OBJECTIVES
This course provides an understanding of contemporary healthcare systems and the related health policy debates through an economic analysis of the health care institutions, organizations and markets. The analytical framework will be developed over the first nine weeks of the course. After a 2-week introduction, components of a healthcare system (insurance, physicians and other individual providers, hospitals, pharmaceuticals and long-term care) will be covered in about 7 weeks. Weeks 10-12 are allocated to the analysis of various healthcare systems. The course covers the Canadian provincial healthcare systems and the several European mixed systems (France, Germany, Holland, Sweden and UK) as well as Australia’s, all with universal coverage. Obamacare will also be studied in section 8 on alternative systems.

DESCRIPTION
The course covers the economic analysis of healthcare. The demand and supply components are separately analyzed and then assembled as healthcare system. Real-life healthcare provision emerges under mixed and regulated systems. Institutional and organizational aspects of the health care systems are examined with an eye to policy-making. Since healthcare is largely a private good, economic analysis would then prescribe private provision on efficiency grounds. However, unlike most other goods and services, its provision is regulated everywhere, mostly on equity grounds but, since healthcare insurance markets exhibit informational problems potentially causing market failures, the case for public intervention may be strengthened. Somewhat similar to mixed systems Canada exhibits a mixed system, with private but not-for-profit yet heavily regulated hospitals and private but contracted physicians. The course includes a description of different health care systems and of the structural and organizational arrangements within each system. Moreover, parts of the Canadian system requiring urgent fixes will be analyzed. For instance, budgetary devolution through regionalized administrations, hospital reorganizations and de-hospitalization, private clinics, primary care reorganization and evolving physician payment systems, clogged long-term care, emergency room overcrowding, technology transfer, spatial access to care, and pharmacare are amongst topics to be covered.

NB 1. Attendance is a must as lectures cover material beyond readings and exams will include questions derived from class discussions. 2. A course in microeconomics is a prerequisite. 3. Queen’s University Academic Integrity Guide must be read.
Queen’s University academic integrity guide

Academic integrity is constituted by the five core fundamental values of honesty, trust, fairness, respect and responsibility (see www.academicintegrity.org). These values are central to the building, nurturing and sustaining of an academic community in which all members of the community will thrive. Adherence to the values expressed through academic integrity forms a foundation for the “freedom of inquiry and exchange of ideas” essential to the intellectual life of the University (see the Senate Report on Principles and Priorities). Students are responsible for familiarizing themselves with the regulations concerning academic integrity and for ensuring that their assignments conform to the principles of academic integrity. Information on academic integrity is available in the Arts and Science Calendar (see Academic Regulation 1), on the Arts and Science website (see http://www.queensu.ca/calendars/artsci/pg4.html), and from the instructor of this course. Departures from academic integrity include plagiarism, use of unauthorized materials, facilitation, forgery and falsification, and are antithetical to the development of an academic community at Queen’s. Given the seriousness of these matters, actions which contravene the regulation on academic integrity carry sanctions that can range from a warning or the loss of grades on an assignment to the failure of a course to a requirement to withdraw from the university.


NB 1. Attendance is a must as lectures cover material beyond readings and exams will include questions derived from class discussions. 2. A course in microeconomics is a prerequisite. 3. Queen’s University Academic Integrity Guide must be read.

COURSE OUTLINE

Course plan

<table>
<thead>
<tr>
<th>Week</th>
<th>Part</th>
<th>Topic covered</th>
<th>Tests</th>
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<tr>
<td>01</td>
<td>Intro</td>
<td>01. Introduction to healthcare systems</td>
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<td>02</td>
<td>Demand</td>
<td>02. Demand for health and healthcare</td>
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<td>03. Demand for healthcare insurance</td>
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<td>04. MD as patient’s agent</td>
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<td>Supply</td>
<td>05. Primary care</td>
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<td>06. Hospitals</td>
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<td>07. Pharmaceuticals and Pharmacare</td>
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<td>08. Long-term care</td>
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<td>09</td>
<td>Systems</td>
<td>09.a. Speaker: Catherine Donnelly on LTC</td>
<td>Midterm test</td>
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<td>b. Cost-benefit evaluation in healthcare</td>
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<td>10</td>
<td>Systems</td>
<td>10.a. Speaker:</td>
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<td>b. Healthcare systems</td>
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<td>11. Healthcare systems</td>
<td>Q3</td>
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<td>12</td>
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<td>12. Student forum on healthcare systems</td>
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Readings

The course is based on lecture notes (available in OnQ) and required articles denoted by *. Recommended books (There are good treatments of some topics in the textbooks below.)

Introduction to healthcare

* The Economist [2016], “Pretend medicine - The quack-up”, May 21 (Chilling but true: “… alternative therapies including chelation, a treatment in which patients ingest or are injected with chemicals that remove heavy metals from their bodies. FDA had approved it for lead and mercury poisoning, but some doctors suggested it could cure autism.”)

Part A: Introduction to healthcare systems

* The Economist [2009], “Universal health insurance is a common good”, http://www.economist.com/blogs/democracyinamerica/2009/10/universal_health_insurance_is (See White [2009].)
Part B: Demand side

1. Demand for health and healthcare

a. The health stock model of the individual
* Grossman, M. & D. Dench [2018], “Health and the Wage: Cause, Effect, Both, or Neither? New Evidence on an Old Question”, NBER WP No. 25264 (Read pp. 1-10, 24-25.)
  http://www.nber.org/papers/w25264
The Economist [2017], “A tissue of truths – Printed human body parts could soon be available for transplant”, January 28 (No longer a need for consent to donate?)
* The Economist [2017], “No guts, no glory – Enhanced understanding of the microbiome is helping medicine”, November 9 (You may become what you eat!)

b. Public health and negative inputs: Sedentary lifestyle, substance abuse and malnutrition
* Cawley, J. et al. [2018], “The impact of the Philadelphia beverage tax on purchases and consumption by adults and children”, NBER WP 25052 (Read pp. 1-4, 23-28.)
  http://www.nber.org/papers/w25052
* Greve, J. et al. [2015], “Fetal malnutrition and academic success: Evidence from Muslim immigrants in Denmark”, NBER WP 21545, (Read pp. 3-9, 16-22.)
  http://www.nber.org/papers/w21545
Griffith, R. et al. [2017], “The importance of product reformulation versus consumer choice in improving diet quality”, Economica 84, 34-53 (Read pp. 36-38, 48-50. Also read The Economist [2017], “Nudge comes to shove – Policymakers around the world are embracing behavioural science – An experimental, iterative, data-driven approach is gaining ground”, May 18)

c. Public health and positive inputs: Prevention
* Ibuka, Y. et al. [2018], "An analysis of peer effects on vaccination behavior using a model of privately provided public goods", CESifo Working Paper Series 6933
  https://ideas.repec.org/p/ces/ceswps/6933.html (Read pp. 1-5, 27-29.)
The Economist [2016], "Antibiotic resistance – The grim prospect", May 21
The Economist [2016], “Vaccination – A jab in time”, March 26
The Economist [2016], “Cancer – A run a day keeps the tumor at bay”, February 27
The Economist [2013], “Pre-empting pandemics – An ounce of prevention”, April 20

2. Demand for healthcare insurance

a. Healthcare insurance demand
* Brot-Goldberg, Z.C. et al. [2015], “What does a deductible do? The impact of cost-sharing on health care prices, quantities, and spending dynamics”, NBER WP 21632,
  http://www.nber.org/papers/w21632 (Read pp. 2-8, 50-52.)
* CBC News – Technology & Science [2007], “Complications higher for obese women after hip
surgery”, February 28, [URL](http://www.cbc.ca/news/technology/complications-higher-for-obese-women-after-hip-surgery-1.681314) (Moral hazard and system inefficiency?)

* Einav, L. [2018], “Moral hazard in health insurance: What we know and how we know it”, J. European Economic Association 16(4), 957-982 (Read pp. 957-963, 978-980.)

* The Economist [1995], “Economics focus: An insurer’s worst nightmare”, July 29 (Maybe the whole healthcare insurance lecture in one page.)

* The Economist [1997], “Coughing up”, October 23 (Against ex post moral hazard?)

* The Economist [2017], “The gene is out of the bottle – Genetic testing threatens the insurance industry”, August 3

* Gowrisankaran, G. et al. [2018], “Reclassification risk in the small group health insurance market”, NBER WP No. 24663, [URL](http://www.nber.org/papers/w24663) (Read pp. 2-8, 40-41.)

The Economist [2017], “Taken for a ride – Second-degree moral hazard”, March 2

The Economist [2017], “Counsel of protection – The coming revolution in insurance”, March 9

b. Single-payer and multi-payer health insurance systems

* Duijmelinck, D.M.I.D. & W.P.M.M. van de Ven [2014], “Choice of insurer for basic health insurance restricted by supplementary insurance”, European J. Health Economics 15, 737–746


White, J. [2009], “Gap and parallel insurance in healthcare systems with mandatory contributions to a single funding pool for core medical and hospital benefits for all citizens in any given geographic area”, J. Health Politics, Policy and Law 34(4), 543-583 (Read pp. 547-556.)


3. Physician as patient’s agent

* Chernew, M. et al. [2018], “Are healthcare services shoppable? Evidence from the consumption of lower-limb MRI scans”, NBER WP 24869, [URL](http://www.nber.org/papers/w24869) (Read pp. 2-9, 19-21.)

* Cohen, M.M. et al. [1992], “Small-area variations: What are they and what do they mean?” CMAJ 146(4), 467-470 (See Finkelstein et al. below for further and recent evidence.)

Finkelstein, A. et al. [2016], “Sources of Geographic Variation in Health Care: Evidence from Patient Migration.” Quarterly J. Economics 131(4), 1681-1726


* Keser, C. & C. Schnitzler [2014], “Money talks – Paying physicians for performance”, CEGE DP 173, October, [URL](http://wwwuser.gwdg.de/~cege/Diskussionspapiere/DP173) (Read sections Intro., The Experiment and Conclusion. B(e) function!)

Kolstad, J.T. [2013], “Information and quality when motivation is intrinsic: Evidence from
Part C: Supply side

4. Physicians and nurses

a. Motivation and incentives: Physician as payer’s agent
* Blomqvist, Å. & C. Busby [2012], “How to pay family doctors: Why “pay per patient” is better than fee for service”, Commentary 365, CD Howe Institute, http://www.cdhowe.org/pdf/Commentary_365.pdf (NB Pay-per-patient should work?)
* Bodenheimer, T., B. Lo & L. Casalino [1999], “Primary care physicians should be coordinators, not gatekeepers”, JAMA 281(21), 2045-2049 (Still gatekeepers in Canada. Will they coordinate secondary care?)
Gravelle, H. et al. [2018], “Spatial competition and quality: Evidence from the English family doctor market”, University of York, Centre for Health Economics Research Paper 151, http://eprints.whiterose.ac.uk/132899/ (Read pp. 1-6, 23.)
Sarma, S. et al. [2018], “Family physician remuneration schemes and specialist referrals: Quasi-experimental evidence from Ontario, Canada”, Health Economics 27, 1533-1549 (Read pp. 1533-1535, 1546-1547.)
* Yong, J. et al. [2018], “Do rural incentives payments affect entries and exits of general practitioners?”, Social Science & Medicine 214, 197-205 (Read pp. 197-198, 204.)

b. Physician practice organization and its role in a healthcare system
Schurtz, I. et al. [2018], “Physician workload and treatment choice: the case of primary care”, CEPR DP No. 13157 (Read pp. 1, 4-6, 29-30.)
* Stange, K. [2014], “How does provider supply and regulation influence health care markets?
Evidence from nurse practitioners and physician assistants”, J. Health Economics 33, 1-27 (Read pp. 1-5, 15-17. See McMichael above for an update.)

c. Regulation of the medical profession
Beck, K. [2013], “Approaches to regulating self-referral in Canada”, Health Law in Canada 34(2), 34-41 http://www.fasken.com/files/Publication/4a8e91f2-c399-4262-8a42-9b3bea6a886b/Presentation/PublicationAttachment/1508b9df-3674-4e69-800b-a3eeef8183c2c/HLIC_342_final.pdf
Jena, A.B. et al. [2011], “Malpractice risk according to physician specialty”, New England J. Medicine 365, 629-36 (NB Which MDs are sued?)
Liu, J. & D.A. Hyman [2018], “Targeting bad doctors: Lessons from Indiana, 1975-2015”, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2994529 (The medical malpractice (“med mal”) system acts through ex post private litigation; the licensing system acts through ex ante permission to practice (i.e., licensure), coupled with ex post disciplinary action against physicians that engage in “bad” behavior.)
Milne, V. et al. [2014], “Is Canada’s medical malpractice system working?”, http://healthydebate.ca/2014/11/topic/cmpa-medical-malpractice

5. Hospital

a. Hospitals as multi-product firms
* Blomqvist, A. & C. Busby [2013], “Paying Hospital-Based Doctors: Fee for Whose Service?”, CDHowe Institute, Commentary no. 392 (Read pp. 4-16.) https://www.cdhowe.org/sites/default/files/attachments/.../Commentary_392_0.pdf
* Clark, J.R. & R. Huckman [2011], “Broadening focus: Spillovers, complementarities and specialization in the hospital industry”, NBER WP 16937 (Read pp. 3-11, 26-28)
http://www.nber.org/papers/w16937


Guccio, C. et al. [2013], “Readmission and Hospital Quality under Prospective Payment System”, http://www.siecon.org/online/wp-content/uploads/2013/09/Guccio-Lisi-Pigniataro.pdf (NB Prospective payment is insufficient to lower readmissions!)


* Mesman, R. [2015], “Why do high-volume hospitals achieve better outcomes? A systematic review about intermediate factors in volume-outcome relationships”, *Health Policy* 119, 1055-1067 (Skip tables. This is related to Gaynor [2005] & Carey [2014].)

* Roberts, R.R. et al. [1999], “Distribution of Variable vs. Fixed Costs of Hospital Care”, *JAMA* 281(7), 644-649 (NB Watch for the complexity of costs!)

* The Economist [2017], “A prescription for the future - How hospitals could be rebuilt, better than before”, April 8

Widmer, P.K. [2018], “Choice of reserve capacity by hospitals: a problem for prospective Payment”, *European J. Health Economics* 19, 663-673 (Public hospitals would have higher reserve capacity to serve all uncertain demand. Read pp. 663-664, 672.)

b. Hospital interactions: Horizontal and vertical

* Carey, K. [2015], “Measuring the hospital length of stay/readmission cost trade-off under a bundled payment mechanism”, *Health Economics* 24, 790-802 (NB A DRG payment per episode doesn’t internalize readmission cost to insurer. (Read pp. 790-791.)

Gobillon, L. & C. Milcent [2017], “Competition and Hospital Quality: Evidence from a French Natural Experiment”, IZA DP No. 10476, https://www.parisschoolofeconomics.eu/.../gobillon_milcent_2017_competition.pdf (Pro-competitive reforms of 2004-2008 that introduced DRG-payment into the French hospital sector with public (university or non-teaching), non-profit or for-profit hospitals. Local competition surely increased. Non-profit hospitals, with no incentive for competition before the reform, enjoyed larger declines in mortality in places where there is greater competition than in less competitive markets.)

Gupta, A. [2017], “Impacts of performance pay for hospitals: The Readmissions Reduction Program”, Becker Friedman Institute for Research in Economics, Health Economics Series No. 2017-07, www.web.stanford.edu/~atulg/Gupta_JMP.pdf (Large federal program which penalizes hospitals with high rates of repeat hospitalizations (“readmissions”). Readmissions and thirty-day mortality drop due to two mechanisms, improvement in treatment quality (which produces most of improvement) and changes in admitting behavior driven by penalties, it causes a substantial decrease in readmissions which suggests evidence of harm to affected patients).  

Hospitals and Care Providers”, CESIFO WP No. 6146, 

Levaggi, L. & R. Levaggi [2017], “Oligopolistic competition for the provision of hospital care”,
www.siepweb.it/siep/images/.../1494929366Levaggi_Levaggi_WP_SIEP_723.pdf
(Public hospitals are perceived differently by patients. In our Salop circle with the public hospital at the centre and private providers along the circle, mixed markets may outperform both the benchmark (one public hospital at the centre) and private competition (N private providers competing along the circle).

Makowsky, M.D. & E. Klein [2014], “Identifying the Relationship between Length of Hospital Stay and the Probability of Readmission”, Johns Hopkins Univ.,

* The Economist [2013], “Schumpeter – A Hospital Case”, May 28 (Lessons for Canada: You can still look after all your people even with private delivery.)


c. Hospital waits
* Bishai, D.M. & H.C. Lang [2000], “The willingness to pay for wait reduction: The disutility of queues for cataract surgery in Canada, Denmark and Spain”, J. Health Economics 19,
(NB Canadians want to wait! Others don’t? Read pp. 220, 228-229.)

* CIHI [2017], “Wait Times for Priority Procedures in Canada, 2017”,


Gaynor, M. et al. [2012], “Free to choose? Reform and demand response in the English National Health Service”, NBER WP 18574 (Read, if interested, 2-3, 8-11, 24-28.)
http://www.nber.org/papers/w18574


Street, A. & S. Duckett [1996], “Are waiting lists inevitable?”, Health Policy 36, 1-15 (NB Where it is inevitable one can still improve: Basically, wait management.)

d. Emergency department in a hospital
* Bruni, M.L. et al. [2016], “Does the extension of primary care practice opening hours reduce The use of emergency services?”, J. Health Economics 50, 144–155 (Read pp. 144-146, 153-154.)

Freeman, M. et al. [2017], “Gatekeeping under congestion: An empirical study of referral errors in the emergency department”, INSEAD Working Paper Series 2017/59/TOM,
http://ssrn.com/abstract=3036999
(While ED physicians make more gatekeeping errors when congestion increases, the change in the rates of false positives (avoidable hospitalization) and false negatives (wrongful discharge) differ substantially: When congestion increases, physicians lower
threshold for admission which surges avoidable hospitalizations and creates 'false demand' for hospital beds.)

* Gruber, J. et al. [2018], “Saving lives by tying hands: The unexpected effects of constraining healthcare providers”, NBER WP No. 24445, http://www.nber.org/papers/w24445 (Read pp. 2-8, 29-30.)


* Weinick, R.M. et al. [2010], “Many emergency department visits could be managed at urgent care centers and retail clinics”, Health Affairs 29(9), 1630-1636

6. Pharma

a. Pharmaceuticals


Kremer, M. & C.M. Snyder [2018], “Preventives versus treatments redux: Tighter bounds on distortions in innovation incentives with an application to the global demand for HIV pharmaceuticals”, NBER WP No. 24206, http://www.nber.org/papers/w24206 (Pharmaceutical companies would produce and market the more lucrative of preventive and curative drugs. This is a suboptimal outcome.)


Moir, H.V.J. [2016], “Exploring evergreening: Insights from two medicines”, Australian Economic Review 49(4), 413–31 (Read pp. 413-416.)

* Outterson, K. [2013], “Pharmaceutical arbitrage: Balancing access and innovation in international prescription drug markets” Yale J. Health Policy, Law, and Ethics 5(1), 1-99 (Read pp. 3-14.)

* Stiglitz, J.E. [2007], “Prizes, not patents”, Project Syndicate (NB Maybe with Brennan [2015]?)

* The Economist [2017], “Hard to swallow: Cancer drugs are getting better and dearer”, May 4

* The Economist [2016], “Vaccine manufacture – Rehydration therapy”, September 24 (How to democratize vaccine production?)

* The Economist [1996], “Economics focus: A patent cure-all?”, June 15

b. Pharmacare

Adams, O. & J. Smith [2017], “National pharmacare in Canada: 2019 or bust?”, Univ. of Calgary, School of Public Policy Research Paper 10(5) (Latest of debate!)
7. Long-term care

a. LTC insurance
* Bakx, P. et al. [2015], “Can universal access and competition in long-term care insurance be combined?”, *International J. Health Economics and Management* 15 (2), 185-213 (Combining universal access and competition among risk bearing LTC-insurers requires an adequate system of risk adjustment. Read pp. 186-188, 198-199.)
* Blomqvist, Å. & C. Busby [2012], “Long-term care for the elderly: Challenges and policy options”, Commentary 367, CD Howe Institute, (Read pp. 3-10, 22-32.)
* Blomqvist, Å. & C. Busby [2014], “Paying for the boomers: Long-term care and intergenerational equity”, Commentary 415, CD Howe Institute, 
* Gleckman, H. [2012], “Should you buy long-term care insurance? Maybe Not”, 
* Cremer, H. et al. [2016], “The design of long-term care insurance contracts”, 
* Hackmann, M.B. & R.V. Pohl [2018], “Patient vs. provider incentives in long term care”, NBER WP No. 25178, 
* Costa-Font, J. et al. [2016], “Thinking of incentivizing care? The effect of demand subsidies on informal caregiving and intergenerational Transfers”, CESIFO WP No. 6124, 
* Costa-Font, J. [2017], “Institutionalization aversion and the willingness to pay for home healthcare”, J. Housing Economics 38, 62-69 (Read pp. 62-63, 68.)

b. Informal and home care
* André Picard [2017], “Learning from the Dutch ‘neighbourhood care’ model”, The Globe and Mail, July 11, 
* Costa-Font, J. et al. [2016], “Thinking of incentivizing care? The effect of demand subsidies on informal caregiving and intergenerational Transfers”, CESIFO WP No. 6124, 
* Hackmann, M.B. & R.V. Pohl [2018], “Patient vs. provider incentives in long term care”, NBER WP No. 25178, 
* Horioka, C.Y. et al. [2016], “Why do children take care of their elderly parents? Are the
* The Economist [2017], “End-of-life care – A better way to care for the dying”, April 29

c. Nursing homes
* Chen, M.M. & D.C. Grabowski [2015], “Intended and unintended consequences of minimum staffing standards for nursing homes”, Health Economics 24(7), 822-839 (Read pp. 822-826, 835-837.)
Schmitz, H. & M.A. Stroka [2014], “Do elderly choose nursing homes by quality, price or location?”, Ruhr Economic Papers #495 (NB This is a choice problem as well as a system design issue.) http://www.rwi-essen.de/media/content/pages/publikationen/ruhr-economic-papers/REP_14_495.pdf

8. Cost-Benefit Evaluation in Healthcare

Lichtenberg, F.R., [2017], “How cost effective are new cancer drugs in the U.S.?”, CESifo WP No. 6683, https://www.cesifo-group.de/dms/doc/15.../am17_Lichtenberg.pdf (Decline in premature mortality from cancers due to large numbers of drugs approved, controlling for changes in cancer incidence and mean age at time of diagnosis?)
* Myerson, R.M. et al. [2018], “Effects of expanding health screening on treatment - What should we expect? What can we learn?”, NBER WP No. 24347, http://www.nber.org/papers/w24347 (Read pp. 3-13, 23.)

Part D: Healthcare Systems

9. System design and classification

Bauhoff, S. & L. Fischer [2017], “Plan responses to diagnosis-based payment: Evidence from Germany’s morbidity-based risk adjustment”, CESifo Working Paper 6507, www.CESifo-group.org/wp (We investigate responses of German health plans to the introduction of
morbidity-based risk adjustment in the Statutory Health Insurance in 2009, which triggers payments based on “validated” diagnoses by providers.)


* Herzlinger, R.E. et al. [2017], “Achieving universal coverage without turning to a single payer: Lessons from 3 other countries”, J. American Medical Association 317(14), 1409-1410

Schütte, S. et al. [2018], “Health systems around the world – a comparison of existing health system rankings”, J. Global Health 8(1), 1-9 (Comparison of comparative methods!)


Rizzo, J.A. & J.H. Goddeeris [1998], “The economic returns to hospital admitting privileges”, J. Health Politics, Policy and Law 23(3), 483-515 (NB This is related to Baker et al. [2015].)

* Swami, M. et al. [2018], “Hours worked by general practitioners and waiting times for primary care”, Health Economics 27, 1513-1532 (Read pp. 1513-1514, 1524-1525.)


Vranbaek, K. et al. [2012], “Choice policies in Northern European health systems”, Health Economics, Policy and Law 7, 47-71 (Read pp. 47-49, 53-54, 57-67.)

White, J. [2009], “Gap and parallel insurance in healthcare systems with mandatory contributions to a single funding pool for core medical and hospital benefits for all citizens in any given geographic Area”, J. Health Politics, Policy and Law 34(4), 543-583 (Read 556-583.)

10. Canadian and US systems

a. Canadian system


* Blomqvist, Â. & C. Busby [2012], “Better value for money in healthcare: European lessons for Canada”, Commentary 339, CD Howe Institute, (Read pp. 2-3, 6-14.)

Carson, D.B. et al. [2015], “The ‘rural pipeline’ and retention of rural health professionals in Europe’s northern peripheries”, Health Policy 119, 1550-1556 (See Shortt et al. [2005] below.)


b. U.S. health care and reforms
Bauchner, H. & P.B. Fontanarosa [2018], “Healthcare spending in the United States compared with 10 other high-income countries - What Uwe Reinhardt might have said”, JAMA 319(10), 990-992
Emanuel, E.J. [2018], “The real cost of the US healthcare system”, JAMA 319(10), 983-985
Kaiser Family Foundation [2012], “Who benefits from ACA Medicaid expansion?” http://www.kff.org//medicaid/quicktake_aca_medicaid.cfm?RenderForPrint=1
* Papanicolas, I. et al. [2018], “Healthcare spending in the United States and other high-income countries”, JAMA 319(10), 1024-1039 (Lots of colourful tables!)
* The Economist [2017], “The expanding universal - The fix for American health care can be found in Europe”, August 10

EVALUATION

<table>
<thead>
<tr>
<th>Activity</th>
<th>Weight</th>
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<tr>
<td>3 OnQ quizzes (weeks 5, 7, and 11 on 6pm Friday - 6pm Saturday)</td>
<td>30%</td>
</tr>
<tr>
<td>1 midterm test (9th week in class)</td>
<td>20%</td>
</tr>
<tr>
<td>Final exam</td>
<td>50%</td>
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14/14