

1. Executive Summary

Canada has been brought into the annual pan-European Index, which has been published by the HCP since 2005. It was done on terms that treated Canada like any European state. The starting point was the Euro Health Consumer Index (EHCI), with 29 nations, which was published on October 1, 2007. Austria emerged as the overall winner. By then, research regarding Canadian data was partially conducted for the expansion of the EHCI into the trans-Atlantic Euro-Canada Health Consumer Index (ECHCI). In the following, Canada is consequently looked upon as one out of 30 national healthcare systems.

In this first edition of the Euro-Canada Health Consumer Index, Canada places 23rd out of 30. With respect to clinical Outcomes, Canada compares well with the best performing healthcare systems. In terms of Generosity, with the exception of the provision of sight restoration surgery, Canada performs poorly, and in the areas of Patients' rights and information, Waiting times and accessibility, and the Provision of pharmaceuticals, Canada's performance is in the bottom tier. These factors, combined with a very high level of spending on healthcare, contribute to putting Canada at the bottom of the Bang-for-the-Buck (BFB) scale.

The scoring was done in such a way that the likelihood that two states would end up sharing a position in the ranking was almost zero. It must therefore be noted that Austria, the Netherlands, France, Switzerland and Germany were very difficult to separate and that very subtle changes in single scores modified the internal order of these top five countries.

The Central and Eastern European member states are doing surprisingly well considering their much smaller healthcare spending in Purchasing Power adjusted dollars per capita. However, adjusting from a planned to a consumer-driven economy takes time. Estonia, the smallest ship to turn around, seems to lead this sub-group and is a clear winner in the academic exercise of the value-for-money adjusted Index – the Bang-for-the Buck score.

All public healthcare systems share one problem: Which technical solution should be used to funnel typically 7 per cent to 10 per cent of the national income into healthcare services? In this context, there are two major approaches.

The Bismarck healthcare system: A system based on social insurance where there are multitudes of insurance organizations that are *independent of* healthcare providers.

The Beveridge healthcare system: A system in which financing and provision are handled within one organizational system, *i.e.*, financing bodies and providers are wholly or partially within one organization.

For more than half a century, particularly since the formation of the NHS, the largest Beveridge-type system in Europe, there has been intense debate over the relative merits of the two systems.

When looking at the results of the Index, it is hard to avoid noticing that the top five countries, which fall within 36 points of each other on a 1,000-point scale, have dedicated Bismarckian healthcare systems. There is a gap of 30 points to the first Beveridge country, which is in sixth place. The introduction of Canada in the first Euro-Canada Index marks the inclusion of another major Beveridge system.

The Canadian system scores respectably on Outcomes, but rather poorly in other measures, something it has in common with other similar systems. As pressure increases for healthcare reform, policy-makers would do well to consider ways in which to make the advantages of a Bismarck system, especially the separation between providers and insurers, and the variety of insurers, available to consumers. These are key qualities among the most successful European healthcare systems.

Thus, while not arguing that the Bismarck-type healthcare system is in every way superior, it seems that for total customer value, the Bismarck model runs rings around Beveridge!