



Comparing health systems across North America – Learning from reforms to expand coverage, improve quality, and recover from COVID-19

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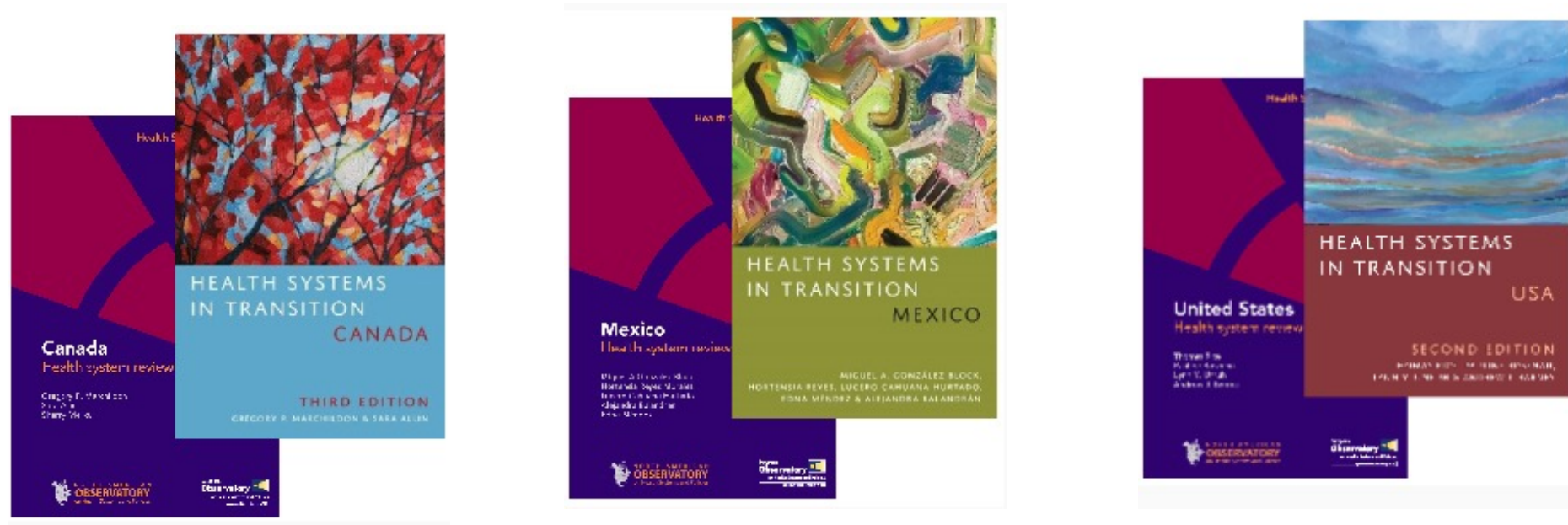
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Outline

- Short overview
- Canada
- USA
- Mexico
- Opportunities for comparative policy learning, and Q&A

National health system profiles: Facilitating comparative analysis and assessment of performance



Health system “types” according to regulation, financing and provision (Bohm et al., 2013)

Regulation	Financing	Provision	Ideal Types (Exemplars)
Statist	Statist	Statist	National Health Service (UK)
		Societal	National Health System, non-profit
		Private	National Health Insurance (Canada)
	Societal	Societal	Social Statist Health System
		Private	Statist Health Insurance (France)
	Private	Private	Statist Private Health System
Societal	Societal	Societal	Social Health System (Mexico)
		Private	Social Health Insurance (Germany)
	Private	Private	Private Corporatist Health System
Private	Private	Private	Private Health System (USA)

Böhm K, Schmid A, Götze R, Landwehr C, Rothgang H. Five types of OECD healthcare systems: empirical results of a deductive classification. Health Policy. 2013 Dec;113(3):258-69. doi: 10.1016/j.healthpol.2013.09.003.

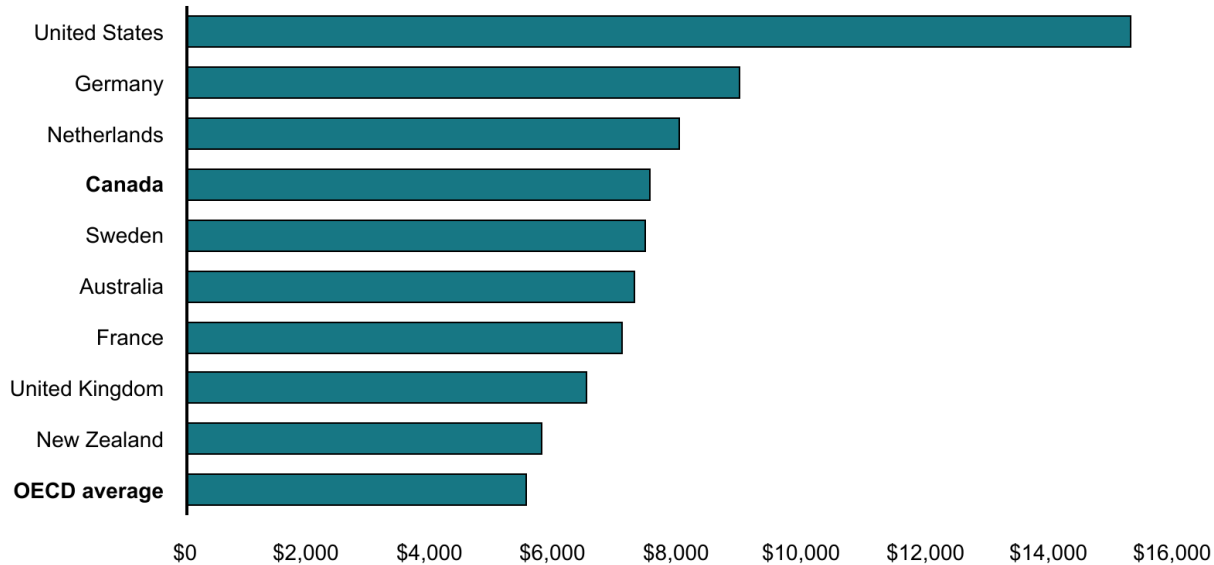
Canada's health system

System characteristics, progress toward UHC and priorities for reform

Spending on health care in Canada is among the highest in the world (CIHI 2022)

How does Canada's health spending compare?

Dollars per person (\$CA), 2020



Bar chart of 2020 per-person spending in Canadian dollars for the OECD as a whole and 9 selected OECD countries, including Canada.

Notes

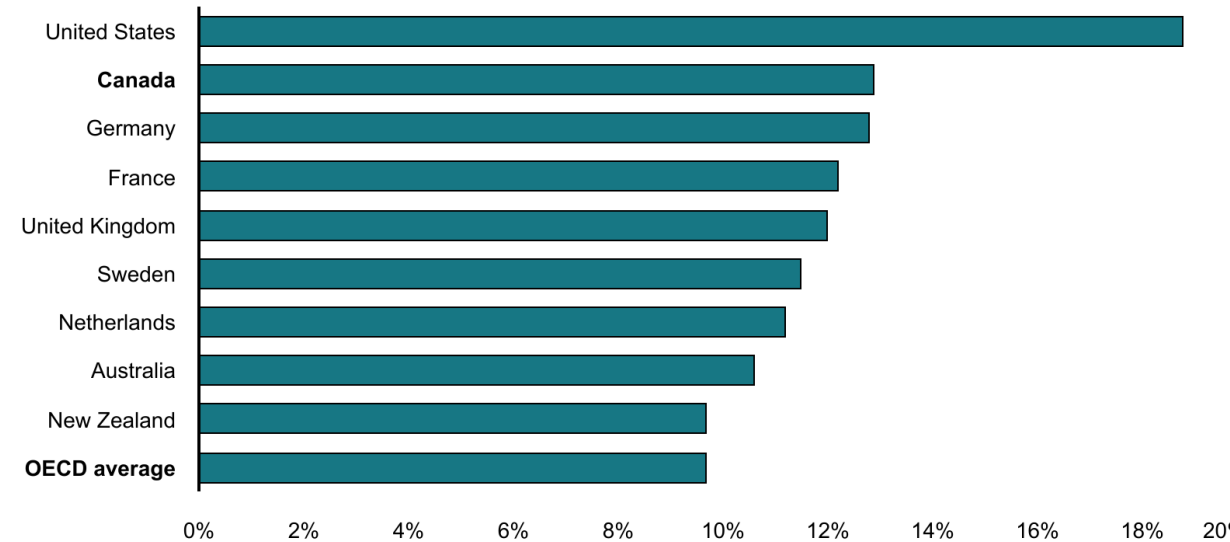
OECD: Organisation for Economic Co-operation and Development. Total current expenditure (capital excluded). Expenditure data is based on the OECD's *A System of Health Accounts 2011*.

Source

Organisation for Economic Co-operation and Development. *OECD Health Statistics 2022*. 2022.

How does Canada's health spending compare?

Percentage of GDP, 2020



Bar chart of 2020 health spending as a percentage of GDP for the OECD as a whole and 9 selected OECD countries, including Canada.

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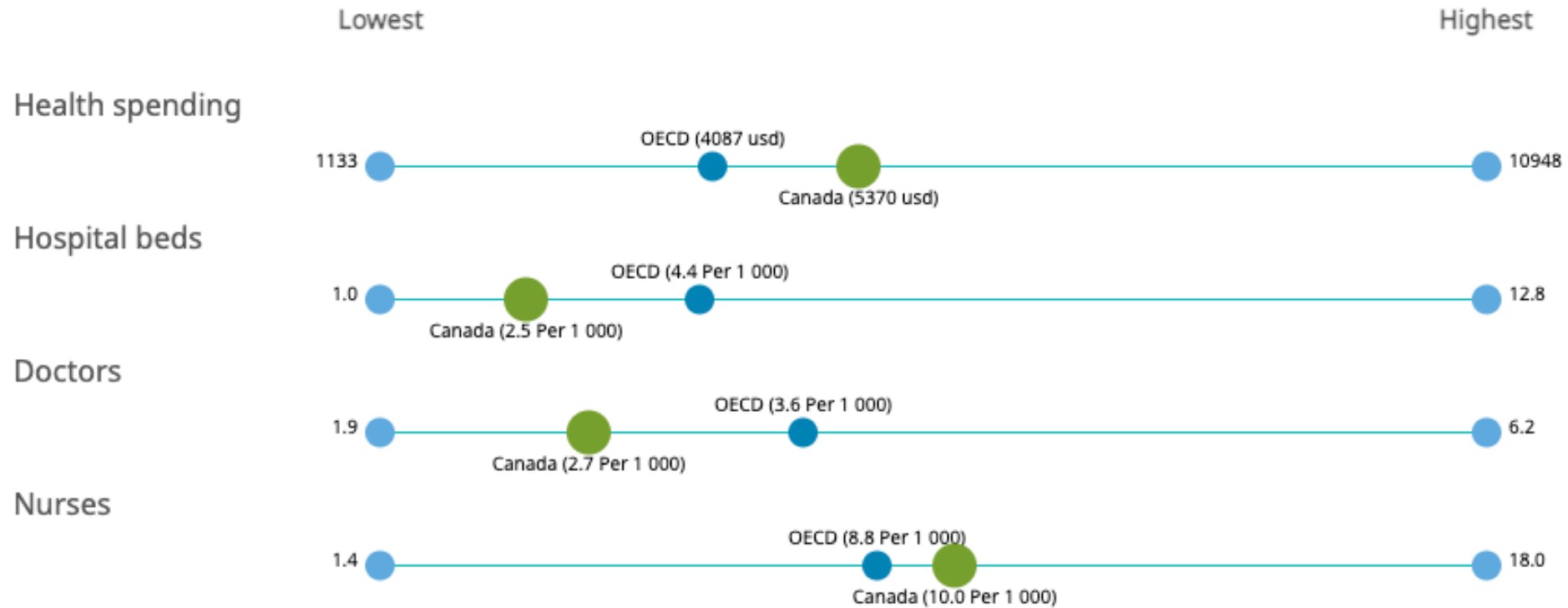
GDP: Gross domestic product. OECD: Organisation for Economic Co-operation and Development. Total current expenditure (capital excluded). Expenditure data is based on the OECD's *A System of Health Accounts 2011*.

Source

Organisation for Economic Co-operation and Development. *OECD Health Statistics 2022*. 2022.

Yet health care capacity is below average

Health care resources

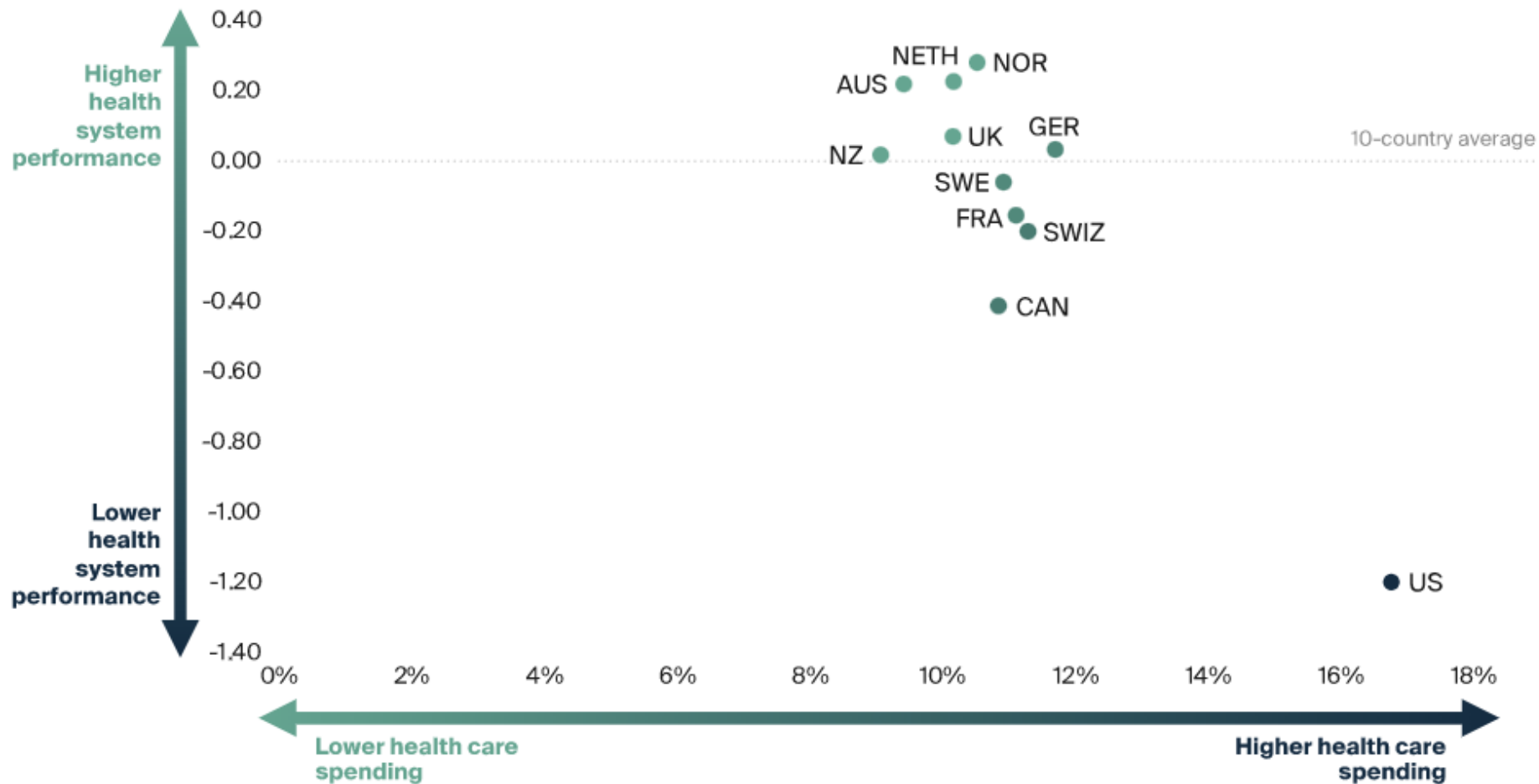


Visit the [Health at a Glance 2021 website](#) for access to the full report, detailed country notes and more information.



And overall health system performance is poor (Commonwealth Fund rankings, 2021)

Health Care System Performance Compared to Spending



Features of health system: Narrow but deep health coverage

- Universal coverage of narrow basket of services –physician and hospital care
 - Coverage based on residency in a province
 - No co-payments/user charges (coverage is deep)
 - Access on uniform terms and conditions – no queue jumping
- All other services are subsidized to various degrees for targeted groups by provincial governments
 - Long-term care (about two-thirds financed publicly)
 - Prescription drugs (about 50% financed publicly)
 - Dental care (about 6% financed publicly), targeted expansion of coverage in 2022

Canada's health systems: public (single) payer, private delivery

- About 70% of total health expenditures is from public sources; mostly provincial health budgets
- Mostly private delivery
 - physicians as independent contractors/small-business owners
 - hospitals as independent not-for-profit organizations (in Ontario)
- Small but growing role of corporate-owned practices (mostly virtual care, but increasingly surgical and diagnostics)
- Rationing is on the supply side, e.g., restricted medical school spots; regulated prices and capital investments, limits to operating room time = long wait lists for specialist and surgical care

Challenges: Access to primary care is inadequate – e.g., limited after hours health care

How Canada Compares: Results From the Commonwealth Fund's 2021 International Health Policy Survey of Older Adults in 11 Countries

2 out of 5 Canadian seniors find it easy to get after-hours medical care

Figure 34: Respondents who reported that it was *very/somewhat easy* to get medical care in the evenings or on weekends or holidays without going to the hospital/emergency department[†]

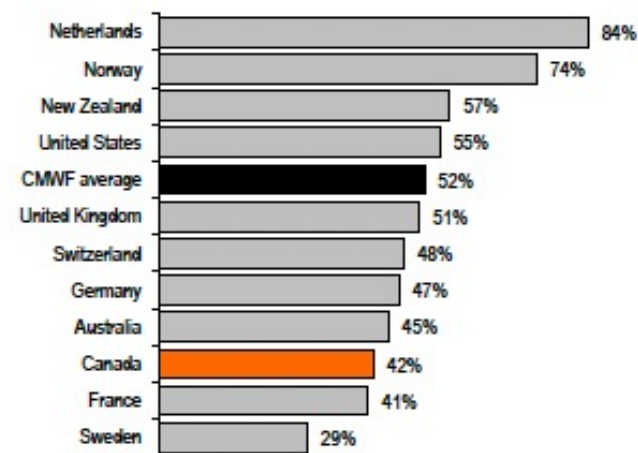


Figure 35: Respondents who reported that it was *very/somewhat easy* to get medical care in the evenings or on weekends or holidays without going to the hospital/emergency department,[‡] by year^{2, 12}

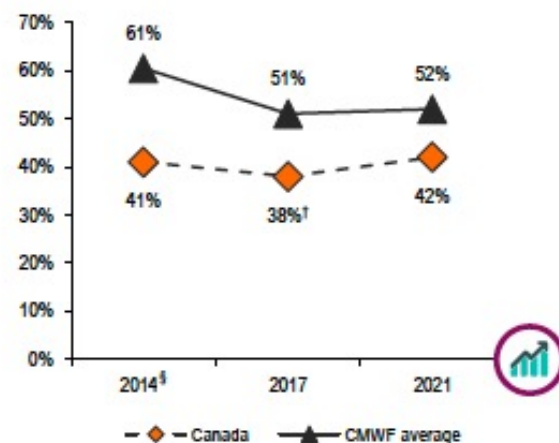


Figure 36: Respondents who reported that it was *very/somewhat easy* to get medical care in the evenings or on weekends or holidays without going to the hospital/emergency department,[‡] by rurality



Notes

[†] 2021 results are significantly different from 2017 or 2014 results.

[‡] Excludes respondents who never needed care in the evening.

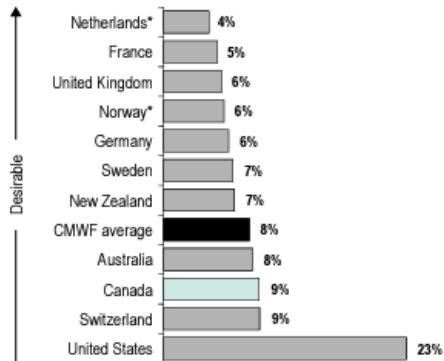
[§] The 2014 CMWF survey of older adults included individuals age 55+. The analyses in this report include the age 65+ subpopulation of those survey respondents.

In the 2019 survey of primary care physicians, more Canadian primary care physicians reported offering weeknight appointments at least once a week (57%) and weekend appointments (50%) compared with the CMWF average (weeknight, 44%; weekend, 36%).¹³

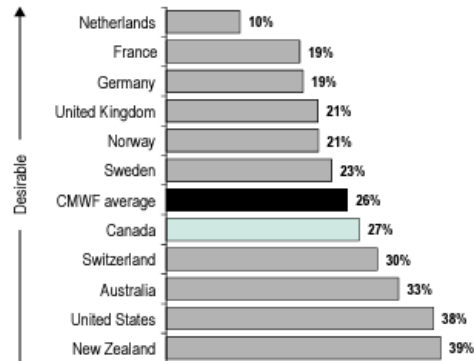
Challenges: Cost-barriers to care in the general population (2020)

Canadians faced similar cost barriers to dental care and prescription drugs

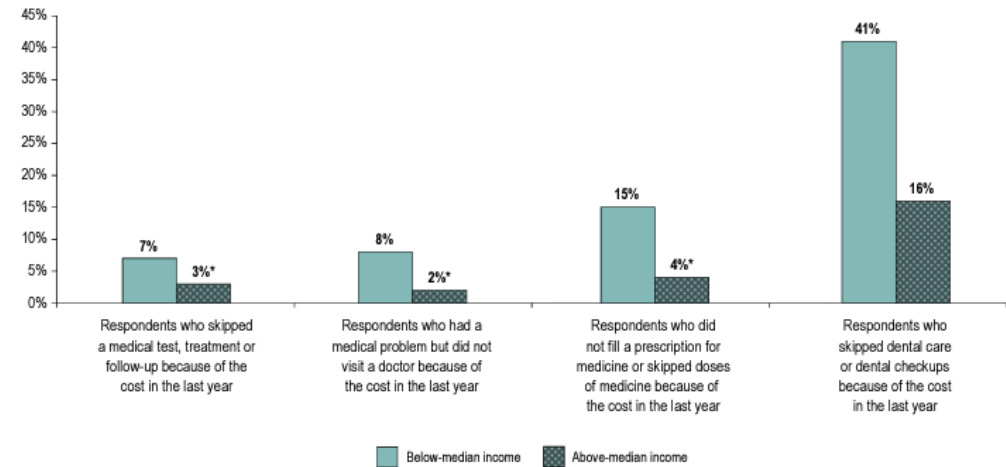
Respondents who did not fill a prescription for medicine or skipped doses of medicine because of the cost in the last year



Respondents who skipped dental care or dental checkups because of the cost in the last year



Cost barriers to care were highest for lower-income Canadians



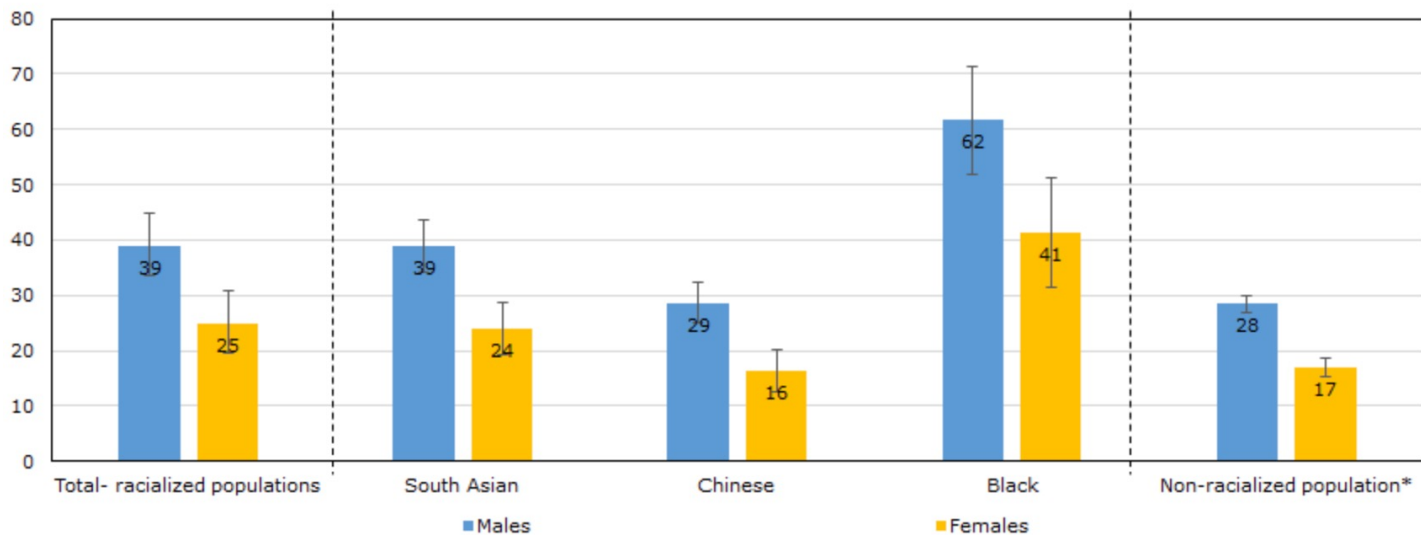
Challenges: Significant inequalities, e.g., in COVID mortality

Statistics Canada, 2022.

<https://www150.statcan.gc.ca/n1/pub/45-28-0001/2022001/article/00010-eng.htm>

Figure 1
Age-standardized COVID-19 mortality rates in Canada between January 1, 2020 and December 31, 2020, by sex and racialized groups in 2016

Age standardized mortality rate (per 100,000)

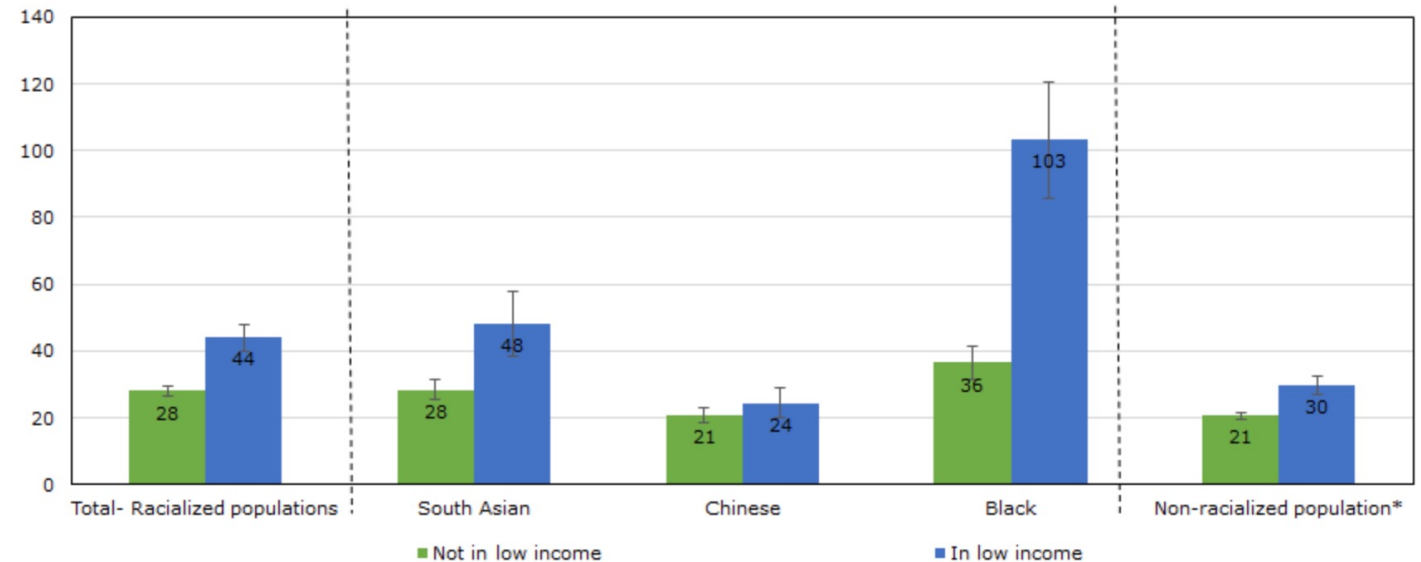


Note: *Non-racialized population excludes Indigenous people.

Source: Canadian Census Health and Environmental Cohort 2016 linked to Canadian Vital Statistics – Death Database from 2016-2020 (#3233).

Figure 2
Age-standardized COVID-19 mortality rates in Canada between January 1, 2020 and December 31, 2020, by racialized groups and low income status (low-income measure (LIM) – after tax) in 2016

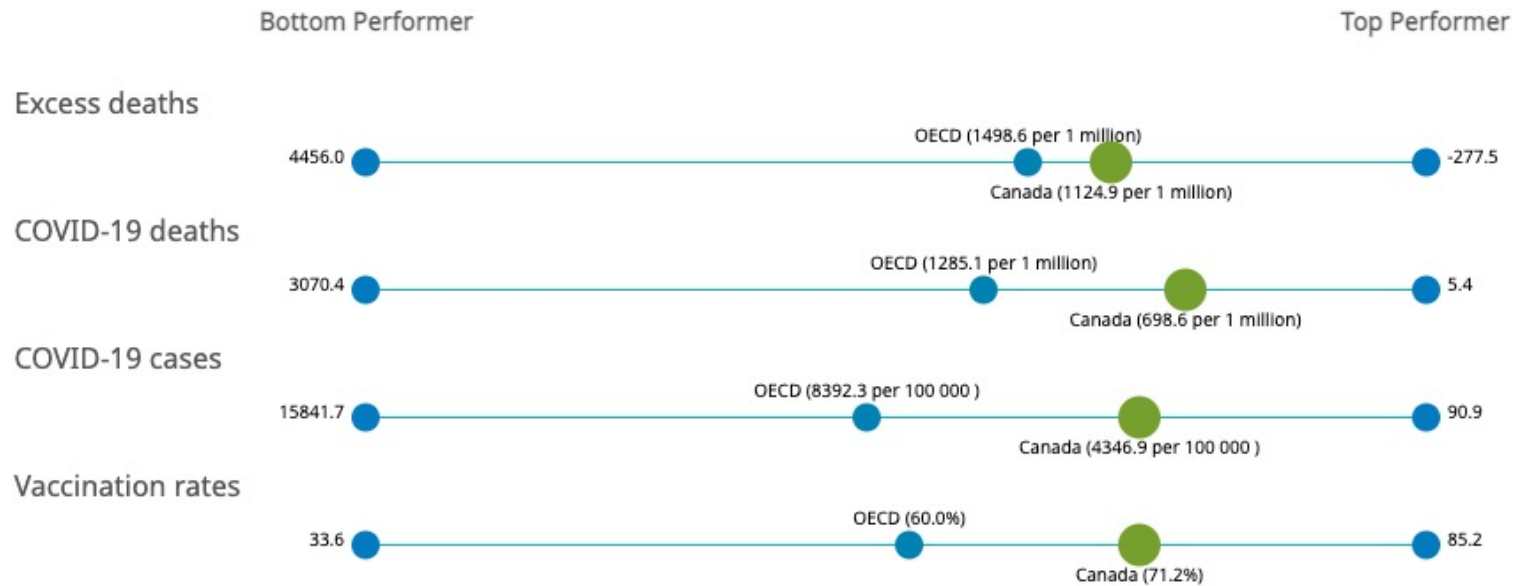
Age standardized mortality rate (per 100,000)



Note: *Non-racialized population excludes Indigenous people.

COVID-19 has shocked health systems yet adverse health outcomes have been mitigated

COVID-19



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Some promising practices

- Address workforce shortages – some increased role of physician assistants, and nurse practitioners
- Reduce burden on hospitals and emergency rooms – social prescribing, supportive housing and new models of urgent care
- Strengthen primary care –invest in team-based primary care, including community-governed clinics in underserved areas, some increase in compensation of family physicians
- Leverage virtual care, building on early successes in rural/remote areas

USA Health System

Features of U.S. Health Care System

- Insurance coverage is not universal and until 2014 relied on a system of voluntary private insurance
 - Employers did not have to offer coverage
 - Individuals did not have to purchase coverage
 - This changed partly on January 1, 2014
- There is no overall budget
- Rationing is largely carried out on the demand rather than supply side
 - Price rather than supply regulations is limiting factor
 - Little regulation of fees or health supplies (hospital beds, specialists, equipment)

Not a Single System, but Many

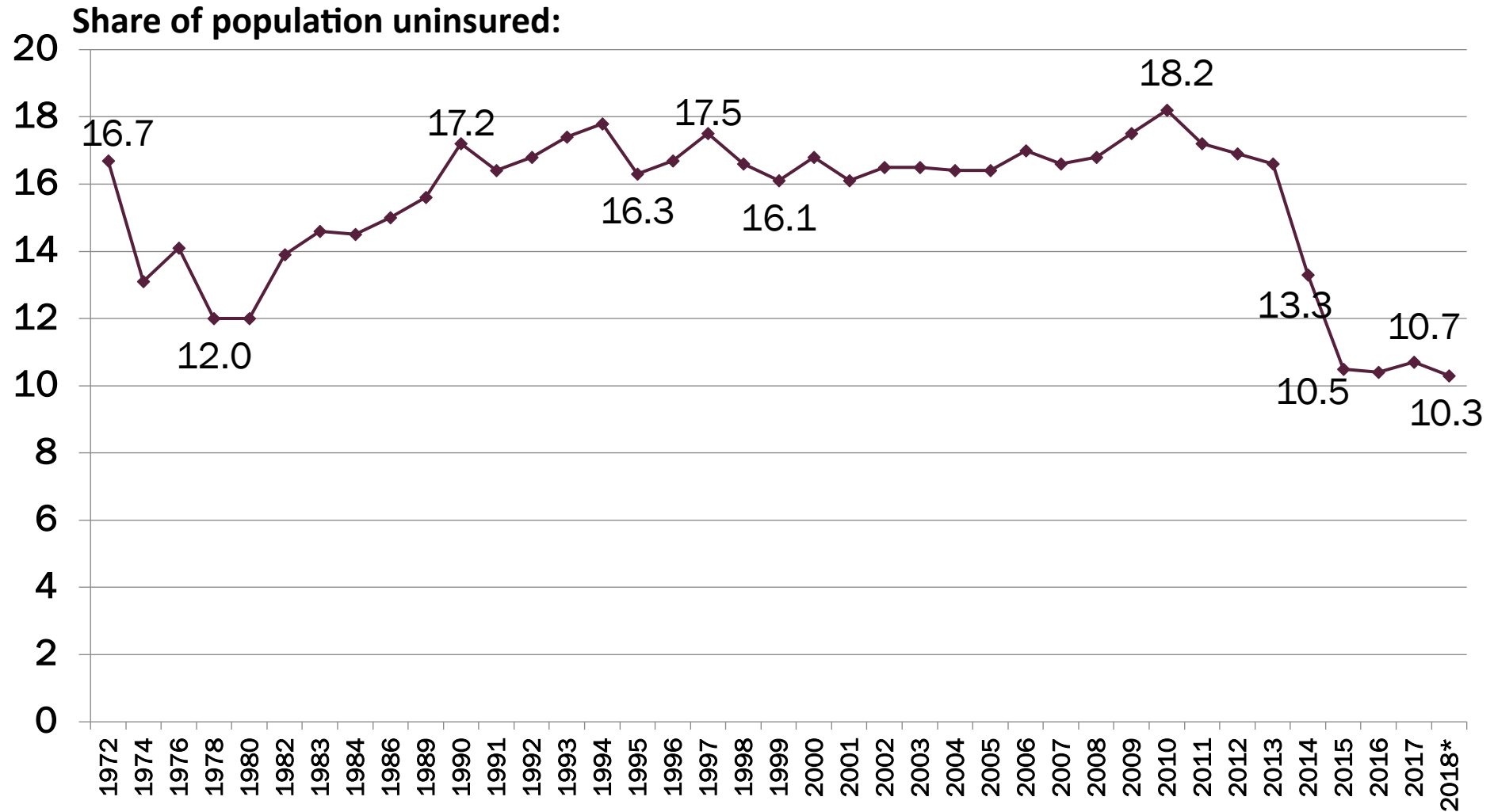
- Private health insurance
 - Group coverage through employers
 - Individual coverage, partly through state-based ACA marketplaces
- Medicare (age 65+, some disabled persons)
- Medicaid (some poor and new poor persons)
- Other government-provided coverage (military, veterans, Native Americans)
- Uninsured
 - People who choose not to purchase coverage
 - Poor persons in states that haven't expanded Medicaid
 - Undocumented immigrants

Role of Health Systems and Corporations in Government Programs

- Medicare: half of enrollees are in managed care systems, mostly for-profit
- Medicaid: also true of over 80% of enrollees
- Half of physicians are employees of hospitals or health systems

Trends and Barriers Towards Universal Coverage

Uninsured Rate Among the Nonelderly Population, 1972-2018*



Source: CDC/NCHS, National Health Interview Survey, reported in http://www.cdc.gov/nchs/health_policy/trends_hc_1968_2011.htm#table01 and <https://www.cdc.gov/nchs/data/nhis/earlyrelease/Insur201808.pdf>.
*Note 2018 data is for Q1 only.

Why Are There Still Uninsured People?

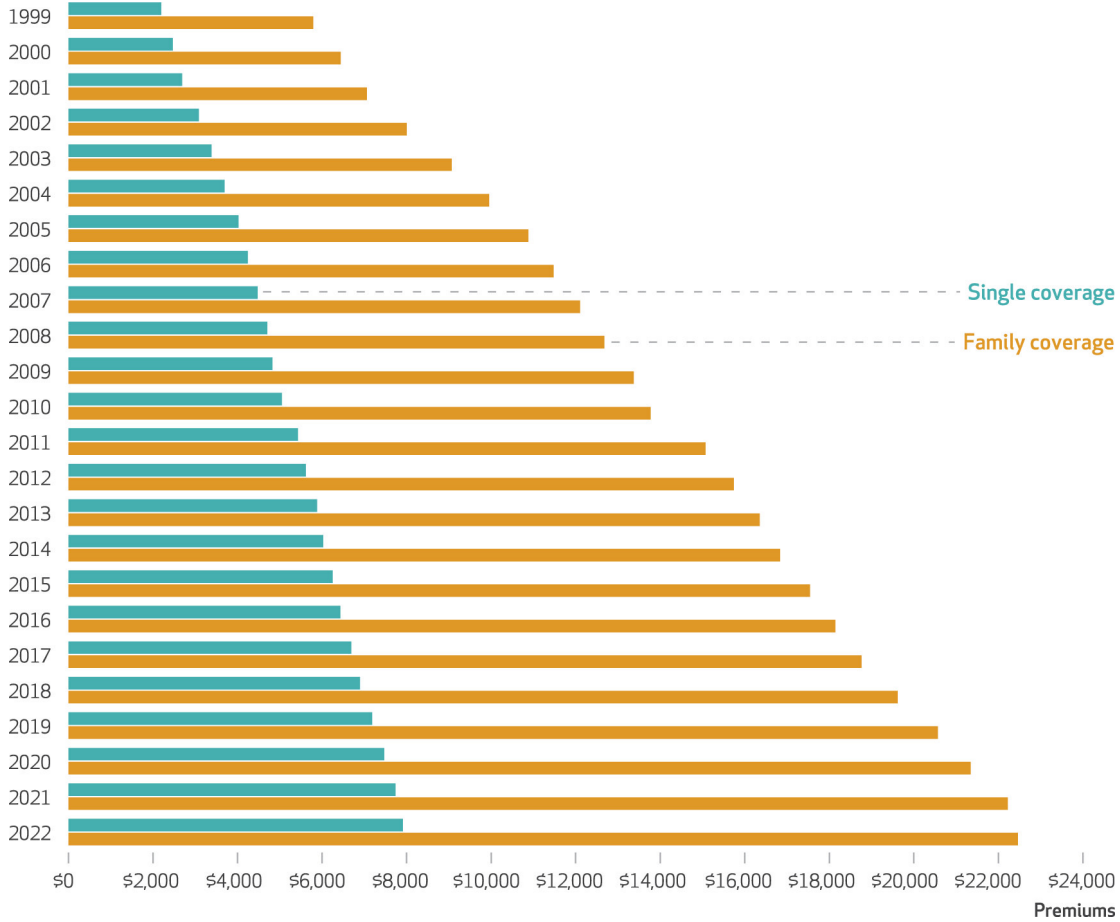
- Health care is expensive!
- 12 states have no expanded Medicaid – although 2 are in the works
- Undocumented individuals are generally not allowed to have public insurance coverage
- Individual mandate was repealed
- Divided Congress

Structural Barriers, Promising Practices

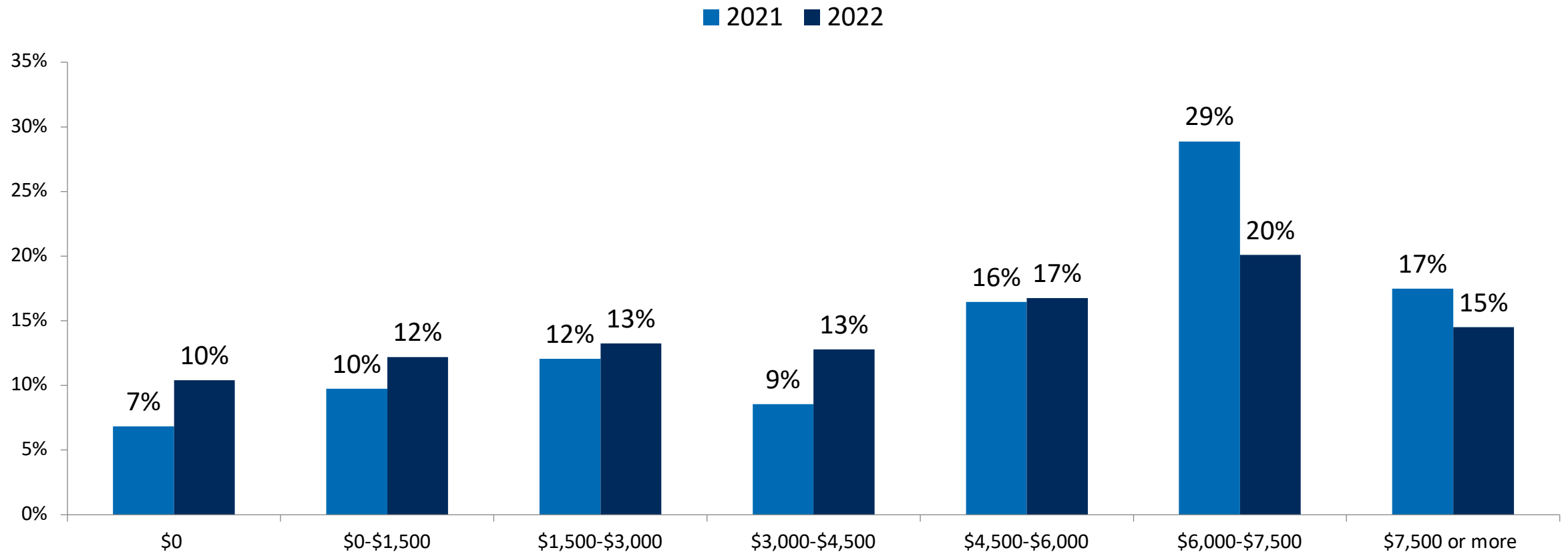
Barriers

- Insurance premiums are unaffordable to many
- High out-of-pocket spending for those with insurance
- Racial and ethnic disparities

Average Annual Premiums for Employer-Sponsored Health Insurance



Distribution of Medical Deductibles Among All Marketplace Plans, 2021 and 2022

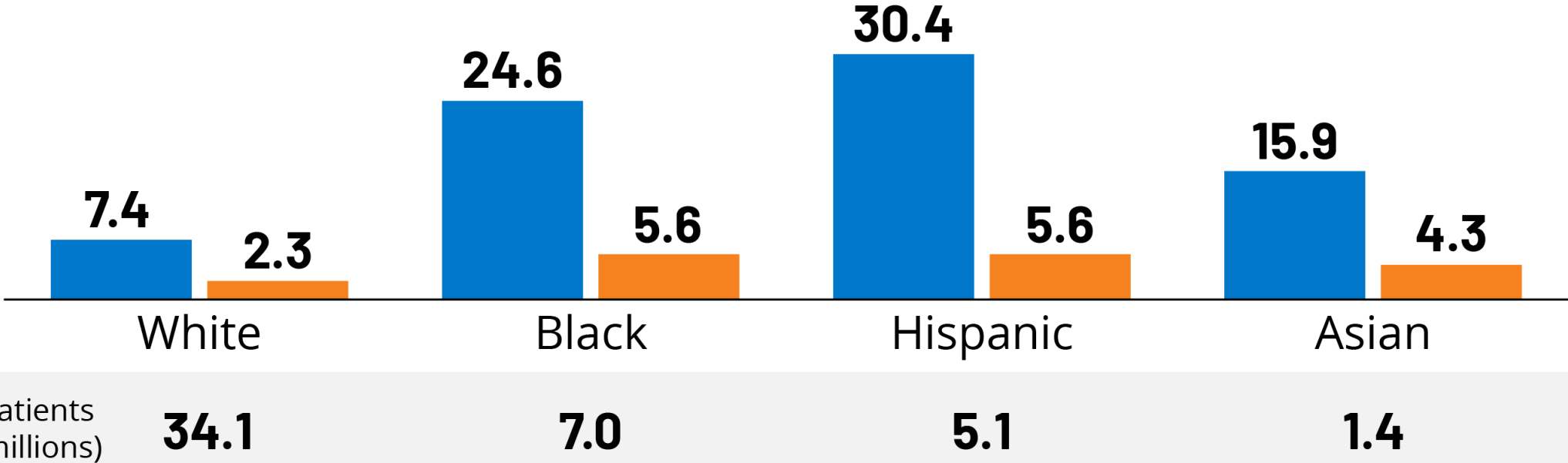


SOURCE: KFF analysis of Marketplace plans in states with Federally Facilitated or Partnership exchanges in 2021 and 2022. Data are from Healthcare.gov.

COVID-19 Hospitalization and Death Rates among Active Epic Patients by Race/Ethnicity

Rate per 10,000, as of July 2020

● Hospitalization Rate ● Death Rate

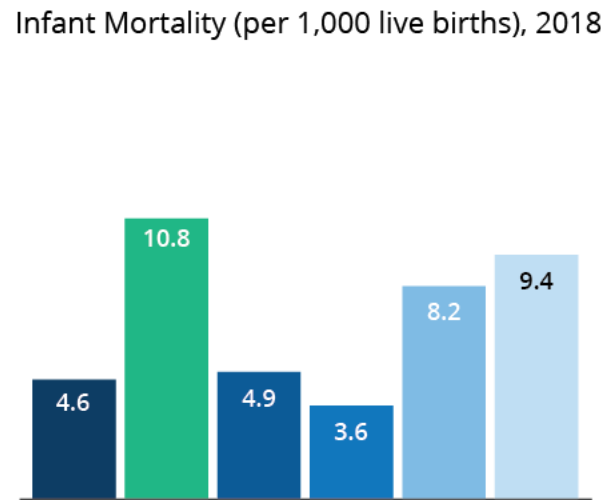
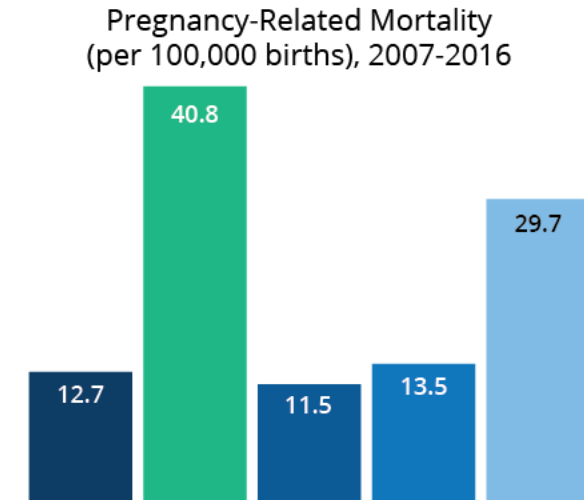
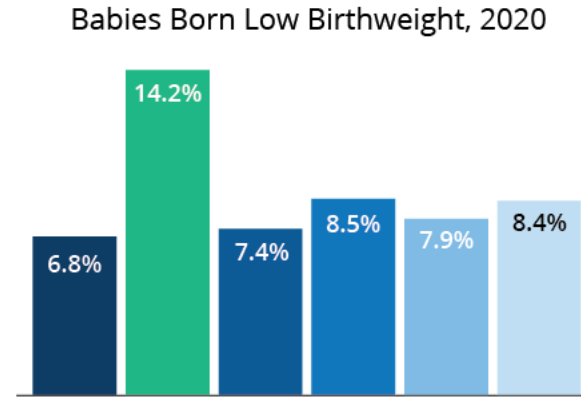
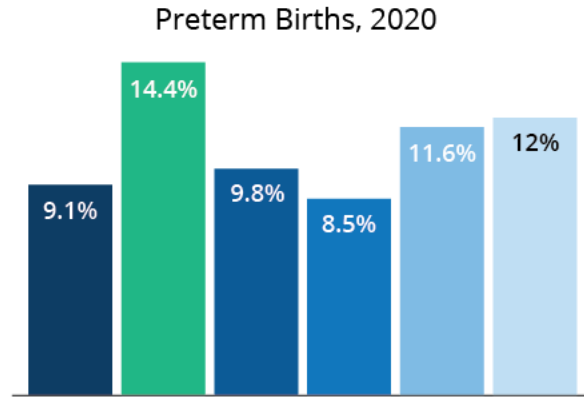


NOTE: Rates for Black, Hispanic, and Asian patients are statistically significantly different from White patients at the $p < 0.05$ level. Persons of Hispanic origin may be of any race but are categorized as Hispanic; other groups are non-Hispanic. Data for other racial groups not shown due to insufficient data.

SOURCE: Epic and KFF analysis of Epic Health Record System COVID-19 related data as of July 2020.

A Look at Key Maternal and Infant Health Disparities Among Black People

● White ● Black ● Hispanic ● Asian ● AIAN ● NHOPI



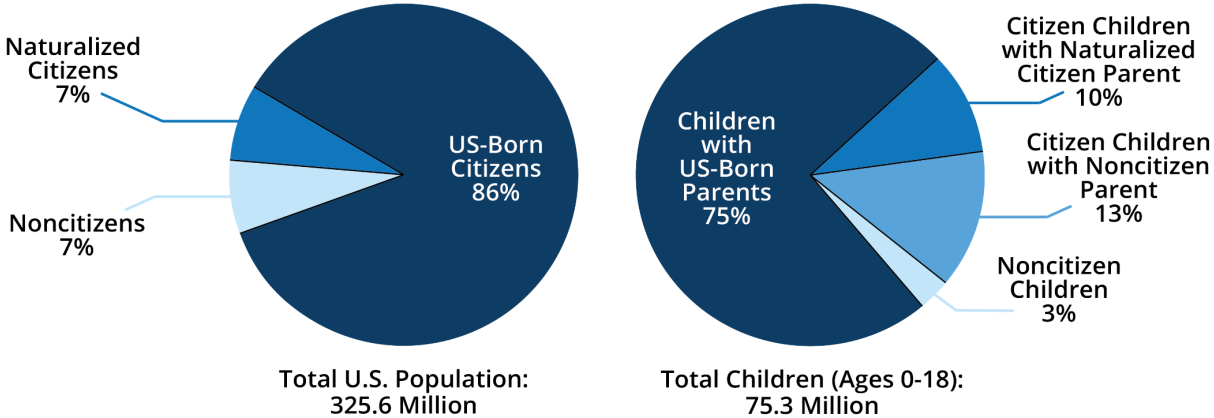
NOTE: AIAN refers to American Indian or Alaska Native. NHOPI refers to Native Hawaiian or Other Pacific Islander.

SOURCE: Original source information and data available at www.kff.org/report-section/key-facts-on-health-and-health-care-by-race-and-ethnicity-health-status-outcomes-and-behaviors/



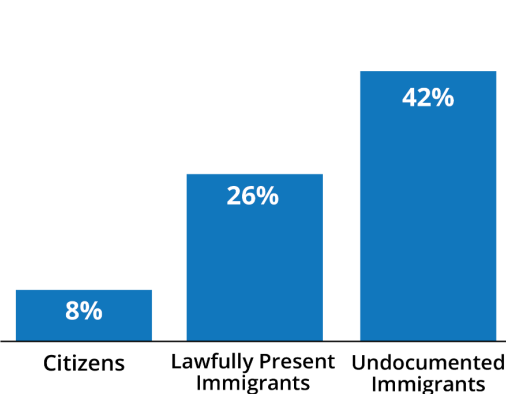
Immigrants in the U.S. Continue to Face Health Care Challenges

There Are Nearly 45 Million Immigrants in the U.S. and 1 in 4 Children Has an Immigrant Parent

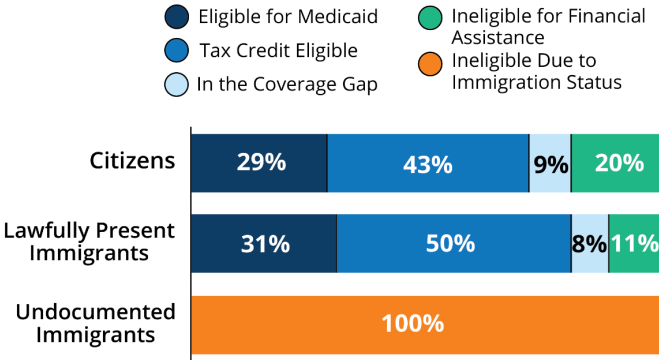


Noncitizen Immigrants Are More Likely than Citizens to be Uninsured and Face Barriers to Enrolling in Health Coverage

Uninsured Rates by Immigration Status, 2020



Eligibility for Affordable Care Act Health Coverage Among Nonelderly Uninsured by Immigration Status



SOURCE: KFF analysis of 2021 Current population Survey Annual Social and Economic Supplement (CPS ASEC).

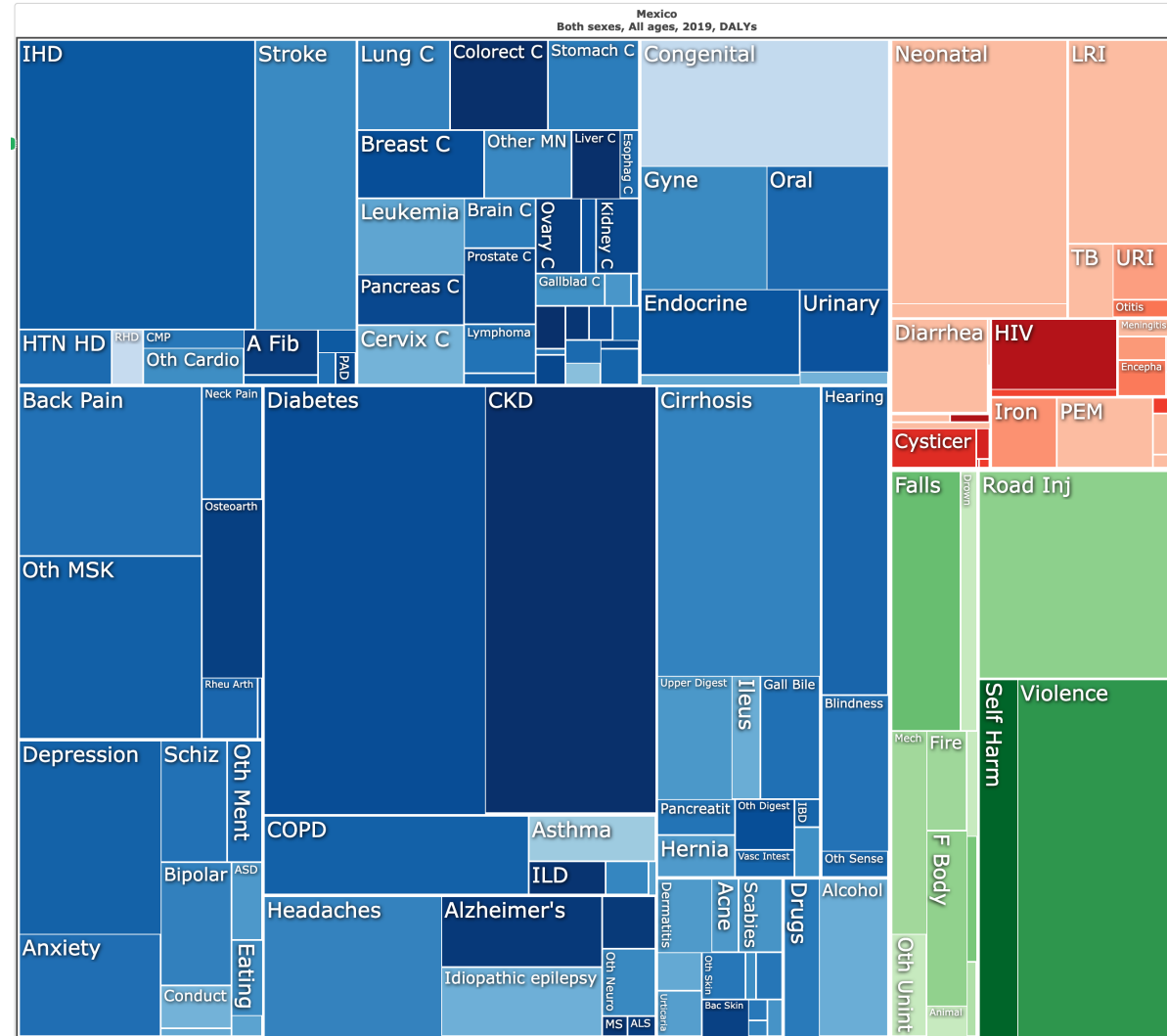
Promising Developments

- Access
 - Continuation of enhanced premium subsidies for marketplace plans extended through 2025
 - North Carolina's acceptance of Medicaid expansion could drive other states
 - A few states are using their own funds to extend Medicaid to undocumented persons
- Spending:
 - Medicare will begin negotiating prescription drug prices beginning in 2026; this could influence private prices
- Quality
 - Continued emphasis on prevention
 - Increased use of electronic health records and telehealth
 - (Slow) increase in consumer use of comparative provider and insurer performance data
 - Myriad of federal and private activities to improve quality of care, including pay for performance

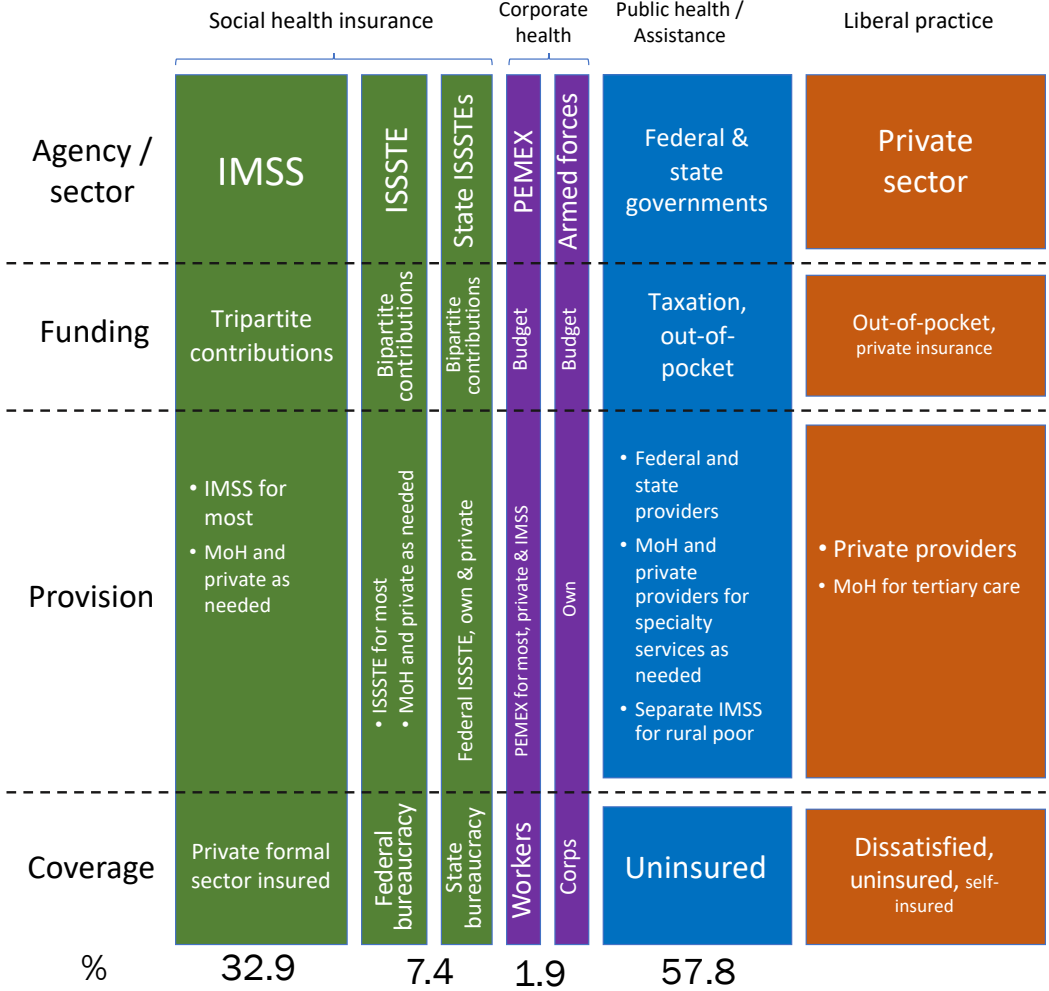
Opportunities for comparative policy learning

Mexico Health System

An accelerated yet protracted epidemiological transition since 1990



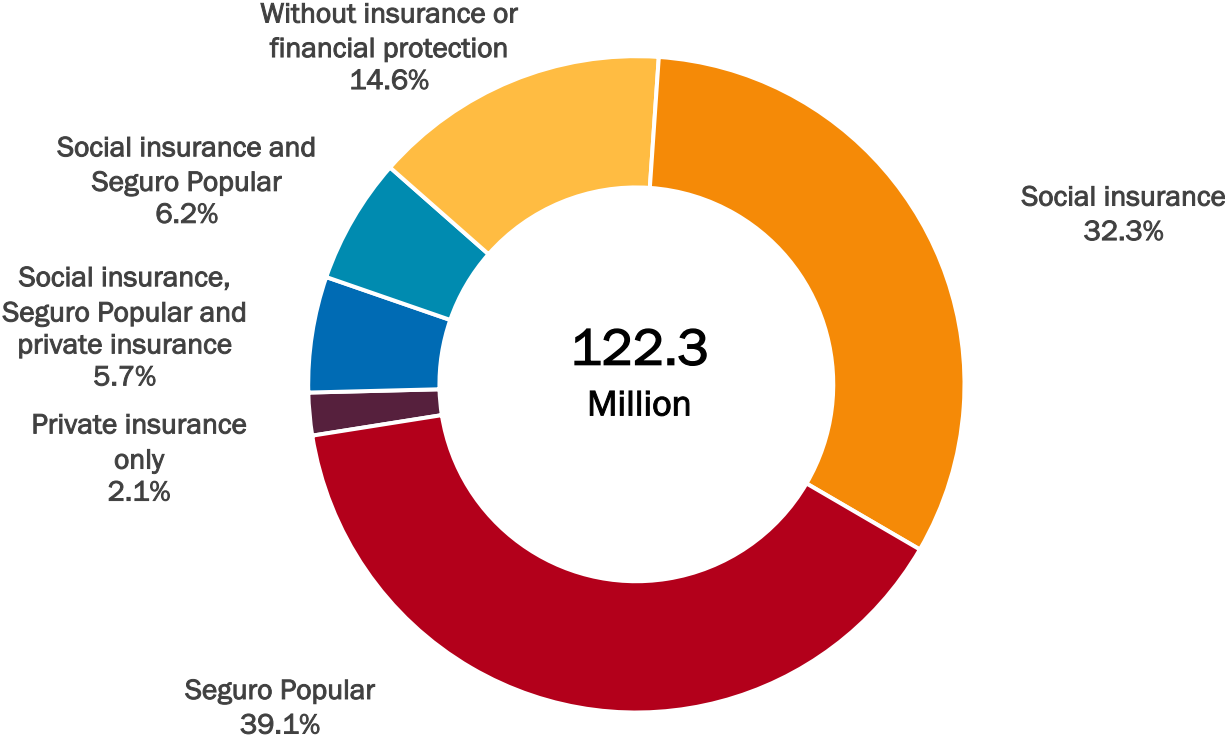
Mexico's segmented health system originated in the context of WW2 policies and has remained unchanged



Trends towards UHC

For 2019 14.6% of the population was uninsured and without financial protection. This figure may have increased

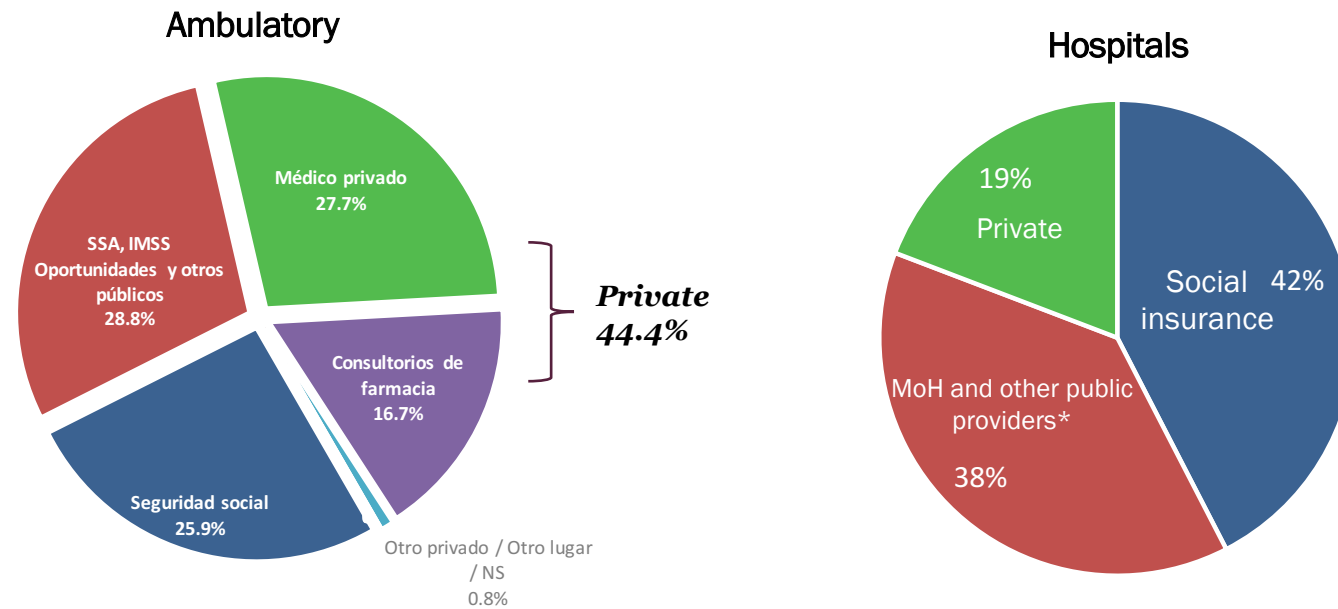
Insurance and financial protection status of the Mexican population, 2019



González Block MA et al. El subsistema privado de salud en México. Retos y oportunidades, 2018.

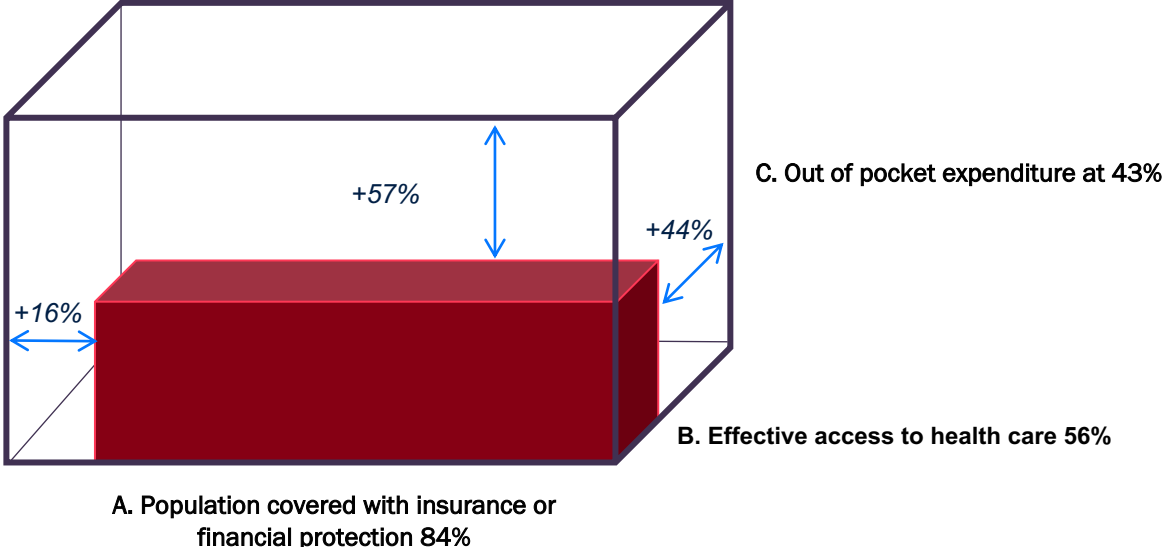
In spite of lack of public financing, private health providers offer basic coverage to the majority of the population, exploiting the low quality of public health services

Participation of health service supply across private, social insurance and public providers, 2019



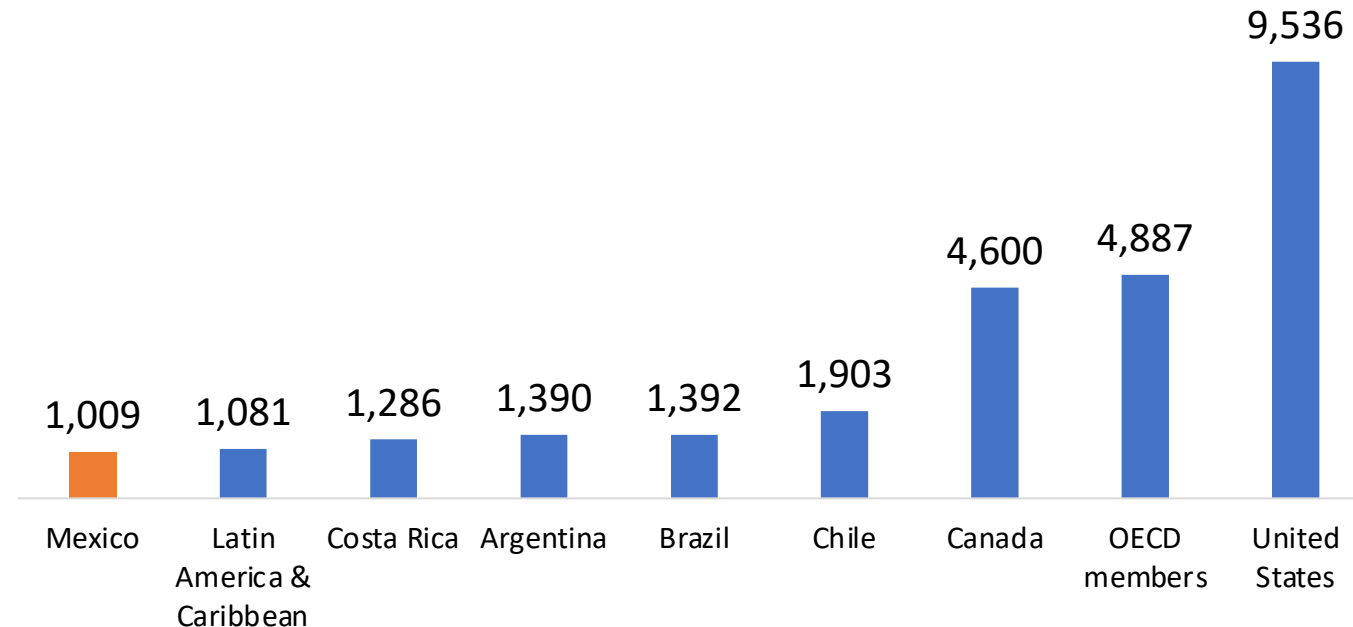
* Other: ISSSTE, ISSSTE Estatal, PEMEX, Defensa, Marina, IMSS-Oportunidades, otro lugar.

Mexico has made important progress towards UHC, but faces limitations

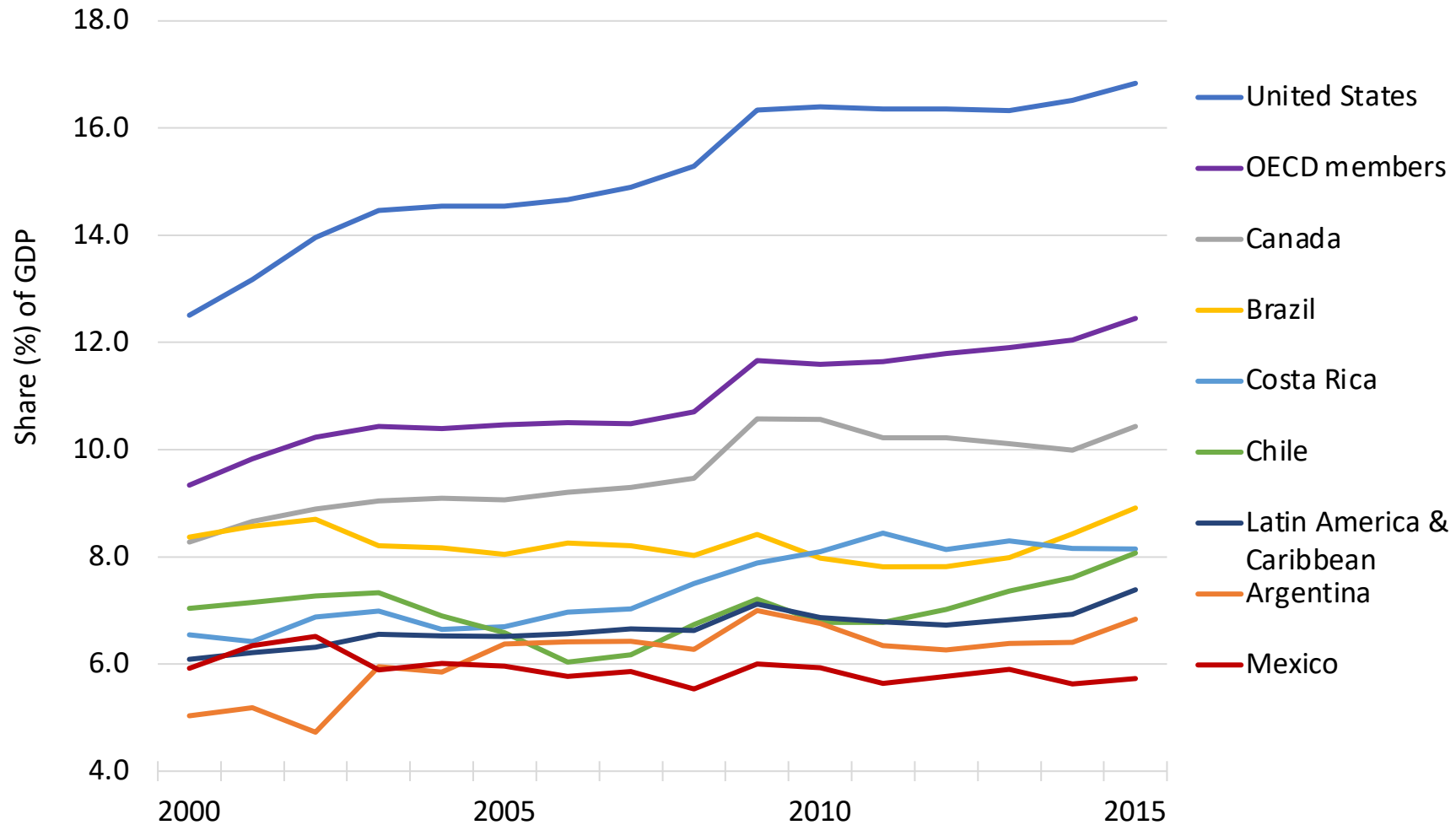


Health expenditure per capita is lower than expected for its level of development

Health expenditure per capita in Mexico and selected countries. USD, 2018



Health expenditure growth has stagnated in Mexico below standards in Latin America



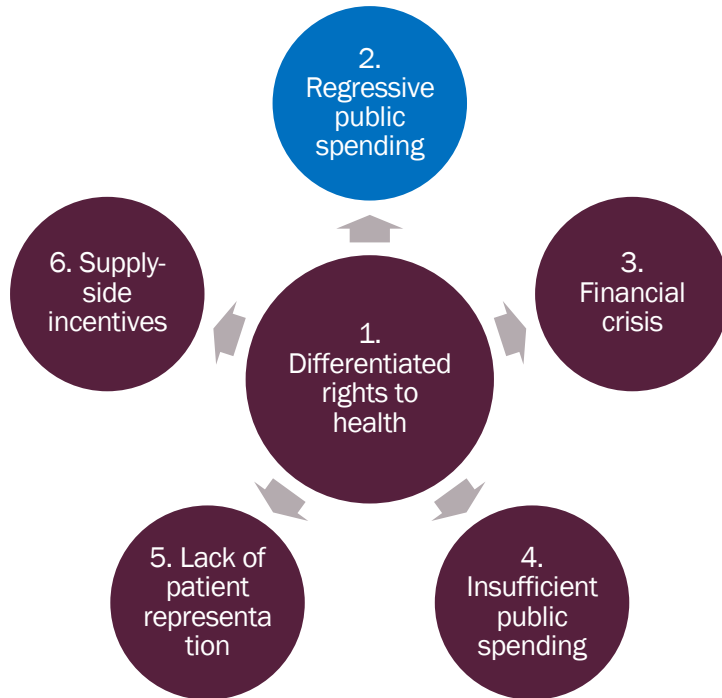
Structural barriers

Differentiated rights to health



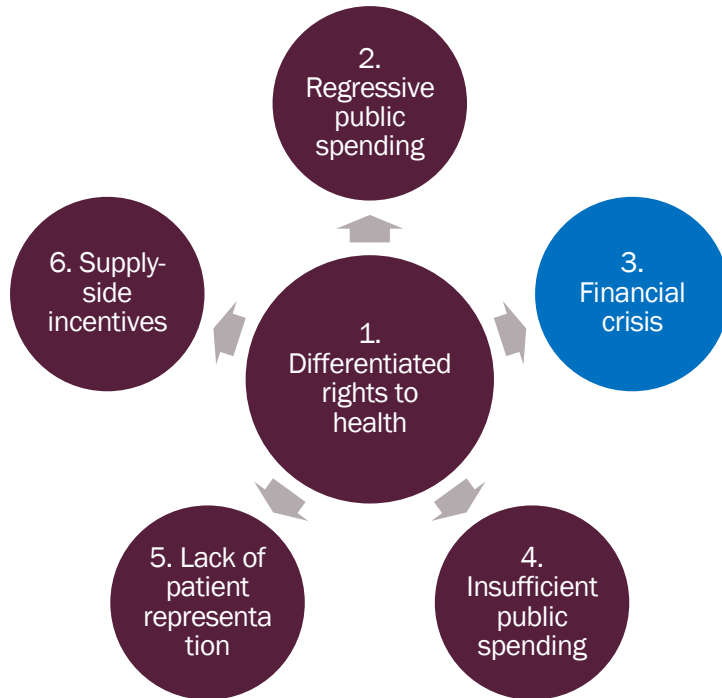
- The Constitution enshrines the Right to Access Health Services
- Yet the Constitutional right is differentiated
 - Formal sector workers have a right to corporatist health care
 - Informal sector workers to government help
- And segmented
 - Federal Health Law excludes the MoH from regulatory powers over services provided by corporatist institutions

Regressive public funding



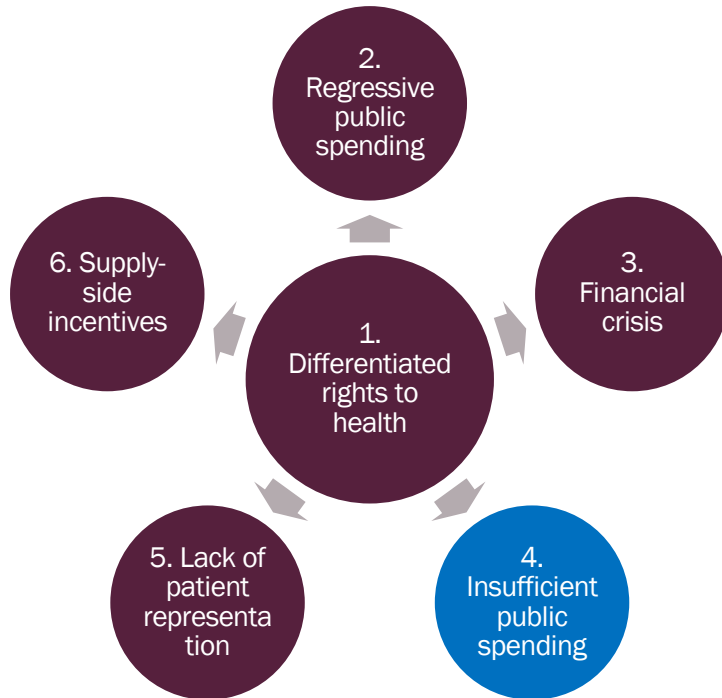
- Corporatist health institutions are financed by special taxes and subsidized by general taxes
- Federal taxes allocate about the same amounts to corporatist health and to the non-insured
- Within IMSS, federal taxes are allocated mostly to pay for IMSS worker pensions, yet
 - IMSS workers retire 12 years younger than the average worker they care for
 - with pensions that are 8 times superior

Financial crisis



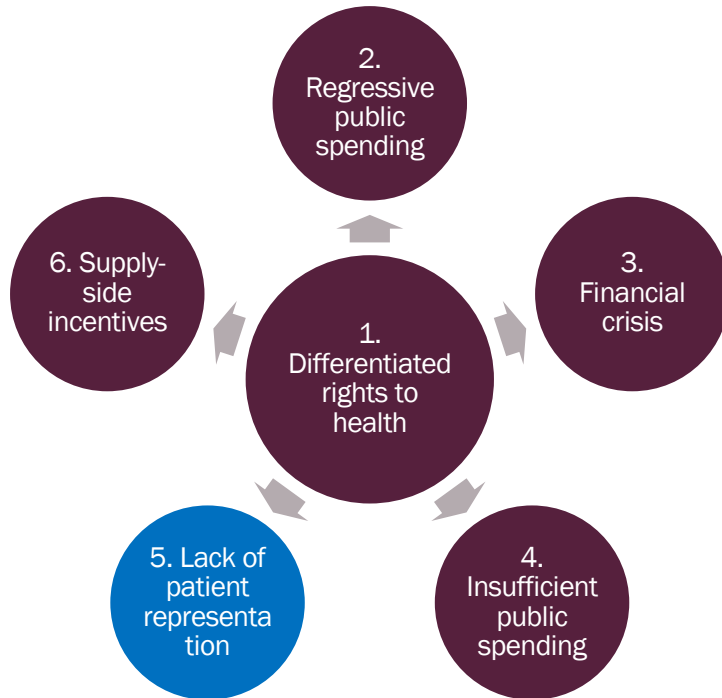
- The pension fund of IMSS workers was mismanaged and has a debt of 8.35% of GDP
- For 2034 up to 63% of the operational budget will be allocated to pay for worker pensions
- Mostly funded through general taxation

Insufficient public spending



- Public spending in health is 3% of GDP
 - A third of that of the average in Latin America
- 49% of total health expenditure was out-of-pocket in 2022
 - Before COVID-19 it was 42%

Lack of patient representation



- Only 3% of workers that are affiliated to IMSS are represented in its corporate board
 - Those militating in vertical trade unions
- Only 0.3% of board decisions in the past 20 years focused on chronic diseases
 - Decision making focuses on administrative matters

Dominance of supply-side incentives



- Every year up to 39% of IMSS affiliates lose their affiliation
 - Leading to lose of access to health services
 - 21% among patients with diabetes

Promising developments and future directions

Health reforms towards universal coverage have maintained segmentation

- In 2004 Seguro Popular established to extend health rights to the uninsured, lowering catastrophic health expenditure
 - ✓ Capitated payment
 - ✓ Explicit package of services
 - ✓ Increased funding for the uninsured
 - ✓ Increased quality of care
 - ✓ Reduced catastrophic expenditure
- But had critical limitations that ultimately lead to its demise
 - ❖ Failed to extend coverage to critical diseases
 - ❖ Funding mostly restricted to MoH providers
 - ❖ Out-of-pocket expenditure remained high
 - ❖ Corruption
- In 2008 selected, high specialty interventions “exchanged” across institutions according to need and capacity
 - ✓ Exchange platform with fixed tariffs
 - ❖ No incentives to exchange
 - ❖ Patients not given provider choice
 - ❖ Cross-service provision insignificant

The government of president López Obrador (2018-2024) aimed to favor the poor and end corruption

- Institute for Health Wellbeing (INSABI) substituted Seguro Popular in 2020
 - ✓ Aims to provide unrestricted services to uninsured
 - ✓ Integrated funding and provision at the federal level
 - ❖ Protection of health rights weakened
- Implementation in process
 - ❖ Uneven implementation
 - ❖ Purchasing of medicines further centralized
 - ❖ Resource shortages
 - ❖ Collaboration with the private sector was curtailed
 - ❖ Health expenditure decreasing
 - ❖ After the failure of INSABI, a new administrative structure was established under IMSS

The Mexican Health System is today more segmented than ever

Future directions

- Opportunities to integrate corporatist and bureaucratic interests under citizens' mandate
- A health mandate for UHC to integrate and co-ordinate regulation and planning at national and state levels
 - ✓ Centralization of regulatory functions
 - ✓ Financial integration
 - ✓ Provider autonomy

Six solutions towards UHC

Challenges



Solutions

1. A single Constitutional right to health
2. Single public payer
 - Reducing special taxes
 - Increasing general taxation
3. Sector debt addressed through productivity
4. Greater allocation of federal and state taxes to health
5. IMSS corporatist board extinguished
 - Local and federal legislative oversight C
 - Citizen-based Quality Commission
6. Universal entry door to the health system
 - Mix of budgets and performance incentives
 - Articulating competitive provider networks

Some possible questions

- **What can the USA and Mexico learn from Canada's single payer to address financial fragmentation?**
- **What can Canada and Mexico learn from competition in the US to increase patient satisfaction?**
- **What can Mexico learn from Canada and the US in public contracting of private providers?**



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