A referee has suggested that allowing this would not be compatible with the federal government's current interpretation of the *Canada Health Act*, strengthening the view that a reform initiative of this kind must have support at the federal level in order to succeed.

25 The experiments with these methods in Canada have so far been relatively limited in scope and hence have not had much of an impact on aggregate healthcare costs (Sutherland and Hellsten, 2017). A country with a longer history of mixed public-private funding of hospital services on whose experience Canada could draw is Australia (Collyer et al. 2015); funding methods that have been used for hospitals in the UK system could also yield useful evidence.

doctors rather than in full-service hospitals. If the vouchers for opted-out individuals did indeed correspond to the costs in the existing model, insurance companies could then make a profit if they could persuade clients to opt out of the provincial plan and join their more efficient plans with these features instead. To the extent that the insurance market was competitive, this could then lead to premium rebates to consumers, or offers of additional benefits (such as free or subsidized dental insurance) beyond those offered under the provincial plans.

Kickstarting Competition: Introducing a Second Public Plan

A well-functioning model of private-public competition would require an effective risk-adjustment mechanism and well-defined legal rules for the obligations of substitute plans. Establishing and testing a framework of this kind would be time consuming, however, meaning that a pluralistic mixed model of private-public competition must be thought of as a long-term objective at best; in the Netherlands, constructing the present one has taken decades (Tuohy 2018).

To set the process in motion in Canada, a possible short-run strategy could be to first introduce a choice for consumers between two alternative public-sector plans. Individuals would be allowed to opt out of the traditional plan and instead choose an alternative government plan with potential efficiency-enhancing features. In particular, provincial governments could offer a substitute plan with gate-keeping primary-care practitioners in which patients would agree to get all their care from the practice that has them on its roster, or after a referral from that practice.[26] Primary-care providers would have to choose between either continuing to practice in the traditional fee-for-service plan, or under the alternative plan in which they would be paid mostly via capitation for some or all of their patients.[27] The capitation rate for a given patient should be risk-adjusted, so as to eliminate providers' incentive to attract patients with low expected utilization of services. Data would also be collected on the cost of drugs and secondary care that patients enrolled in a given alternative-plan practice had incurred after referral elsewhere. At the end of each year, the total cost of the healthcare received by patients in the practice would be recorded and be compared with what the same patients would have cost if they had remained in the traditional plan. Part or all of any savings to the government could then be returned to the patients as an incentive to stay with the alternative plans, or to the primary-care doctors as year-end bonuses.[28] The data generated by an experiment of this kind could later be used as the basis for constructing the schedule of risk-adjusted vouchers that would be necessary, along with a set of rules for minimum coverage, to further open up the system so that consumers could choose approved private plans as well.

26 Blomqvist (2002) has a discussion of a version of a model of this kind.

27 An experiment under which primary-care providers have had a choice of this kind has been going on in the province of Ontario for some time (Blomqvist and Wyonch 2019). A version of the model discussed here could be created with a few modifications of plans currently available in Ontario, such as adding a formal gate-keeping function and making the capitation rate for given patients risk-adjusted.

28 Alternatively, savings in low-cost plans could be used to offer incremental coverage of items not included in all plans, or just to enhance the quality of the services offered. An external referee has noted that in the Israeli system, all the competing plans among which people can choose must charge the same premium, so that the competition among them takes place entirely in the quality dimension.

In the introduction, I observed that the most pressing current concerns of Canadian health policymakers have to be those of trying to ensure that we have enough doctors and nurses to deal with the health problems that the boomer generations will experience as they age. Having enough trained personnel is clearly a prerequisite for a well-functioning healthcare system, no matter how it is financed and organized, and the potential advantages of a competitive multi-payer system will only be realized where that applies as well. For example, one cannot expect that it would be possible for a range of competing plans to be available everywhere in Canada, in remote communities or in the countryside with few health professionals per capita. With too few doctors, specific measures may be needed to ensure that too many of them will not work for high-cost plans that cater to the wealthy. But over time, the supply of health professionals can be increased to staff a range of competing plans, and the focus can shift to the question of how to make the best use of them, and the other resources in the system.

Section 4. Conclusion: Politics, Inequality and Healthcare Financing

Reform to improve the performance of Canada's healthcare system can only happen as a result of decisions made by the politicians we have elected to form our federal and provincial governments. For the reasons I have discussed in this *Commentary*, I think it unlikely that effective reform will be possible if we continue to insist on a version of the single-payer model under which the only comprehensive health insurance that is available is through a single government plan, and all medically necessary hospital and physician services must be provided on the terms specified by this plan.

The example of countries like Israel and the Netherlands suggests that a mandatory insurance model with managed competition among regulated insurance plans, along the lines sketched in the previous section, could be designed in a manner that would not lead to increased overall economic inequality. Government support for those with low income consists not only of paying for the healthcare that they use, but also for programs like social assistance, subsidized housing, and various kinds of refundable tax credits. If the overall redistribution of real income through such programs remains the same, allowing people with low income to choose a low-cost health insurance plan does not increase economic inequality. In fact, one may argue that it reduces it, since those who choose low-cost insurance plans do so because it enables them to spend more on other things (such as better housing, diets, or education for their children) that they value more highly.

Canada's single-payer healthcare system is sometimes referred to as a national icon, and proposals to re-design an icon are necessarily contentious. In describing the debate that preceded the agreement to enter into a free-trade agreement with the US in 1987, the late politician Donald Macdonald referred to the decision by the Canadian government to proceed, as a "leap of faith" (Macdonald 1991). Replacing our single-payer system with a pluralistic compulsory-insurance model would be another such leap. Most Canadians clearly are not yet ready to contemplate taking it, but we should at least start a serious debate about the possibility.

Appendix: Equity, Efficiency and Healthcare

The extent to which government should attempt to reduce economic inequality by redistributing income and wealth from rich to poor is a fundamental issue in the political debate about economic policy. Inequality in Canada is reduced through social insurance programs like OAS/GIS and EI, and provincial government programs assist the disabled and those who, for various reasons, cannot earn enough on their own. However, like most capitalist countries, Canada tolerates a relatively high degree of economic inequality in general, even though it leads to large differences in individuals' access to various goods and services, such as housing and education.

Policies to reduce economic inequality generally focus on improving the distribution of income (general purchasing power); decisions on how to spend the resources at their disposal are largely left up to each person or family. In Canada, however, many seem to feel that the latter principle should not apply when it comes to healthcare. Pretty much everyone agrees with the idea that a good society must ensure that every citizen, regardless of ability to pay, should have access to "medically necessary" healthcare whenever they "need" it, however the terms in quotes are defined. But many Canadians go beyond this to argue in favour of rules that prevent, or at least discourage, anyone from getting health services that go beyond those to which everyone is entitled, even people who are willing to pay on their own for the additional services they seek, or for insurance that goes beyond the common plan.

A fundamental principle in economics is that it is inefficient to restrict people's right to spend their own resources on whatever they like, at least as long as their choices don't affect the well-being of anyone else. According to this principle, it is inefficient to prevent well-to-do individuals from getting more healthcare than the public plan offers. Except in the very short run, the supply of healthcare is not fixed: If well-to-do people are willing to pay on their own for the additional care they want, more can be produced and there doesn't have to be a reduction in the care supplied to those in the public plan. In the Canadian debate, the idea that more healthcare can be produced sometimes seems to be forgotten, and more energy is spent on preventing "queue-jumping by the rich" than on coming up with ways to increase the supply of the various services for which there currently are waiting lists.[29]

Economic analysis also gives examples of instances where restrictions on the choices that poor people can make are inefficient and imply a waste of resources. Poor families may need access not only to the physician and hospital services that are covered by the provincial plans, but also to things like better housing, education for their children, and dental care. If they could get more money to spend on other things by opting for a less expensive health plan than the provincial one, some families might do so even if the substitute plan had more restrictions on their choices of providers. In the parlance of economics, denying them that option is inefficient: If giving families this choice makes them better off with the same budget as before, denying them this opportunity means forgoing an opportunity to make them better off without making anyone else worse off.

The main thesis in the text is that it would be good public policy to allow a pluralistic health

29 In her call for new priorities in Canadian health policy, Shaw (2022) lists a number of ways to increase the supply of doctors and nurses in the system as particularly urgent.

financing system with a choice among several plans because competition would increase the likelihood that the healthcare system could adapt to changing needs and medical technology. Effective regulation to ensure that everyone has enough coverage so that they have access to urgently needed care is a necessary condition for this to work well; the US system serves as an example of what happens when that is not present. Nevertheless, the notion that a single-payer system implies some degree of economic inefficiency adds strength to the argument in favour of pluralism. And while allowing individuals to choose among plans may lead to more inequality in the way individuals get health services when they are sick, it need not lead to greater overall economic inequality in society. The reduction in expected healthcare costs among those choosing less-expensive plans enables them to spend more on other things such as housing or education for their children, or on better dental care.

REFERENCES

America's Health Insurance Plans (AHIP. 2016. "The Medicare Advantage Risk Adjustment System." Available at https://www.ahip.org/wp-content/uploads/2016/04/Risk-Adjustment-Why-is-it-important.pdf

Anderson, Gerard F., Peter Hussey, and Varduhi Petrosyan. 2019. "It's still the prices, stupid: Why the U.S. spends so much on health care, and a tribute to Uwe Reinhardt." *Health Affairs* (Web exclusive)38 (1):87-95.

Baker, Laurence. 2011. "Managed care", Chapter 18, pp. 405-30, in Sherry Glied and Peter C Smith, eds., *The Oxford Handbook of Health Economics*. Oxford University Press.

Barer, M. L., Robert G. Evans and G. L. Stoddart. 1979. "Controlling health care costs by direct charges to patients, snare or delusion?" Toronto: Ontario Economic Council, p. 126.

Bhatia, R. Sacha, and William Falk. 2018. "Modernizing Canada's Healthcare System through the Virtualization of Services." E-Brief. Toronto: C. D. Howe Institute. May 23

Blomqvist, Åke, and Henrik Horn. 1984. "Public Health Insurance and Optimal Income Taxation." *Journal of Public Economics* 24(3): 353 373. August.

Blomqvist, Åke. 2002. *Canadian Health Care in a Global Context: Diagnoses and Prescriptions*, Benefactors Lecture, p. 61.Toronto: C.D. Howe Institute, Toronto.

Blomqvist, Åke, and Colin Busby. 2012a. *Better Value for Money in Healthcare: European Lessons for Canada*. Commentary 339. Toronto: C. D. Howe Institute.

_____. 2012b. *How to Pay Family Doctors: Why 'pay per patient' is better than fee for service*. Commentary 365. Toronto. C. D. Howe Institute.

_____. 2013. *Paying Hospital-based Doctors: Fee for Whose Service?* Commentary 392. Toronto: C. D. Howe Institute.

Blomqvist, Åke, and Frances Woolley. 2018. *Filling the Cavities: Improving the Efficiency and Equity of Canada's Dental Care System*. Commentary 510. Toronto: C. D. Howe Institute.

Blomqvist, Åke, and Rosalie Wyonch. 2019. *Health Teams and Primary-care Reform in Ontario: Staying the Course*. Commentary 551. Toronto: C. D. Howe Institute.

Boychuk, Gerard W. 2012. *Grey Zones: Emerging Issues at the Boundaries of the* Canada Health Act. Commentary 348. Toronto: C. D. Howe Institute.

Boston Consulting Group. 2017. "The Electronic Health Records System in the UK." Centre for Public Impact Case Study. April 3. Available at https://www.centreforpublicimpact.org/case-study/electronic-health-records-system-uk

Busby, Colin, Ramya Muthukumaran, and Aaron Jacobs. 2018. "Reality Bites: How Canada's Healthcare System Compares to its International Peers. E-Brief. Toronto: C. D. Howe Institute. January 25.

Collins, Ben. 2019. "Payments and contracting for integrated care: The false promise of the self-improving health system." The Kings Fund. Available at https://www.kingsfund.org.uk/publications/payments-contracting-integrated-care

Collyer, Fran, Kirsten Hurley, and Stephanie Short. 2015. "Money and Markets in Australia's Healthcare System," Chapter 8, pp. 257-91 in Meagher, Gabrielle, and Susan Goodwin, editors, *Markets, Rights, and Power in Australian Social Policy*. Sydney University Press.

Commonwealth Fund. 2014. "Mirror, Mirror on the Wall, 2014 update: How the U.S. Health Care System Compares Internationally." (Karen Davies, Kristof Stremikis, David Squires and Cathy Schoen). Available at https://www.commonwealthfund.org/search?search_api_fulltext=mirror%20mirror

_____ 2017. "Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care." (Schneider, Eric C, Dana O Sarnak, David Squires, Arnav Shah and Michelle M Doty). Available at https://interactives.commonwealthfund.org/2017/july/mirror-mirror/

_____. 2020a. "International Health System Profiles: Israel." Available at https://www.commonwealthfund.org/international-health-policy-center/countries

_____. 2020b. "International Health System Profiles: Netherlands." Available at https://www.commonwealthfund.org/international-health-policy-center/countries

_____. 2021. "Mirror, Mirror 2021: Reflecting Poorly. Health care in the U.S. Compared to Other High-income Countries." (Schneider, Eric C, Arnav Shah, Michelle M Doty, Roosa Tikkanen, Katherine Fields, and Reginald Williams II). Available at https://www.commonwealthfund.org/publications/fund-reports/2021/aug/mirror-mirror-2021-reflecting-poorly

Cutler, David M., and Sarah J. Reber. 1998. "The Trade-off Between Competition and Adverse Selection." *Quarterly Journal of Economics* 113(2): 433-66.

Cylus, Jonathan, Erica Richardson, Lisa Findley, Marcus Longley, Ciaran O'Neill and David Steel (2015), *Health Systems in Transition: United Kingdom* 17(5). European Observatory on Health Systems and Policies. Available at https://eurohealthobservatory.who.int/countries/united-kingdom-of-great-britain-and-northern-ireland/

Government of Canada. 2015. *Unleashing Innovation: Excellent Healthcare for Canada*. Report of the Advisory Panel on Healthcare Innovation (chaired by David Naylor). Available at https://www.canada.ca/en/health-canada/services/publications/health-system-services/report-advisory-panel-healthcare-innovation.html

Ham, Chris. 2010. "GP budget holding: Lessons from across the pond and from the NHS." University of Birmingham Health Services Management Centre, Policy paper No 7. Available at http://www.hsmc.bham.ac.uk/publications/policy-papers/HSMC-policy-paper7.pdf

Harris, Mark F., Jenny Advocat, Benjamin F. Crabtree, Jean-Frederic Levesque, William L. Miller, Jane M Gunn, William Hogg, Cathie M. Scott, Sabrina M. Chase, Lisa Halma, and Grant M. Russell. 2016. "Interprofessional teamwork innovations for primary health care practices and practitioners: Evidence from a comparison of reform in three countries." *Journal of Multidisciplinary Healthcare*, Vol. 9:35-46, available at https://pubmed.ncbi.nlm.nih.gov/26889085/

Healthpayer Intelligence. 2020. "Medicare Advantage Risk Adjustment Model Continues to Phase In." (Kelsey Waddill.) Available at https://healthpayerintelligence.com/news/medicare-advantage-risk-adjustment-model-continues-to-phase-in

Labrie, Yanick, and Marcel Boyer. 2008. "The Private Sector within a Public Health Care System: The French Example." Montreal Economic Institute Economic Note

Lazar, Harvey, John N. Lavis, Pierre-Gerlier Forest and John Church, eds. 2013. *Paradigm Freeze: Why it is so Hard to Reform Health-care Policy in Canada*. Montréal and Kingston: McGill-Queen's University Press.

Liao, Joshua M., Amal S. Navathe and Rachel M. Warner. 2020. "The Impact of Medicare's Alternative Payment Models on the Value of Care." *Annual Review of Public Health* 41:551-65. Available at https://www.annualreviews.org/doi/10.1146/annurev-publhealth-040119-094327

Macdonald, Donald. 1991. "A Leap of Faith: The Canadian Decision for Free Trade." *American Review of Canadian Studies* 21 (2-3): 155-61.

Nielsen, Marci, Lisabeth Buelt, Kavita Patel and Len M. Nichols. 2016. "The patient-centered medical home's impact on cost and quality: Annual review of evidence 2014-15." Patient-Centered Primary Care Collaboration, available at https://www.pcpcc.org/resource/patient-centered-medical-homes-impact-cost-and-quality-annual-review-evidence-2014-2015

Protti, Denis. 2015. *Missed Connections: The Adoption of Information Technology in Canadian Healthcare*. Commentary 422. Toronto: C. D. Howe Institute.

Shaw, Maria Lily. 2022. "Real solutions for what ails Canada's health care system: Lessons from Sweden and the United Kingdom." Montreal Economic Institute Research Paper

Soroka, Stuart N. 2007." Canadian perceptions of the health care system: A report to the Health Council of Canada."

Sutherland, Jason M., R. Trafford Crump, Nadya Repin, and Erik Hellsten. 2013. *Paying for Hospital Services: A Hard Look at the Options*. Commentary 378. Toronto: C. D. Howe Institute.

Sutherland, Jason M., and Erik Hellsten. 2017., *Integrated Funding: Connecting the Silos for the Healthcare We Need*. Commentary 463C. D. Howe Institute

Supreme Court of British Columbia. 2020. *Cambie Surgeries Corporation v. British Columbia* (Attorney General), 2020 BCSC 1310, available at https://www.bccourts.ca/jdb-txt/sc/20/13/2020BCSC1310.htm

Tuohy, Carolyn Hughes. 2018. *Remaking Policy: Scale, Pace and Political Strategy in Health Care Reform*. University of Toronto Press.

van de Ven, Wynand .P. M. M., and Frederik T Schut. 2008. "Universal Mandatory Health Insurance in the Netherlands: A Model for the United States?" *Health Affairs* 27(3): 771-81.

van de Ven, Wynand P. M. M,, Richard C van Kleef, and Rene C J A van Vliet. 2015. "Risk Selection Threatens Quality of Care for Certain Patients: Lessons from Europe's Health Insurance Exchanges." *Health Affairs* 34(10): 1713-20.

Whatley, Shawn. 2020. *When Politics Comes Before Patients: Why and How Canadian Medicare is Failing*. Toronto and Montréal: Optimum Publishing International, ISBN 978-0-88890-311-2.

World Population Review. 2021. Available at: https://worldpopulationreview.com/country-rankings/best-healthcare-in-the-world

NOTES:

NOTES:

Recent C.D. Howe Institute Publications

April 2022	Ciuriak, Dan. "The Economic Consequences of Russia's War on Ukraine." C.D. Howe Institute Verbatim.
April 2022	Lester, John. "An Intellectual Property Box for Canada: Why and How." C.D. Howe Institute E-Brief.
March 2022	Drummond, Don, and Duncan Sinclair. "Fixing, Funding, and Reforming Health Services." C.D. Howe Institute E-Brief.
March 2022	Marshall, David. *Time for a Tune-up: Reforms to Private-Sector Auto Insurance could Lower Costs and Add Value for Consumers*. C.D. Howe Institute Commentary 619.
March 2022	Robson, William B.P., Don Drummond, and Alexandre Laurin. "Getting Serious: A Shadow Federal Budget for 2022." C.D. Howe Institute E-Brief.
March 2022	Gros, Barry. *The Challenges Facing Target-Benefit Plans: Changes Are Needed to Provincial Pension Standards*. C.D. Howe Institute Commentary 618.
February 2022	Krane, Joshua, Stephen Wortley, and Connor Campbell. "A Friend in High Places: A Proposal to Add a National Security Amicus to Canada's Investment Review Regime." C.D. Howe Institute E-Brief.
February 2022	Ciuriak, Dan, Lucy Ciuriak, Ali Dadkhah, Yingkang Lyu, and Yun Wen. "Canada's Pivot to the Indo-Pacific: The Strategic Importance of Prioritizing a Trade Agreement with ASEAN." C.D. Howe Institute Working Paper.
February 2022	Robson, William B.P., and Miles Wu. *Solving the Municipal Budget Mystery: Fiscal Accountability in Canada's Cities, 2021*. C.D. Howe Institute Commentary 617.
January 2022	Laurin, Alexandre, and Nicholas Dahir. *Automatic Tax Filing: A Challenging Idea for Canada*. C.D. Howe Institute Commentary 616.
January 2022	Milton, Leslie, Jay Kerr-Wilson, and Paul Burbank. *Building Bridges for 5G: How to Overcome the Infrastructure Barriers to Deployment of Canada's Next-Generation Broadband Networks*. C.D. Howe Institute Commentary 615.

Support the Institute

For more information on supporting the C.D. Howe Institute's vital policy work, through charitable giving or membership, please go to www.cdhowe.org or call 416-865-1904. Learn more about the Institute's activities and how to make a donation at the same time. You will receive a tax receipt for your gift.

A Reputation for Independent, Nonpartisan Research

The C.D. Howe Institute's reputation for independent, reasoned and relevant public policy research of the highest quality is its chief asset, and underpins the credibility and effectiveness of its work. Independence and nonpartisanship are core Institute values that inform its approach to research, guide the actions of its professional staff and limit the types of financial contributions that the Institute will accept.

For our full Independence and Nonpartisanship Policy go to www.cdhowe.org.

C.D. HOWE
INSTITUTE

67 Yonge Street, Suite 300,
Toronto, Ontario
M5E 1J8

Canadian Publication Mail Sales
Product Agreement #40008848