Comparative Health Systems

- What They Get Right?
- What They Got Wrong ?

Pacific North West
Border Health Alliance

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Comparative Health Systems

Health System

CANADA

- A mix of public (70%) and private (30%) funding
- Universal public coverage for hospital and physician services
- Employer based and supplemental gov't programs for other health services.
- Low admin and legal costs.
- Majority of health funding is provincial with some federal government providing some funding with conditions.
- Slower adopters of new technology.
- 2009 per capita spending was US $4,363 (OECD average – $3250).
- **Peace, order and good government**

UNITED STATES

- A mixed public/private system.
- Largest public (and private) spender in the world but with major gaps in coverage.
- Employer based coverage for many.
- High administrative and legal costs.
- Federal government provides funding through Medicare, Medicaid, SCHIP, and the VA
- Fast adopters of new technology for those with good coverage.
- Pockets of excellence in health management.
- 2009 per capita spending was US $7,960 (next closest Norway $5352)
- **Life, liberty and the pursuit of happiness**

Comparative Health Systems

Comparative Health Systems

Canada

RIGHT

- Five fundamental values
- A National system
- Noncompetition
- Cost controls
- Macro management
- A Royal College concept over medical and surgical specialty training, program evaluation, and examination
- Residency training only in university programs.

WRONG

- Inadequate research support
- Global cuts without much planning
- Poor planning of physician, nurse numbers
- Waiting lists.

Comparative Health Systems

United States

RIGHT

- Opportunities for the individual
- Innovation and creativity
- Research support
- Benefits for risk takers
- Expertise in specialty care.

WRONG

- 45 million uninsured and an equal number underinsured
- No coherent system
- No overriding principles
- Expensive, complex administration
- Excessive controls on physicians
- Excessive physician paperwork
- Micromanagement
- Powerful competing forces that can resist change
- Expensive specialty care
- Inadequate and complex concept of primary care
- No plan for when profit goes out of the system

Some Things Neither Got Right

- Physician distribution
- Long-term planning
- Patient advocacy
- Support for academic centers
- Big Pharma influence
- Public health support
- Population health perspective
- A rational approach to rationing
- Balance of income for cognitive and proceduralist physicians
- Drug costs.

Canada's Publicly Funded Health System

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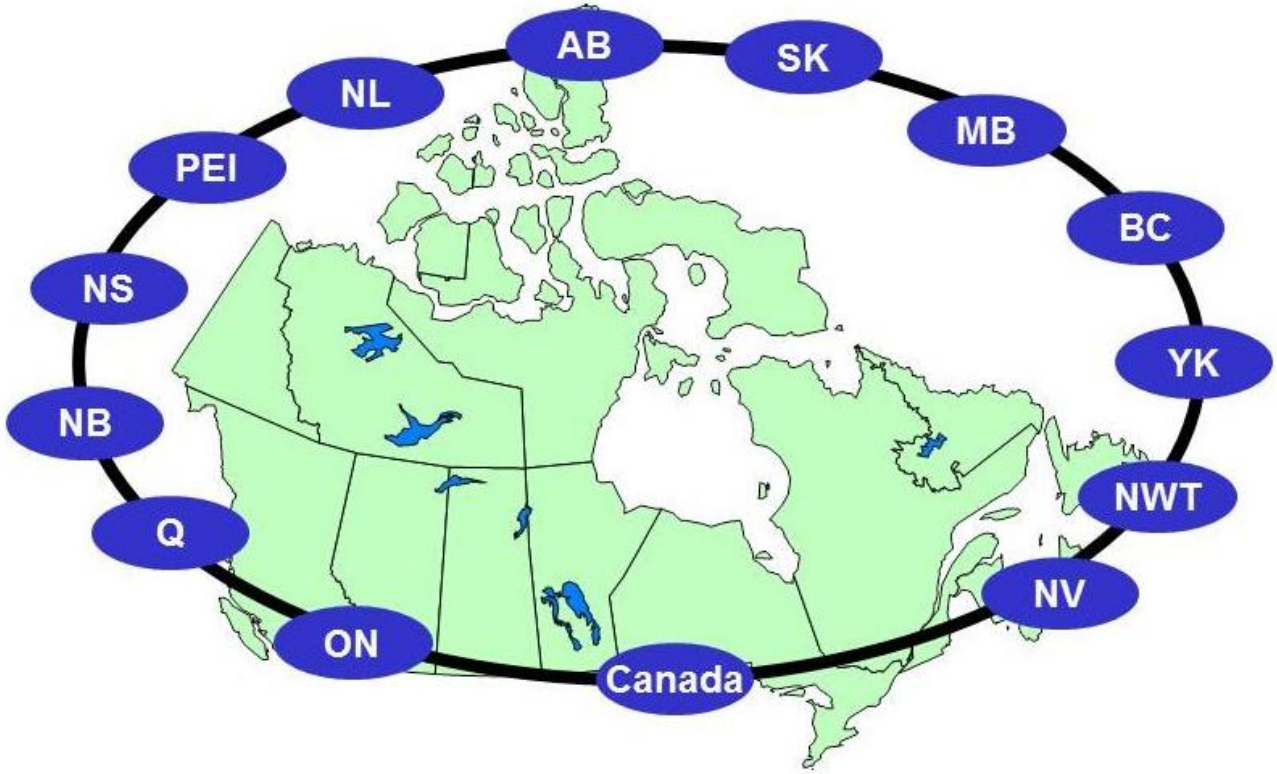
Canada's Publically Funded Health System

Health Federation



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Canada's Publically Funded Health System

Federal Legislation

- Canada Health Act
- Controlled Drugs and Substances Act
- Quarantine Act
- Pest Control Products Act
- Tobacco Act

Canada's Publically Funded Health System

Typical Provincial Health Legislation

- Public Health Act
- Hospital Act
- Health Authorities Act
- Health Emergency Act
- Health Insurance Act
- Medical Practitioners Act
- Health Professions Act

CANADA • USA

PAN-BORDER
PUBLIC HEALTH
PREPAREDNESS
COUNCIL

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INTRODUCTION

The Canadian-US border is the longest non-militarized border in the world with more than 4,900 kilometers (3,100miles) on land and nearly 3,900 kilometers (2,400 miles) by water. Approximately 90 percent of Canada's population lives within 160 kilometers of the border and crossings are frequent with more than 200 million two-way border crossings occur each year.

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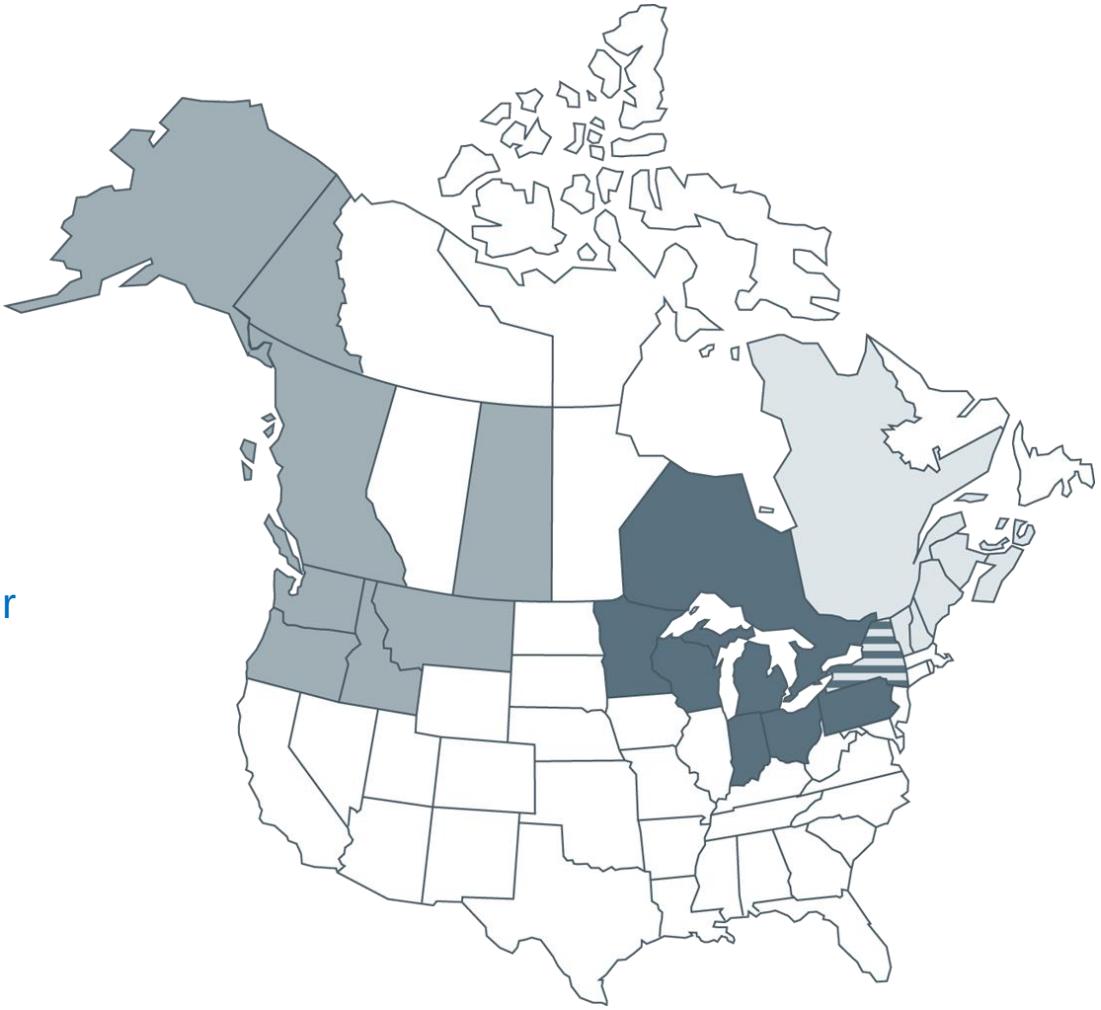
THE CHALLENGE

Differences in epidemiological case definitions, communication systems and professional licensure are among the issues that must be resolved in order for provinces/territories and states to enhance cross-border public health emergency preparedness and response.

PAN-BORDER PUBLIC HEALTH PREPAREDNESS COUNCIL

THE APPROACH

The Canada – United States Pan Border Public Health Preparedness Council (PBPHPC) is comprised of health department/ministry representatives from the three regional border health collaboratives (Eastern, Great Lakes and Pacific NorthWest); four unaligned provinces and states (Alberta, Manitoba and North Dakota); and the Canada and United States federal government



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AUTHORITY

The PBPHPC draws it authority from the November 2007 trilateral public health MOU entitled “Declaration among the Department of Health and Human Services of the United States of America, the Department of Health of Canada, the Public Health Agency of Canada and the Ministry of Health of the United Mexican States”.

MANDATE

The mandate of the PBPHPC is to facilitate regional pan-border public health preparedness collaborations to collectively strengthen capacity at all levels to address all nature of public health threats, including: responding to severe or novel outbreaks of infectious disease; augmenting disease surveillance in the face of an evolving or yet-undefined threat; or a need to address non-urgent public health issues that arise, e.g., transportation of infectious disease samples across the border.

GOALS AND STRATEGIC PRIORITIES

PBPHPC activity is chiefly focused on:

- Providing a forum for facilitating pan-border emergency preparedness collaboration
- Promoting local and regional collaborations in emergency public health activities.
- Ensuring all pan-border activities are deliberate, realistic and value added for all members.
- Addressing Federal issues that are common to all Canada – U.S. cross border health collaborations and require resolution at the Federal level.
- Engaging other pan-border stakeholders when appropriate to assist regional alliances and activities across the border; and
- Avoiding duplication of established initiatives and alliances across the Canada – U.S. border

ACHIEVEMENTS

- **Solidified a Council business plan through the development of a work plan rooted in three themes:**
  1. Information sharing and border stakeholder outreach and engagement;
  2. Monitoring council resources; and,
  3. Federal government engagement.
- **Conducted an analysis of pan-border case studies leading to development of a standardized case study template to facilitate future research and analysis of cross-border case studies.**
- **Coordinated a submission of cross-border pandemic H1N1 response issues to the North American Plan for Animal and Pandemic Influenza Revision Working Group.**
- **Developed and maintains a repository of cross-border public health collaboration documents, e.g. Agreements, Memoranda of Understanding, etc.**
- **On an on-going basis, facilitates information sharing through:**
  - Council website;
  - Bi-monthly teleconference and annual face-to-face meetings; and,
  - Participation in regional collaboratives' conferences

QUESTIONS

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