Institute of Health Policy, Management & Evaluation
UNIVERSITY OF TORONTO

Bending the Cost Curve in Canadian Health Care

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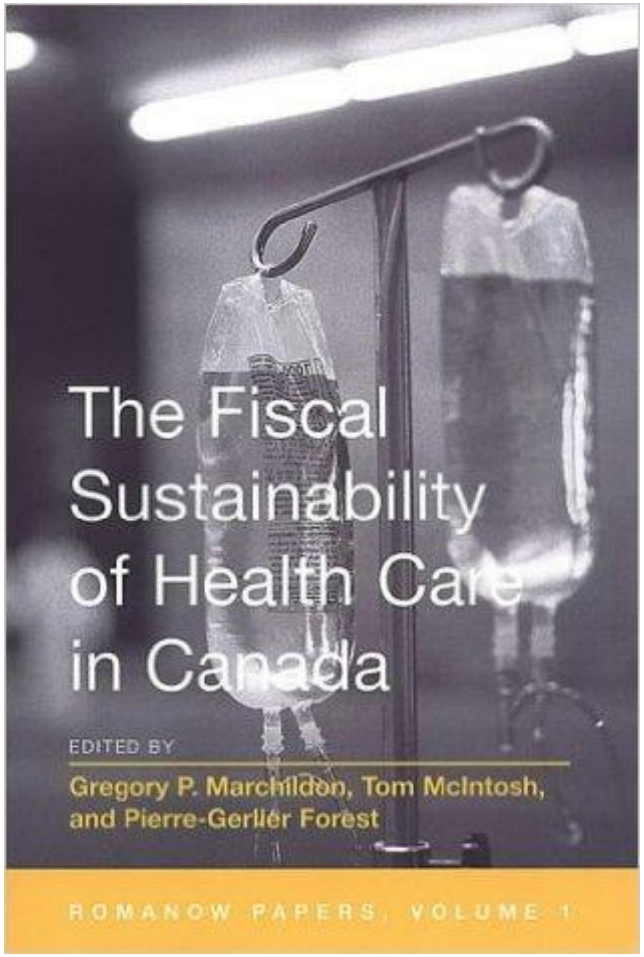
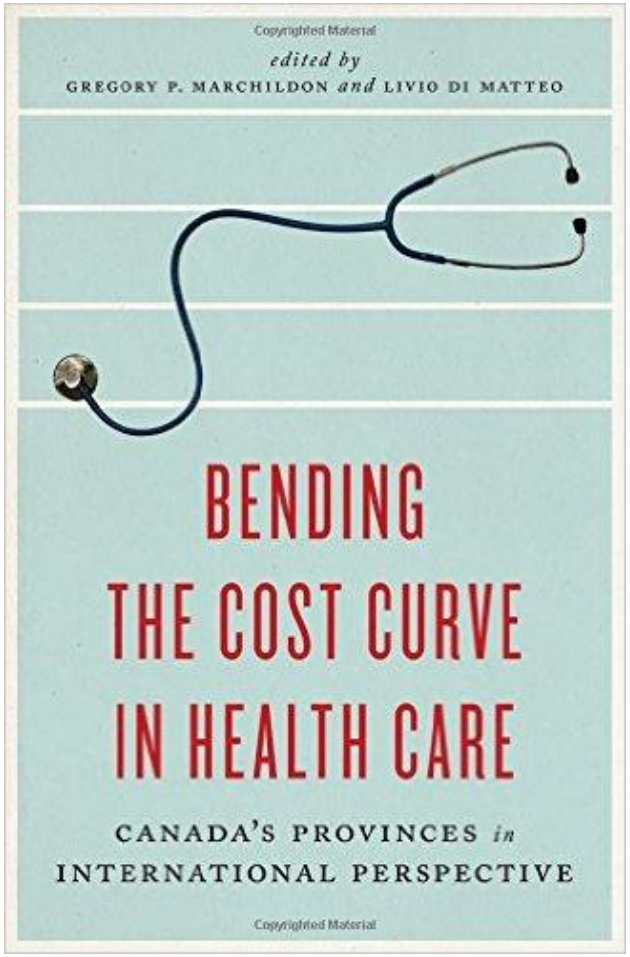
IHPME

Personal History

- Saskatchewan and Fiscal Crisis of early and mid-1990s
  - Conversion/closure of hospitals
  - Response to transfer cuts and intergovernmental negotiations on transfers (SUFA)
- Commission on the Future of Health Care in Canada
  - Mandate: future sustainability
  - Studies on Fiscal Sustainability
- Health Care Cost Drivers
  - Canadian Institute for Health Information study
  - Book highlighting key cost drivers and implications in a narrative
  - Re-examining federal transfers



Conundrums in Bending the Cost Curve (Still Valid?)



1. Inherently long-term relative to simple cost-cutting but public impatient and governments face electoral cycle
2. Almost all efforts in Canada have focused on volumes of output and number of providers yet price should be key factor (largely undiscovered)
3. Although fiscal sustainability is as much about revenues as spending, the former is treated as fixed while focus only on latter - and public demands lower taxes + more/better health care
4. While decisions on bending cost curve should be evidence-based, it is almost impossible to draw a straight line from change to value of outcome
5. While comparative evidence is essential to better understanding cost challenges and potential interventions, these solutions are context specific

Insights from Above and Below

(Reinhardt)

- Perception of sustainability crisis for at least four decades
- Definition: “bending down the future time path of national and per capita health spending”
- Slower economic growth + more unequal distribution of income = greater pressure on health costs
- Health care as source of income and creator of jobs = defense of status quo health spending
- Three-fold thrust of policies to discourage excessive use of health care resources:
  - Improving clinical integration across continuum of health services
  - Achieving greater economy in the use of real resources in treating patients
  - Improving the quality (in each of its many dimensions) of health care provided

Financial Incentives and P4P

(Hurley and Li)

- Active use of financial incentives to achieve targeted policy objectives
- Broad summary of international evidence
  - Prove effective for lower-skilled workers
  - Mixed to poor results for physicians
  - Overall, however, too little evidence of impact on cost control or quality improvement
  - Problem at the design-evaluation stage
- Focus on Ontario primary care remuneration reforms to improve quality
  - Should lead to reduced hospital and specialist care (and to less prescription drug use)
  - But only as a consequence of providing more consistent, responsive and coordinated care
- Shift from global budgets to case-based (activity-based) payment
  - Increased hospital throughput, decreased length of stay
  - Evidence on productive efficiency more equivocal

Tax Burdens and Aging

(Richards and Busby)

- Fiscal drift is natural inclination of provincial governments
- Pressures eventually force governments to act
  - Debt crisis and early to mid-1990s
  - Demographic bubble
- Although Canada is demographically young relative to most OECD countries
- Aging will eventually put pressure on governments: degree debated
- Decline of taxes as share of GDP since late 1990s
- Their cost constrained (modest) scenario sees significant increase in provincial spending on health from **7.7%** of 2012 GDP to:
  - Slightly less than **10%** of 2030 GDP
  - Slightly more than **11%** of 2050 GDP

Pharmaceuticals

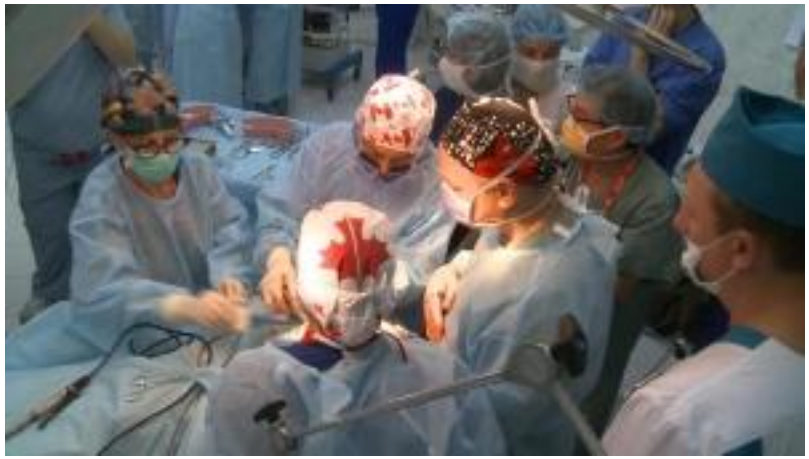
(Morgan, Daw and Thomson)

- Fastest growing segment of health expenditures until recently
- Second-highest real per capita spending on drugs in the OECD
- Among highest drug prices in the OECD
  - Generic drugs – lack of price regulation
  - Less discounting
  - Fragmented public purchasers
- Grew at real rate of 6% per year between 1997 and 2007
- Question of whether we are in temporary lull
- Supply-side cost controls
  - International and therapeutic reference pricing
  - Generic licensing and regulation
- Demand-side cost controls
  - Patient-based (e.g. co-payments)
  - Physician-based (e.g. budget caps)

Paying the Health Workforce

(Leonard and Sweetman)

Real pre-tax mean annual earnings, Canada		
	Physicians	Nurses
1995	$152,290	$45,139
2005	$182,532	$56,127



Three possible cost-reduction paths:

1. Providing less
   - Reducing services directly or indirectly
   - Reducing public coverage (shifting from public to private payment)
2. Paying less
   - Subject HHR to same public sector constraints
   - Target overpayments
3. Doing more with the same resources (higher efficiency)
   - “Most difficult but most fruitful”
   - Payment reforms with effective monitoring and systematic evaluation
   - System integration and coordination reforms

Provincial Health Spending Patterns

Common Features

- Spending phases, 1975-2015 (real average annual growth)*
  - 1975-91 – accelerate (2.7%)
  - 1991-96 – brake (-0.5%)
  - 1997-2010 – accelerate (3.3%)
  - 2010-15 – brake (-0.6%)
- Common cost drivers
  - Health sector price inflation
  - General inflation
  - Technology
  - Pharmaceutical prices

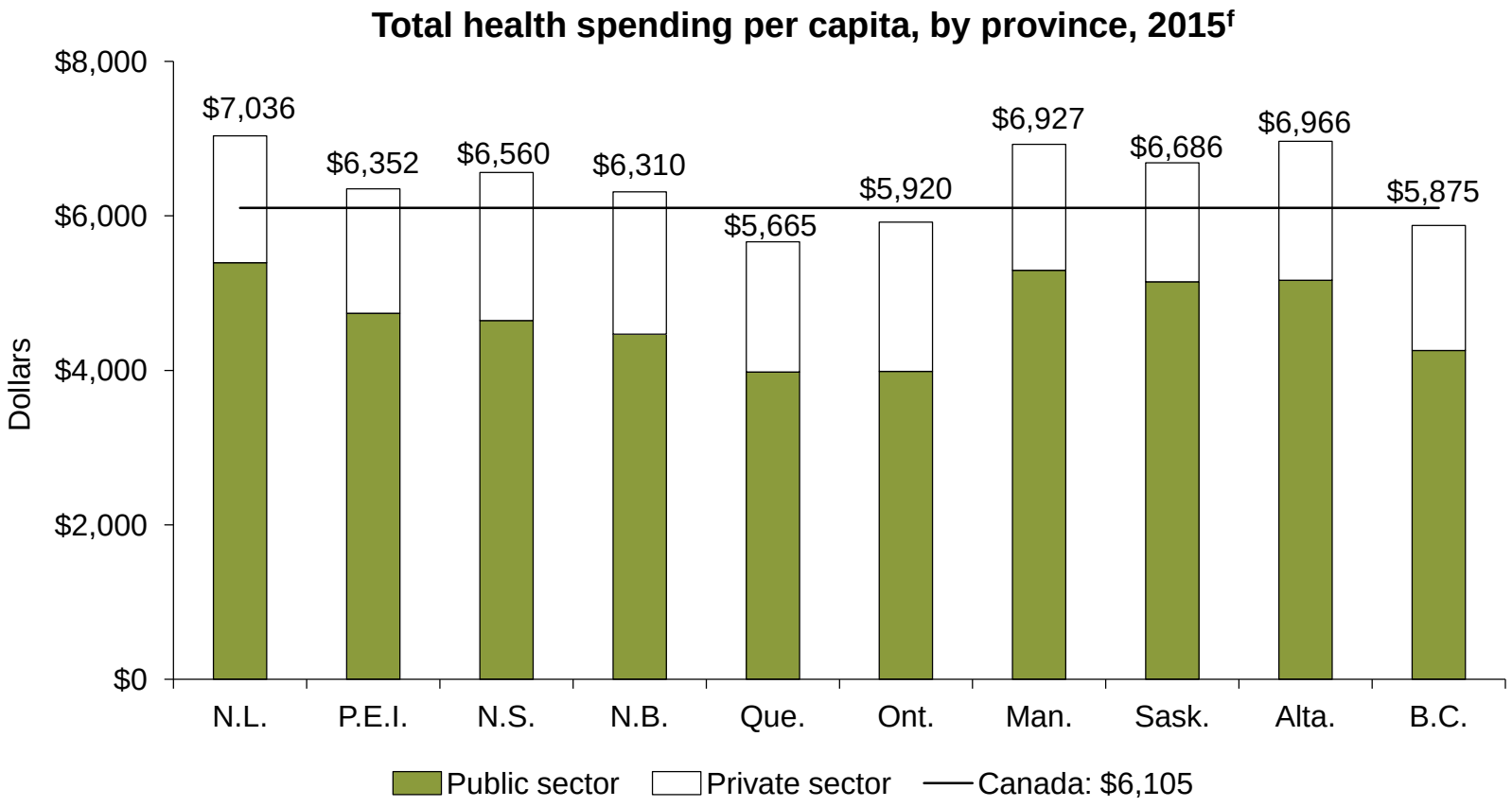
*CIHI, National Health Expenditure Trends, 1975-2015

Differences

- Average annual growth rate of real per-capita health spending, 1975-2011
  - From 3.4% in NL to 1.7% in QC
  - Atlantic provinces all at high end
  - More populous provinces (ON, BC, QC) at low end
- Very different geographic and demographic distributions
- Variable cost drivers
  - Population growth
  - Aging
  - Rural and remote delivery
  - Drug coverage plans

Provincial Differences and Efforts to Bend the Cost Curve

Variation in Provincial Health Spending Per Capita



Note
f: Forecast.
Sources
National Health Expenditure Database, CIHI; Statistics Canada.

Provincial Policies to Bend the Cost Curve

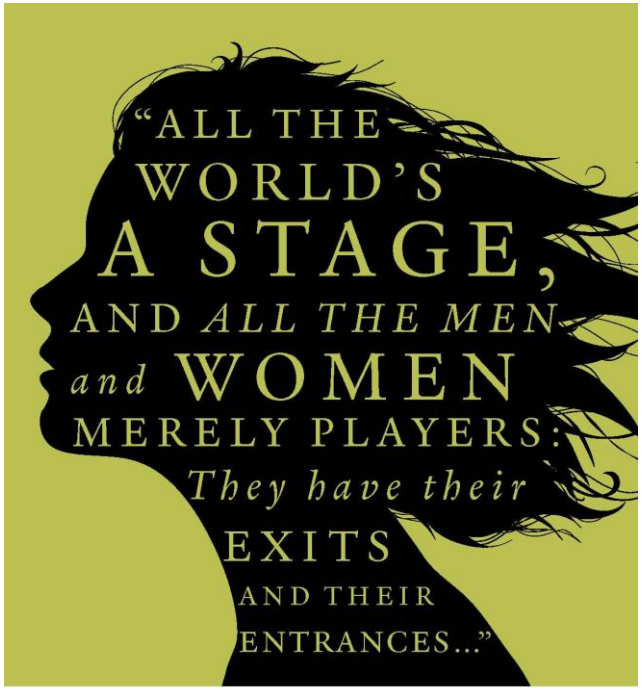
(incomplete list – up to 2012-13)

- ON (Deber and Allin)
- QC (Béland and Galland)
- BC (McGrail and Evans)
- AB (Duckett)
- SK and MB (Marchildon)
- Atlantic (Ruggeri)

- Activity-based hospital payment (BC and ON)
- Primary care reform (ON)
- Eliminating “unnecessary” layers or structures (MB, QC, NB) or creation of single RHA (AB, PE)
- Lean process reforms (SK)
- Substitution of providers (MB, ON)
- Investment in assisted living (BC)
- Contracting out elective surgery to private sector (AB, SK)
- Controlling wage demands (QC, NB, NS, PE)

Current Drama in Canada

- *Deus ex machina*
  - "god from the machine"
  - Plot device used by Euripedes (Medea) and later playwrights
  - Seemingly unsolveable problem is miraculously resolved by some event, character or object external to play
  - Allows story to be resolved because playwright has painted him/herself into corner
  - Increases to the Canada Health Transfer has become the *deus ex machina!*



As You Like It

WILLIAM SHAKESPEARE

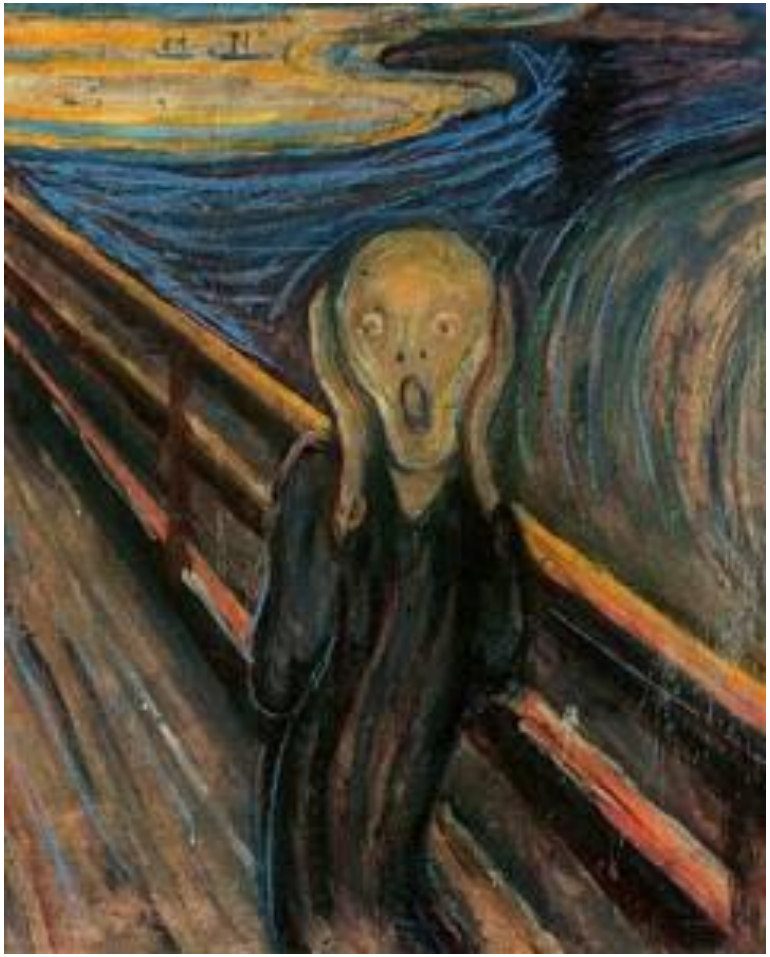
edited by David Bevington

BROADVIEW / INTERNET SHAKESPEARE EDITIONS

The Federal Government and Transfers

- Federal government impacts provincial spending
  - Transfers (CHT, CST and Equalization)
  - Canada Health Act
  - First Nations and Inuit health
  - Health Research and data
  - Pharmaceutical regulation and safety
  - Creation, funding and direction of intergovernmental health agencies (CIHI, CADTH, etc.)
- Quick fix? Or major Change?
  - CHT – per capita and 3% escalator
  - Purpose of CHT – being fulfilled?
  - More federal cash? Why?
  - Conditional transfers through bilateral agreements? Coalition of the willing?

Conclusions: Bending the Cost Curve



- Extremely hard work with few easy answers
- Requires long-term goals with strategy and political patience
- Reasonably effective health system structures to ensure coordination
- Focus on measuring and evaluating impact on service delivery
- Courage by health system stewards to change in face of significant support for status quo
- Public sector leadership, insight and expertise
- Includes F/P/T leadership!