GERMAN HEALTHCARE SYSTEM
AN OVERVIEW

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The Beginning

- The world's oldest national social health insurance system
- Dates back to Otto Von Bismarck’s social legislation
  - Health Insurance Bill of 1883
  - Accident Insurance Bill of 1884
  - Old Age and Disability Insurance Bill of 1889
Decentralized System

- Mandatory health insurance originally applied only to low-income workers and certain government employees, but gradually expanded to cover the great majority of the population.
- Private practice physicians provide ambulatory care
- Independent, mostly non-profit hospitals provide the majority of inpatient care
- Coverage through any one of approximately 1,100 public or private sickness funds [in essence insurance plans]
System Summary, continued

- Multi-Payor system with 2 types of insurances:
  - Gesetzliche Krankenkasse > Social or Public Health Insurance [SHI] covers about 92% of the population
    - Required up to a certain income level [opt-out at EUR 49K salary]
  - Common rates
  - Jointly paid by employer and employee
  - Pricing/benefits based on complex bargaining between autonomous interest groups [i.e. physician, federal states]
  - Demographic, actuarial or other discrimination prohibited
  - Provides social welfare and government employee insurance
Private Krankenversicherung > Private Health Insurance (PHI)

- Premiums based on individual risk assessed prior to enrollment
- Contracts for life [terminable only by insured]
- May not exclude pre-existing conditions
- May increase premiums only for general expenditure increase effecting the entire pool
- Must provide “standard tariff” option for the 55+ age group falling into financial distress mirroring SHI cost and coverage
Long Term Care

- Part of the standard SHI benefit package
- Additional contributions for coverage are required since 2007
- Not part of the PHI Insurance package but required to be purchased
- **Effective 1/1/2013** a subsidy of EUR 60/year for additional nursing care is provided for members covered by PHI and have a certain income level
What is covered?

- Preventive services, particularly during pregnancy and for the early detection of cancer or other major illness, such as heart and circulatory disorders
- Physician services
- Inpatient and outpatient hospital care
- Rehabilitation
- Mental health care [including drug rehabilitation]
- Dental care [including 80% – 90% of bridges and crowns]
System Summary, continued

- What is covered...continued
  - Prescription drugs [EUR 10 max for self-pay]
  - Sick leave compensation [6 weeks at 100% of salary, 70% salary until well or retired because of health]
  - Domestic nursing care
    - Where it is not possible to hospitalize patients
    - Patients with children under the age of 12, or who are handicapped, and who cannot be looked after by another person at home, may also receive domestic help
System Summary, continued

- **Cost**
  - **SHI**
    - General HC > 15.5 percent of salary [7.3% employer/8.2% employee]
    - Long Term > 1.95 Percent of Salary [0.975% employer/employee]
  - **PHI**
    - Varies based on benefit package and risk assessment
Cost and Expenditure Trends

Spending growth smooth and modest

Total health care spending per capita, thousands US-$ at ppp

- France
- Netherlands
- United States
- Germany
- United Kingdom

West Germany

Data source: OECD Health Data 2010
Cost and Expenditure Trends, continued

Growth in contribution rates has slowed

Annual average SHI contribution rates, now fixed at 15.5% for all (after 14.9% in 2010)

Data source: BMG (Arbeits- und Sozialstatistik, Bundesarbeitsblatt, KJ 1, KM 1, KV 45), destatis
Cost and Expenditure Trends, continued

Out-of-pocket payments up
Out-of-pocket payments in % of total health spending

- France
- Germany
- United Kingdom
- United States

Data source: OECD Health Data 2010

West Germany
Reforms 1970 - 2005

- 1972 – Hospital Financing Act
  - Regulates basic provisions for hospital care
  - Provides guidelines for planning and financing, including accounting for operational cost

- 1976 – Annual Commission enacted
  - Reps from business, labor, providers, payors and pharmaceutical industries
  - Tasked with recommending expenditure targets

- 1980s Member Contribution Requirements
  - Co-pay implementation
  - Increase in contribution rates

- 1986 Expenditure Caps implemented
  - Tied to local demographics and overall wage increases
  - Attempts to implement capitated care failed but fee for service is determined retrospectively to ensure targets are met

- Budget caps for hospital expenditures > principle of case or diagnostic code reimbursement was introduced into the system
- Flat rate per case replaced per diem for 30 percent of the hospitals by 1997
Reforms 1970 – 2005, continued

Cost Containment Measures through Budget Caps

<table>
<thead>
<tr>
<th>Year</th>
<th>Ambulatory care</th>
<th>Hospitals</th>
<th>Pharmaceuticals</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989 to 1992</td>
<td>negotiated regional fixed budgets</td>
<td>negotiated target budgets at hospital level</td>
<td>no budget or spending cap</td>
</tr>
<tr>
<td>1993</td>
<td><strong>legally set regional fixed budgets</strong></td>
<td><strong>legally set fixed budgets at hospital level</strong></td>
<td><strong>legally set national spending cap</strong></td>
</tr>
<tr>
<td>1995</td>
<td>negotiated regional fixed budgets</td>
<td>negotiated target budgets at hospital level</td>
<td>negotiated regional spending caps</td>
</tr>
<tr>
<td>1996</td>
<td>(target volumes for individual practice)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1997</td>
<td>negotiated regional fixed budgets</td>
<td>negotiated target budgets at hospital level</td>
<td></td>
</tr>
<tr>
<td>1998</td>
<td><strong>negotiated regional fixed budgets with legally set limit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2000</td>
<td>negotiated regional fixed budgets with legally set limit</td>
<td>negotiated target budgets at hospital level with legally set limit</td>
<td>negotiated regional spending caps</td>
</tr>
</tbody>
</table>

Note: The larger the size of text, the more strictly regulated the sector.
Recent Reforms

- **Financial**
  - 2008 Partial portability of aging provisions in PHI
  - 2009 Central Health Fund for SHI
  - 2009 Morbi RSA

- **Provider Competition**
  - 2003 – 2009 Gradual implementation of DRG system
  - 2005 Quality Control
  - 2009 Diagnosis related payment for physicians in ambulatory care
  - 2004 – 2011 Comparative Cost Effective Studies [evidence based medicine]

- **Drug Prices**
  - 2011 Reimbursement based in incremental benefit
Reforms Marginally Successful

Past reforms with merely temporary effects

Total expenditures (blue) and revenue (red) of Germany’s SHI system, in billion 2005 euros, and contributing SHI membership in millions (right scale)

- Global budgets introduced, private co-pay for drugs increased
- Sickness funds opened to competition
- 1999—2004: Six reforms relying on global budgets and private co-pay
- Central health fund

Data source: BMGS (Arbeits- und Sozialstatistik, Bundesarbeitsblatt, IU 1, KM 1, KV 45), using the consumer price index for health care
## Issue Comparison U.S. / Germany

<table>
<thead>
<tr>
<th>Category</th>
<th>Germany</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coordination of Care</strong></td>
<td>- Fragmented continuum of care</td>
<td>- Fragmented continuum of care</td>
</tr>
<tr>
<td></td>
<td>- Specialization</td>
<td>- Division in state, local, federal regulation</td>
</tr>
<tr>
<td></td>
<td>- No shared health record</td>
<td>- Specialization</td>
</tr>
<tr>
<td></td>
<td>- Maintaining health information problematic</td>
<td>- Difficult information sharing</td>
</tr>
<tr>
<td></td>
<td>- Difficult information sharing</td>
<td></td>
</tr>
<tr>
<td><strong>Access</strong></td>
<td>- Universal HC, full access</td>
<td>- No Universal HC, limited access for un- and under insured</td>
</tr>
<tr>
<td></td>
<td>- Increased demand, longer waiting periods for primary care only</td>
<td>- All care quickly accessible for the fully insured</td>
</tr>
<tr>
<td><strong>Efficiency</strong></td>
<td>- $4,875/per capita [2011/12]</td>
<td>- $8,608/per capita [2011/12]</td>
</tr>
<tr>
<td><strong>Equity</strong></td>
<td>- High, full access</td>
<td>- 46 mil patients without HC</td>
</tr>
<tr>
<td></td>
<td>- Providers may favor PHI patients because of higher reimbursement rates</td>
<td>- Low income patients even if insured forego care because of high self-pay cost</td>
</tr>
</tbody>
</table>
German Response to American Aversion to Obama Care

- Baffled about the hostility against the plan
- Reject the portrayal of solidarity = socialism
- Believe system only works if all are covered [distributive]
- A basic human principle: The people’s health is critical to economic health. This means not only your own, but also that of your neighbor’s
- The U.S. system is inefficient, which makes it expensive, which makes it uncompetitive
- U.S. stance on healthcare contradicts their Christian principles
- Does the U.S. want to be known as the place where the poor die young?
References

- “Reforming Healthcare, the German Experience” by Michael Stolpe, Kiel Institute for the World Economy, Christian-Albrechts-Universität Kiel, Germany, version of June 19, 2011
- Wikipedia, The free encyclopedia
- The German healthcare system and healthcare, reform, Kerstin Kamke, National Association of Statutory Health Insurance Physicians; 1997
- Schneider, Markus, Academic journal article from Health Care Financing Review, Vol. 12, No. 3
- European Observatory, on Health Care Systems, 2000
- JHU, American Institute for Contemporary German Studies, Business and Economics, Issues in German and U.S. HC, March 2012
- Spiegel on-line, 5/11/2012
Questions
HEALTHCARE OVERVIEW IN BRAZIL

ROGERIO COSTA
INTERNAL AUDITOR
AMILPAR CORPORATION
<table>
<thead>
<tr>
<th>DATE</th>
<th>HEALTH HISTORICAL EVENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1850</td>
<td>Delegation of Health Standard to Municipal Councils and control of Ships and ports</td>
</tr>
<tr>
<td>1920</td>
<td>National Public Health Department – Carlos Chagas</td>
</tr>
<tr>
<td>1923</td>
<td>Creation of “Retirement and Pension Public Bank” – financed by urban employee to guarantee health care.</td>
</tr>
<tr>
<td>1953</td>
<td>Creation of Ministry of Health</td>
</tr>
</tbody>
</table>
| 1988 | Brazilian Federal Constitution  
Art. 196 Health constitutes a right of all and duty of the State  
Art. 198 SUS - universal, integral and equal right of access to health care, descentralization and social participation |
<p>| 2000 | National Agency for Supplementary Health (“ANS”) |</p>
<table>
<thead>
<tr>
<th><strong>Public Health Care Sector</strong></th>
<th><strong>Private or Supplemental Health Care System</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Free health services funded by taxes</td>
<td>Individual / Familiar 20% or Corporate 80% Health plans (State foregoes tax)</td>
</tr>
<tr>
<td>Federal, State and Municipal Institutions</td>
<td>Owned or Contracted Network</td>
</tr>
<tr>
<td>Spends around $300 per capita per year in SUS</td>
<td>$600 in the private system</td>
</tr>
<tr>
<td>90% of Brazilians use SUS</td>
<td>25% Medical Managed Care Penetration</td>
</tr>
<tr>
<td>Underfunding, long wait times and low quality of care</td>
<td>Quality of care controlled by ANS (FINES)</td>
</tr>
</tbody>
</table>
HEALTHCARE SECTOR: NON-MATURE MARKET WITH SEVERAL OPPORTUNITIES

POPULATION COVERED - MEDICAL (MILLION)

<table>
<thead>
<tr>
<th>Year</th>
<th>Population (Million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>31.7</td>
</tr>
<tr>
<td>2004</td>
<td>33.6</td>
</tr>
<tr>
<td>2005</td>
<td>35.0</td>
</tr>
<tr>
<td>2006</td>
<td>36.9</td>
</tr>
<tr>
<td>2007</td>
<td>38.7</td>
</tr>
<tr>
<td>2008</td>
<td>40.7</td>
</tr>
<tr>
<td>2009</td>
<td>42.0</td>
</tr>
<tr>
<td>2010</td>
<td>45.6</td>
</tr>
<tr>
<td>2011</td>
<td>47.0</td>
</tr>
<tr>
<td>2012</td>
<td>47.9</td>
</tr>
</tbody>
</table>

CAGR = 4.7%

POPULATION COVERED – EXCLUSIVELY DENTAL (MILLION)

<table>
<thead>
<tr>
<th>Year</th>
<th>Population (Million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>4.5</td>
</tr>
<tr>
<td>2004</td>
<td>5.5</td>
</tr>
<tr>
<td>2005</td>
<td>6.1</td>
</tr>
<tr>
<td>2006</td>
<td>7.3</td>
</tr>
<tr>
<td>2007</td>
<td>8.8</td>
</tr>
<tr>
<td>2008</td>
<td>10.3</td>
</tr>
<tr>
<td>2009</td>
<td>12.6</td>
</tr>
<tr>
<td>2010</td>
<td>14.5</td>
</tr>
<tr>
<td>2011</td>
<td>16.0</td>
</tr>
<tr>
<td>2012</td>
<td>18.6</td>
</tr>
</tbody>
</table>

CAGR = 17.1%

SOURCE: NATIONAL HEALTH AGENCY (ANS)
HEALTHCARE SECTOR: NON-MATURE MARKET WITH SEVERAL OPPORTUNITIES

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Companies</th>
<th>Number of Members (in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>2.709</td>
<td>34.9</td>
</tr>
<tr>
<td>2012 *</td>
<td>1.571</td>
<td>66.3</td>
</tr>
<tr>
<td>Growth (Reductio)</td>
<td>-42%</td>
<td>90%</td>
</tr>
</tbody>
</table>

*Source = ANS + Annualization (Revenue and Cost until sep/12 with a forecast based on the growth compared with the same period on 2011)
### HEALTHCARE SECTOR: NON-MATURE MARKET WITH SEVERAL OPPORTUNITIES

<table>
<thead>
<tr>
<th>Year</th>
<th>Premiums (in billions)</th>
<th>Total Costs (in billions)</th>
<th>MLR</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>22.1</td>
<td>17.5</td>
<td>79%</td>
</tr>
<tr>
<td>2012*</td>
<td>91.5</td>
<td>78.2</td>
<td>85%</td>
</tr>
<tr>
<td>Growth</td>
<td>313%</td>
<td>347%</td>
<td>8%</td>
</tr>
</tbody>
</table>

*Source = ANS + Annualization (Revenue and Cost until sep/12 with a forecast based on the growth compared with the same period on 2011)
## The Brazil MCO Market Has a Number of Potential Avenues for Growth

<table>
<thead>
<tr>
<th></th>
<th>UNITED STATES (1)</th>
<th>BRAZIL (2)</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population (MM)</td>
<td>314</td>
<td>194</td>
<td>Higher population growth in Brazil</td>
</tr>
<tr>
<td># of People in Managed Care (MM)</td>
<td>253</td>
<td>49</td>
<td>Low MCO penetration in Brazil</td>
</tr>
<tr>
<td>Medical Managed Care Penetration</td>
<td>81%</td>
<td>25%</td>
<td>Significant cross-selling opportunities</td>
</tr>
<tr>
<td>Dental Managed Care Penetration</td>
<td>57%</td>
<td>10%</td>
<td>Significant consolidation opportunities</td>
</tr>
<tr>
<td># of Managed Care Organizations</td>
<td>500</td>
<td>1,542</td>
<td></td>
</tr>
</tbody>
</table>

Source: (1) US Census Bureau, AIS’s Directory of Health Plans, 2012 and National Association of Dental Plans (2) ANS and IBGE 2012
**BRAZIL: STRONG FUNDAMENTALS TO SUSTAIN DEMAND GROWTH**

**ANNUAL GDP GROWTH**

<table>
<thead>
<tr>
<th>Year</th>
<th>Growth (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>1.1%</td>
</tr>
<tr>
<td>2004</td>
<td>5.7%</td>
</tr>
<tr>
<td>2005</td>
<td>3.2%</td>
</tr>
<tr>
<td>2006</td>
<td>4.0%</td>
</tr>
<tr>
<td>2007</td>
<td>6.1%</td>
</tr>
<tr>
<td>2008</td>
<td>5.2%</td>
</tr>
<tr>
<td>2009</td>
<td>-0.6%</td>
</tr>
<tr>
<td>2010</td>
<td>7.5%</td>
</tr>
<tr>
<td>2011</td>
<td>2.7%</td>
</tr>
<tr>
<td>2012</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

(Source: IBGE, www.economywatch.com)

**UNEMPLOYMENT RATE**

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>12.3%</td>
</tr>
<tr>
<td>2004</td>
<td>11.5%</td>
</tr>
<tr>
<td>2005</td>
<td>9.9%</td>
</tr>
<tr>
<td>2006</td>
<td>10.0%</td>
</tr>
<tr>
<td>2007</td>
<td>9.3%</td>
</tr>
<tr>
<td>2008</td>
<td>7.9%</td>
</tr>
<tr>
<td>2009</td>
<td>8.1%</td>
</tr>
<tr>
<td>2010</td>
<td>6.7%</td>
</tr>
<tr>
<td>2011</td>
<td>6.0%</td>
</tr>
<tr>
<td>2012</td>
<td>5.5%</td>
</tr>
</tbody>
</table>

(Source: BACEN and IBGE)
BRAZIL: STRONG FUNDAMENTALS TO SUSTAIN DEMAND GROWTH (CONT’D)

ANNUAL PER CAPITA INCOME (US$)

<table>
<thead>
<tr>
<th>Year</th>
<th>Income (US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>3,042</td>
</tr>
<tr>
<td>2004</td>
<td>3,610</td>
</tr>
<tr>
<td>2005</td>
<td>4,743</td>
</tr>
<tr>
<td>2006</td>
<td>5,793</td>
</tr>
<tr>
<td>2007</td>
<td>7,197</td>
</tr>
<tr>
<td>2008</td>
<td>8,628</td>
</tr>
<tr>
<td>2009</td>
<td>8,251</td>
</tr>
<tr>
<td>2010</td>
<td>10,710</td>
</tr>
<tr>
<td>2011</td>
<td>12,696</td>
</tr>
</tbody>
</table>

CAGR = 19.6%

SOURCE: WORLD BANK
**GDP Growth x Health Plan Growth**

- Health Plan Variation
- GDP Variation

**Number of Beneficiary x Number of Formal Employment**

- Correlation Coefficient: 0.29

- Number Health Plan Beneficiary in Brazil:
  - 4Q05: 30,000
  - 4Q07: 32,000
  - 4Q09: 34,000
  - 4Q11: 36,000

- Number Formal Employment (Thousand):
  - 2006: 110
  - 2007: 120
  - 2008: 130
  - 2009: 140
  - 2010: 150
  - 2011: 160

- CORRELATION COEFFICIENT: 1
BRAZIL: STRONG FUNDAMENTALS TO SUSTAIN DEMAND GROWTH (CONT’D)

DEMOGRAPHIC SHIFT

2003

<table>
<thead>
<tr>
<th>Class</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>A+B</td>
<td>22%</td>
</tr>
<tr>
<td>C</td>
<td>31%</td>
</tr>
<tr>
<td>D+E</td>
<td>47%</td>
</tr>
</tbody>
</table>

2011

<table>
<thead>
<tr>
<th>Class</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>A+B</td>
<td>34%</td>
</tr>
<tr>
<td>C</td>
<td>50%</td>
</tr>
<tr>
<td>D+E</td>
<td>16%</td>
</tr>
</tbody>
</table>

24 MILLION NEW PEOPLE IN CLASSES A+B AND 38 MILLION NEW PEOPLE TO CLASS C

SOURCE: ABEP

SOURCE: IBGE 2008
BRAZIL Facing THE CHALLENGE TO DEVELOP AS IT GETS OLDER

THE POPULATIONAL AGING PACE: NUMBER OF YEARS FOR THE POPULATION OF 65 OR MORE TO GROW FROM 7% TO 14%

**DEVELOPED COUNTRIES**

- JAPAN (1970-1996)
- SPAIN (1947-1992)
- UK (1930-1974)
- POLAND (1966-2013)
- HUNGARY (1941-1994)
- CANADA (1944-2009)
- USA (1944-2013)
- AUSTRALIA (1938-2011)
- SWEDEN (1890-1975)
- FRANCE (1865-1980)

**DEVELOPING COUNTRIES**

- SINGAPORE (2000-2019)
- COLOMBIA (2017-2037)
- BRAZIL (2011-2032)
- THAILAND (2003-2025)
- SRI LANKA (2004-2027)
- TUNISIA (2008-2032)
- JAMAICA (2008-2033)
- CHINA (2000-2026)
- CHILE (1998-2025)
- AZERBAIJAN (2000-2041)

**SOURCE:** NATIONAL INSTITUTES OF HEALTH 2009

**KEY FEATURES**

- Economic Stabilization
- Opening Market
- Epidemiologic Transition
- New Technologies
- Internet
- One Single Generation
AN ABYSS SEPARATE THE QUALITY OF LIFE
QUESTIONS ?
THANK YOU!
CANADIAN HEALTHCARE SYSTEM

GIVONNA DE BRUIN, CA, CIA, CRISC
CORPORATE DIRECTOR, INTERNAL AUDIT
INTERIOR HEALTH AUTHORITY
Kelowna, British Columbia, Canada
Canada 101

Interior Health Authority
The Interior of British Columbia....
About the Interior Health Authority

- 1 of 5 regional health authorities in the province of British Columbia
- 215,000 sq km - larger than England and Scotland combined
- 749,000 residents across 68 Municipalities & Regional Districts and 55 First Nation Communities
- $1.9 Billion Budget ($1Cdn approx. $1US)
- 18,766 active employees and 1,483 privileged physicians
- 2 Tertiary Referral Hospitals (614 beds), 4 Service Area Hospitals (426 beds), 16 Community Hospitals (238 beds)
- 6,475 Residential and Assisted Living Beds

For more information visit www.interiorhealth.ca
Before World War II, healthcare in Canada was, for the most part, privately delivered and funded.

1947 Saskatchewan was the first province to introduce a universal hospital care plan (post Depression Socialism)

1957 and 1966 the federal government introduced two acts which implemented cost-sharing between federal and provincial governments for both hospital and non-hospital services.

1984 Canada Health Act introduced
The Canada Health Act provides:

- Key system principles
- Provides reasonable access to medically necessary hospital and doctors' services on a pre-paid basis, without direct charges at the point of service.
- Limitation on extra-billing and user fees
- Criteria and conditions for cash transfers from the federal government to the provinces
Five Canada Health Act Principles

1. Public Administration:
   ▪ The provincial and territorial plans must be administered and operated on a non profit basis by a public authority accountable to the provincial or territorial government.

2. Comprehensiveness:
   ▪ The provincial and territorial plans must insure all medically necessary services provided by hospitals, medical practitioners and dentists working within a hospital setting.

3. Universality:
   ▪ The provincial and territorial plans must entitle all insured persons to health insurance coverage on uniform terms and conditions.

4. Accessibility:
   ▪ The provincial and territorial plans must provide all insured persons reasonable access to medically necessary hospital and physician services without financial or other barriers.

5. Portability:
   ▪ The provincial and territorial plans must cover all insured persons when they move to another province or territory within Canada and when they travel abroad. The provinces and territories have some limits on coverage for services provided outside Canada, and may require prior approval for non-emergency services delivered outside their jurisdiction.
Canadian Healthcare System Summary

- Each of the 10 provinces and 3 territories are responsible for healthcare delivery.
- The majority of Canadian hospitals are operated by community boards or municipalities.
- Hospitals are paid through annual global budgets from the provincial Ministries of Health.
- Nation wide accreditation program provided by Accreditation Canada
Canada’s health care system (Medicare) is best described as an interlocking set of provincial government health insurance plans supplemented by private/insured funding.

- 70% federally/provincially funded
- 30% funded through extended health, other insurance benefits and self-pay.

Provincial health insurance plans go beyond the basic services outlined in the Canada Health Act.

- such as: subsidized residential care, home care and community care.

Funding sources vary by province including various tax sources and individual income linked medical insurance plan premiums (if premiums are not paid basic service must still be provided.)
A Canadian’s View of the Healthcare System

- No user fees for medically necessary services - ie visits to GP’s, public health services, acute care, ERs.
- No bills to pay upon discharge from hospital. Costs for patients care are not individually tracked.
- Ambulances self paid (in BC flat fee of $65/ride).
- Hospital provided drugs are free; community pharmacy drugs are on sliding scale with limits based on income level.
- Only public system choice for primary care, acute care.
- Private options exist for homecare/residential care. Provincial government provides homecare nursing/home support assistance and residential care on a subsidized basis.
- In BC, residential care cost for seniors is 80% of after-tax income.
- Personal homecare supplies/equipment are personally paid.
- Chiropractor, physiotherapy, occupational therapy services outside the hospital are personally paid.
- Dental care is self paid except for surgeries requiring general anesthetic.
BC Healthcare System Challenges

- **79%** of health budget controlled/influenced by **contracted** physicians with limited accountability (admit/discharge, prescribing/referral, MSP billings). Few physicians are employees.

- System does not have control over **physician** cost/quality.

- BC Health Authorities funded on blended model – population need, utilization, complexity, rurality and shifting to Pay for Performance model (UK).

- Highly unionized workforce with collective agreement language which increasingly limits management’s rights to manage and make system changes.
<table>
<thead>
<tr>
<th>Country</th>
<th>Total Health Expenditure per Capita (USD)</th>
<th>Total Health Expenditure (Percentage of GDP)</th>
<th>Public Share of Total Health Expenditure</th>
<th>Public-Sector Health Spending per Capita (USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canada</td>
<td>4,445</td>
<td>11.4%</td>
<td>71.1%</td>
<td>3,158</td>
</tr>
<tr>
<td>U.S.</td>
<td>8,233</td>
<td>17.6%</td>
<td>48.2%</td>
<td>3,967</td>
</tr>
<tr>
<td>Germany</td>
<td>4,338</td>
<td>11.6%</td>
<td>76.8%</td>
<td>3,331</td>
</tr>
<tr>
<td>U.K.</td>
<td>3,433</td>
<td>9.6%</td>
<td>83.2%</td>
<td>2,857</td>
</tr>
</tbody>
</table>
Comparison to the US Healthcare System

- Canada spends half of what the US does per capita on healthcare
  - In 2013: $4,000 Canada vs. $8,000 US
- Canada is ranked 30th and the US is 37th/191 countries by the WHO for overall healthcare system performance
- 2011 average Canadian life expectancy was 2.3 years longer
  - 80.93 years in Canada vs. 78.64 years in US
- Longer wait times in Canada to advanced diagnostic testing and elective surgeries
  - Canada has 4.6 MRI’s/mil population vs. US at 19.5 MRI’s/mil.
- “Managed Care” is not a concept in Canada due to the public health delivery system!
- The average income for Canadian physicians is half that of US physicians; fees are set through negotiated contracts between the provincial governments and physician professional organizations.
- Fewer physicians: 2.1 physicians in Canada /1000 population vs. the US's 2.4 (2010).
- In Canada all drugs provided in hospitals are funded through Medicare. Drugs provided outside of hospitals for seniors and the poor are government subsidized. Drugs for approximately 2/3 of working Canadians are paid through private extended medical insurance plans provided through employers (ie Blue Cross).
- Malpractice costs are significantly lower – in Canada $4 pp /yr vs. US $16 pp /yr.


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