The Challenges of Sustaining Excellence in Canadian Health Care

Craig Mitton, PhD

Professor and Senior Scientist
Centre for Clinical Epidemiology and Evaluation, Vancouver Coastal Health Research Institute
School of Population and Public Health, University of British Columbia

craig.mitton@ubc.ca

Session objectives

- Describe the structure and basic financing of Canadian health care
- Outline key challenges for the system related to both patients and physicians
- Describe a policy approach that has had much success in Canada and overseas
- Open discussion about the role of Christian values in the face of economic issues like system sustainability

Health Economics

- Economics = study of choice
- Not about cutting costs!
- Basic premise:
  - how to allocate resources in a way that does the most benefit within a budget constraint
- Requires knowledge of costs *and* benefits of alternative courses of action

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The drug itself has no side effects …
but the number of health economists needed to prove its value may cause dizziness and nausea

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"If we are ever going to get the 'optimum' results from our national expenditure on the NHS we must finally be able to express the results in the form of the benefit and the cost to the population of a particular type of activity, and the increased benefit that would be obtained if more money were made available."

Cochrane AL. Effectiveness and Efficiency: random reflections on health services. Nuffield Provincial Hospitals Trust, London, 1972.

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Common questions

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- What is the structure of our system in Canada and overall how do we perform?
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Spending in Canada

- $200B+ in total health care spending in 2012
- On average about $5500 per person
  - Canada ranks in top 5 of OECD countries
  - $37 billion spent in 1984
  - Greatest increases in drugs
  - Myth buster: only about 4% on health care administration
- Translates to 10.7% of GDP and in most provinces over 40% of provincial expenditure

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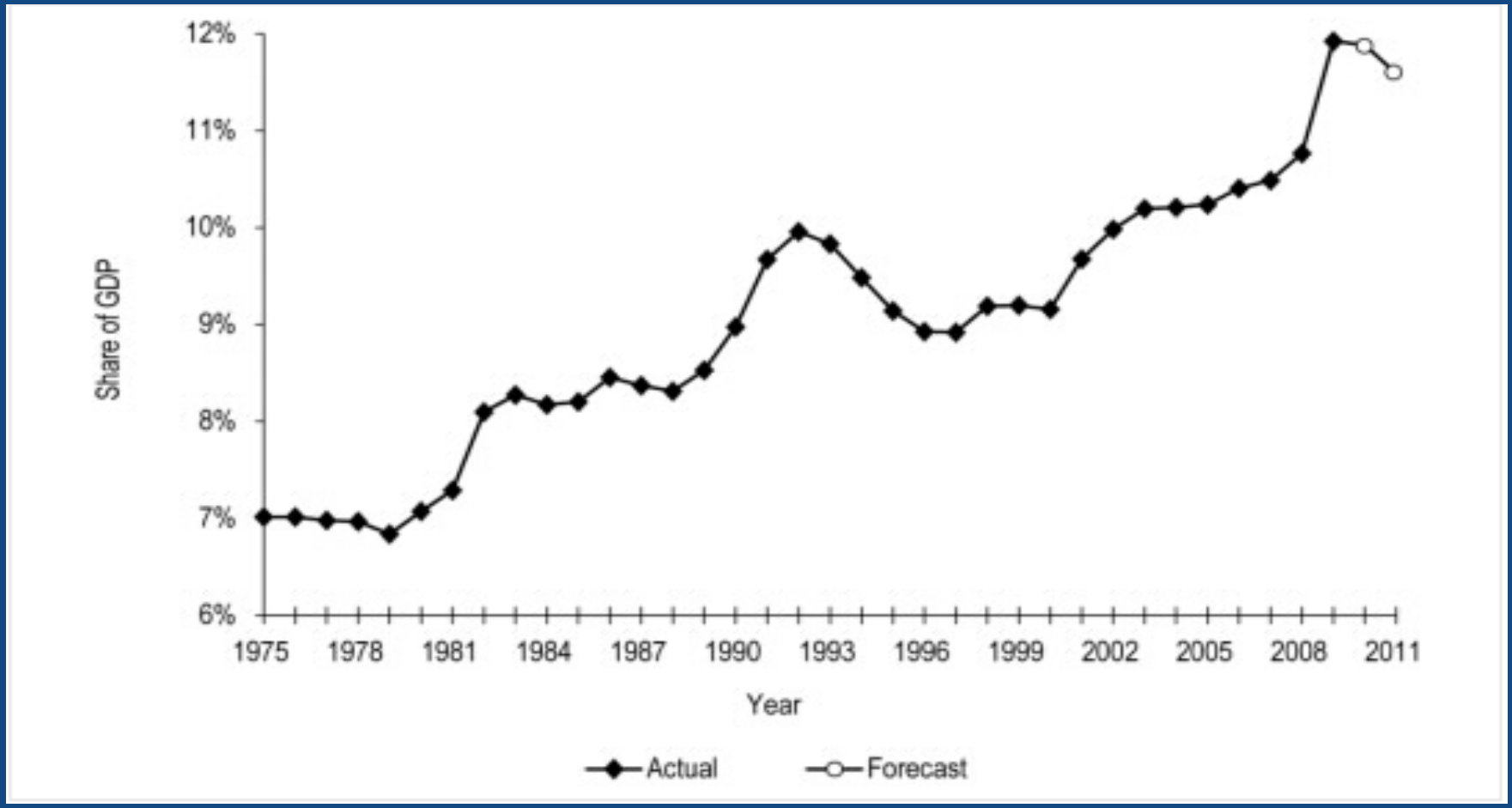
Total spending as % GDP



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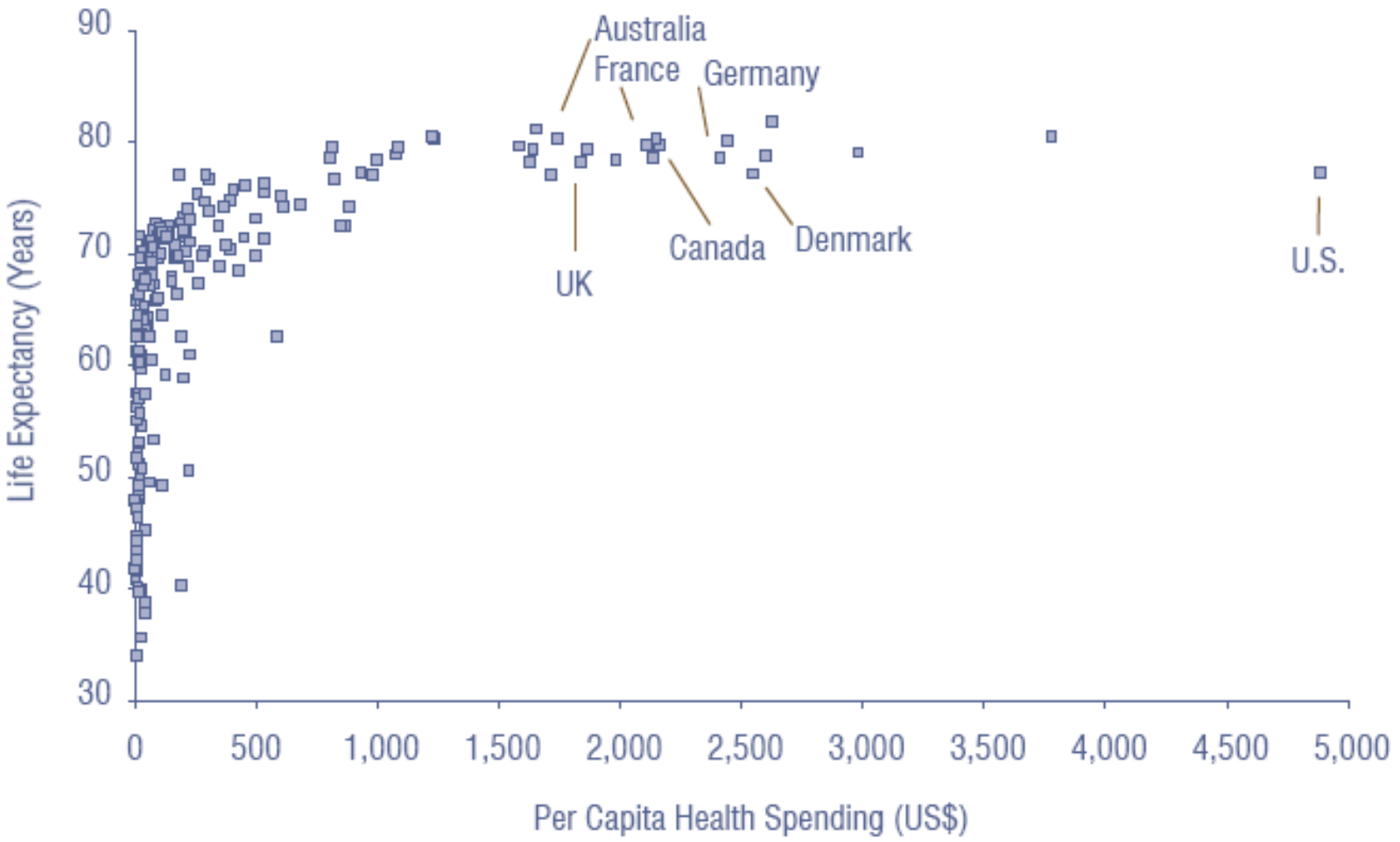
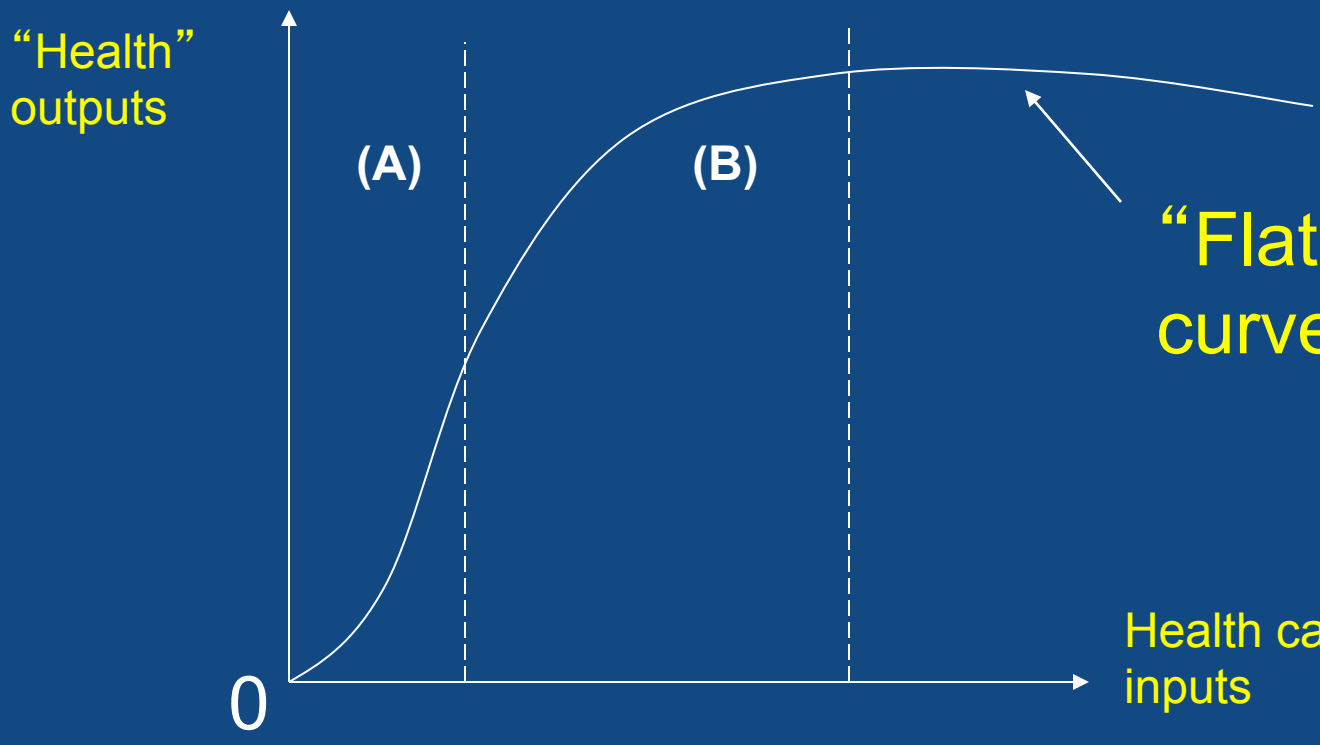
Health Spending and Life Expectancy



Effects of Increased Health Care Spending



(A) Returns increasing at a growing rate.
(B) Returns increasing but at a slower rate.

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Across OECD

- OECD countries range in total health expenditure from between 7-18% GDP
- After decades of growth over 4% per year, as of 2009 growth in public expenditure has declined in most OECD countries
  - Lower prices on medical products and drugs
  - Hospital budget constraints
  - Negotiations on wages
  - Cost shifting to private insurance or out of pocket
- Diminishing access for health prevention/ promotion services; raises equity issues

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General trends (OECD)

- More physicians working (absolute and per capita), not less, but working in different ways
- Average growth in physician reimbursement outpaced inflation by 2:1 year on year over the last decade
- Hospital length of stays have seen large declines
- Investment in out of hospital programs mixed trends
- On average 20% of health expenditure is out of pocket; again, greater burdens on lower SES

Wildavsky's (1997) law of medical money: 'costs will increase to the level of available funds… that level must be limited to keep costs down'

Drivers: drugs, technologies, aging, **GDP**

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Take home #1

- We spend a lot on health care in Canada as is
- More money equates to better outcomes only to a point
- Growth in health expenditure overall across countries is slowing
- Governments can limit expenditure on health care (for good reason as we'll see)

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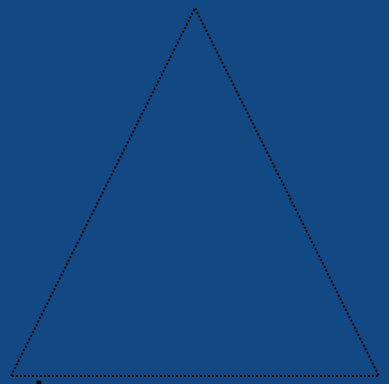
Health care Organization

Public Sector (70%)

Feds: aboriginal health, safety & protection branch

Provincial Ministries (10+3)



Health regions
-Hospitals
-community

Physicians

CADTH: drug & non-drug HTA

Private Sector (30%)

Out of hospital drugs
PT, chiropractor, dentist

$200B or just over $5500 per capita - equates to about 10.5% GDP

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Key features

- We do not have universal first dollar coverage of pharmaceuticals (equity issues)
- We do not have a universal home care program
- Some provinces have a monthly premium (income adjusted), others do not
- Programs and institutions are largely funded on a global budget basis
- Majority of physicians are still paid on a fee for services basis

How do we do?

- About 88% of Canadians self-rate their health as good or very good
  - 3rd in the OECD ranking and well ahead of the average at 69%
  - However the gap between lowest and highest income earners is 15%
  - Worse than NZ in terms of this gap but on par with Australia, UK, Switzerland, Sweden, Netherlands

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Other indicators

- One of the lowest smoking rates among teens across OECD countries
- Slightly above average (bad) on child obesity and well above average on adult obesity
- Prevalence of chronic disease is escalating
- Above average (good) on healthy eating and physical activity in children and adults
- Progress in key life threatening conditions
- Wide variations in clinical practice persist

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Take home #2

- We look different than almost every other OECD country in terms of structure
- On balance we fair reasonably well against comparable countries (as in we are not an outlier)
- It is naïve to point to a single country (eg Sweden) and say we should emulate what they have
- We already have a sizeable parallel 'private' system (more to come on this)

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Universality and Accessibility

- Two key elements of Canada Health Act (1984)
  - "In order to satisfy the criterion respecting universality, the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions."
  - "In order to satisfy the criterion respecting accessibility, the health care insurance plan of a province: (*a*) must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons."

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Access issues

- Leads to rationing by wait time
- Arbitrary targets from MoH
- Public perception of 'crisis'
- Chaoulli decision in Quebec (2005)
- More court challenges to come
- Ideological debate that masks the fundamental issue facing health care today

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So what's the real issue?

"Talk of crisis and calls for more funds obscure the fact that scarcity is a normal condition in publicly funded health care. Resources devoted to one service provided by a hospital or doctor are of necessity not available for other services." [Donaldson et al. 2002]

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Politics and perceptions

Talking points:

- Reforms and court challenges don't address the fundamental issue that choices have to be made
- Everyone loves their local hospital (but personally I wouldn't stop there)
- Public expectations and disinvestment
- Four year political cycle

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Take home #3

- There are ways to better use existing resources with significant savings attached
  - Choosing Wisely campaign
  - NHS: 'do not do' lists
  - Assessing marginal costs and benefits
    - Archie Cochrane had it right (40 years ago!!!)

- *We do not require fundamental re-design (although fewer hospitals, greater investment in primary care and changes to physician reimbursement would help)*

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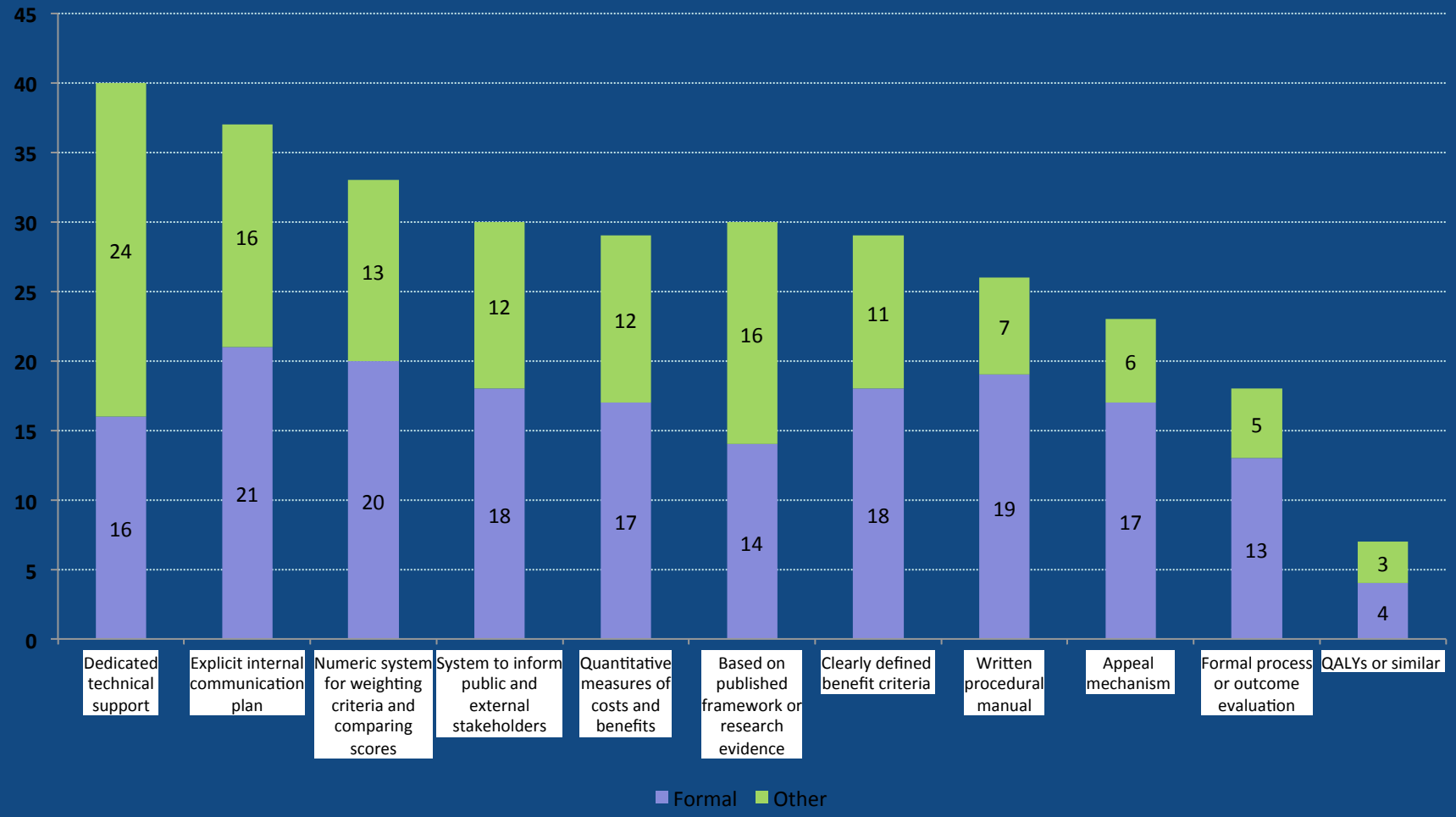
Reform vs. management

- "There is no health care system that performs systematically better in delivering cost-effective health care. It may thus be less the type of system that matters but rather how it is managed." [OECD Economics Department Policy Notes, No. 2, 2010]

Aspects of Formalization



2012 Canadian survey, n=90
[Smith et al. 2013]

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Historical vs. formal process

	Poor or very Poor	Fair	Good or very Good
Historical or Political Process	18%	50%	32%
Formal/Rational Process	2%	25%	73%

Those who stated their organization used a formal/ rational process tended to be more satisfied with the priority setting process than those without.

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Economics and ethics

- Literature on priority setting has economics and ethics contributions
- Useful to see these disciplines as complementary
  - Value for money
  - Fair process
- Develop and implement an approach to priority setting which incorporates both perspectives

[Gibson et al. 2006]

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What is priority setting?

- Given that we can't do everything, choices must be made about what to fund and what not to fund

- Priority setting is about making these choices:
  - *Health authorities*
  - *Hospitals*
  - *Program areas*
  - *Individual services*

Mitton and Donaldson CERA 2004

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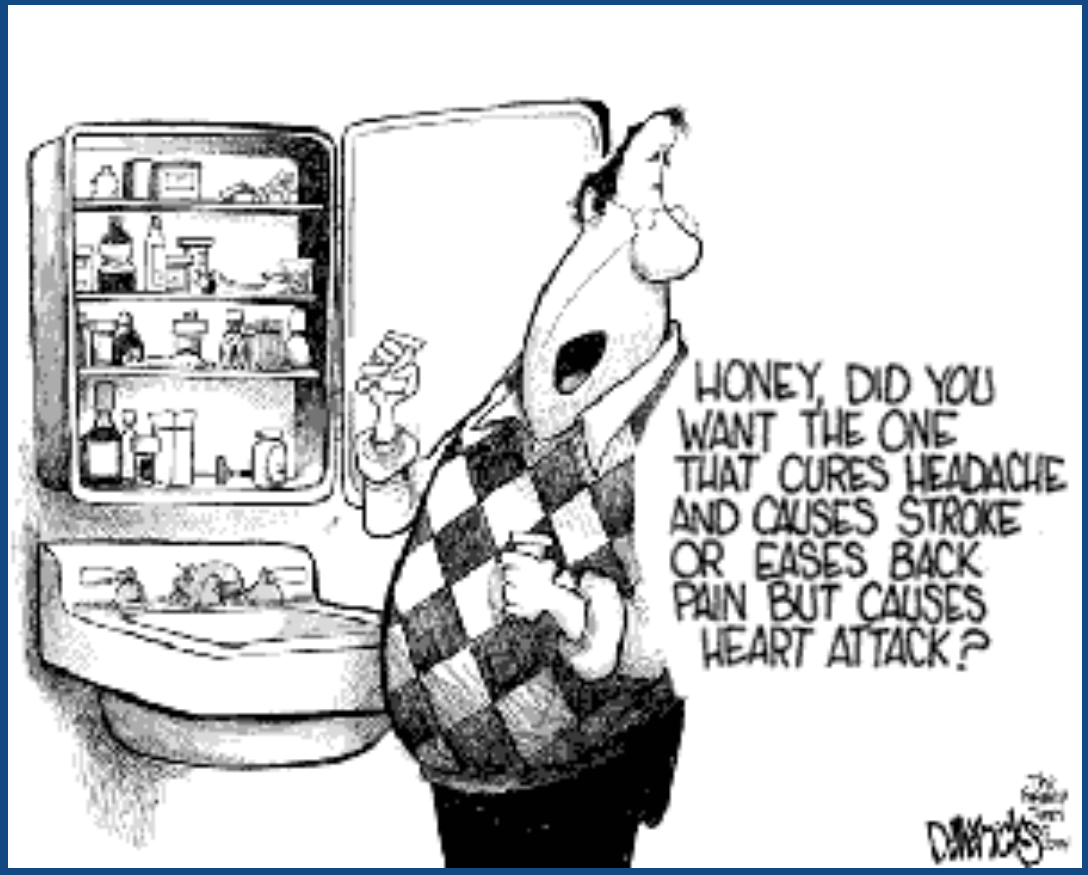
Explicit trade-offs



Trade-offs have to be made, important to weigh out both costs and benefits and apply knowledge within broader framework

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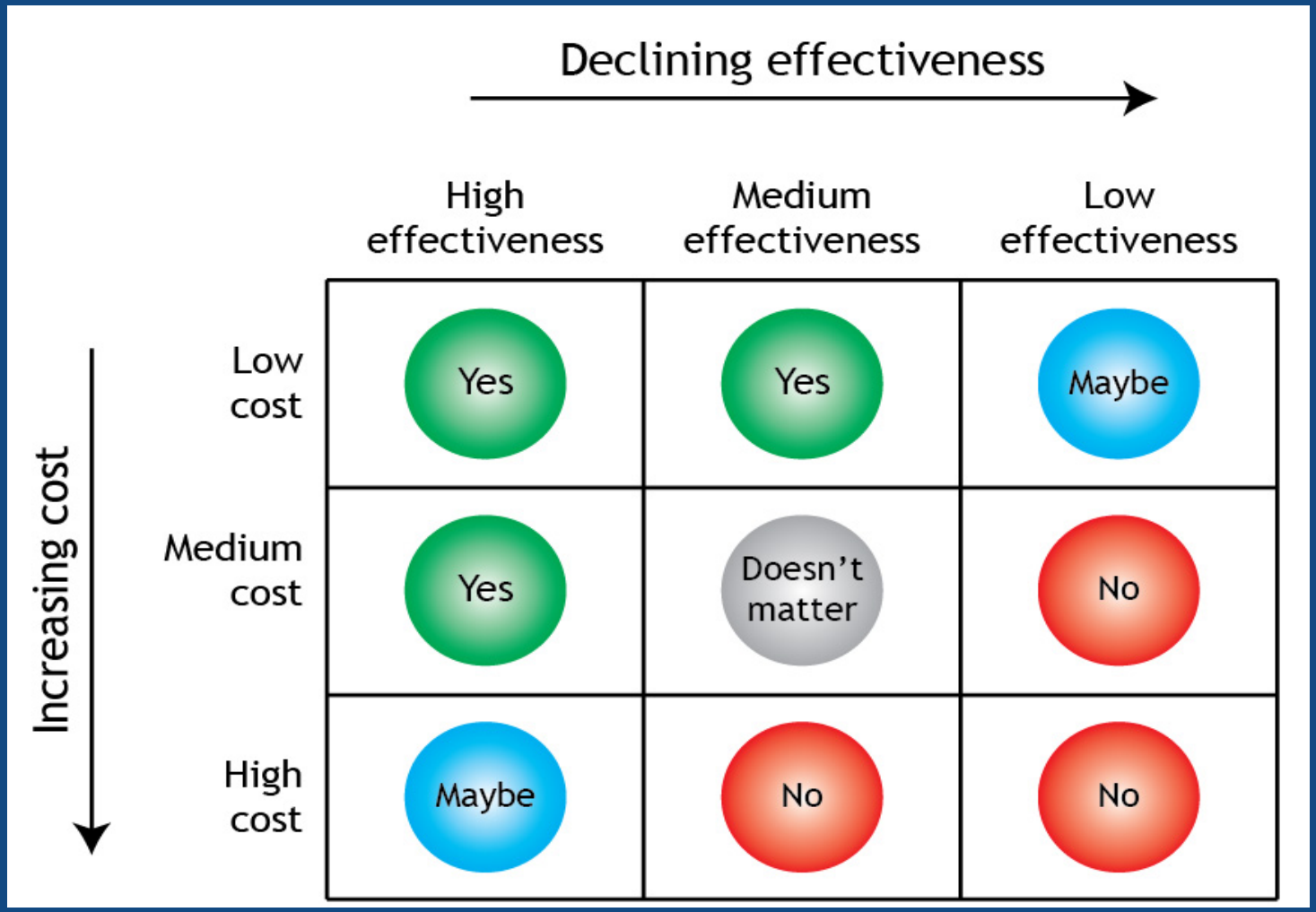
Simple decision matrix



So what's the answer?

- Identify stakeholder values
- Use this to construct decision criteria
- Determine costs and 'benefits' of options
- Explicitly assess trade-offs
- Validate and communicate
- Accept winners and losers

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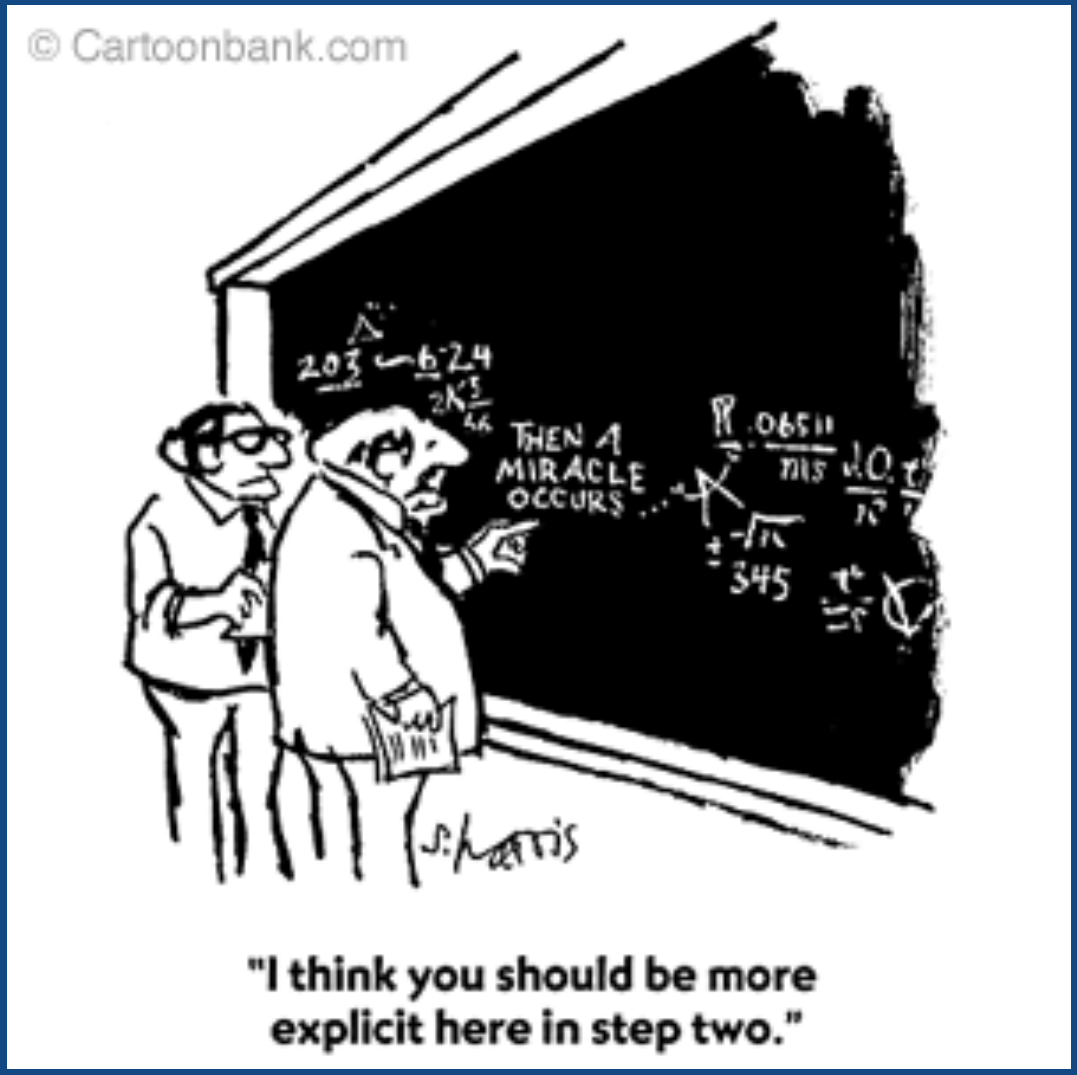

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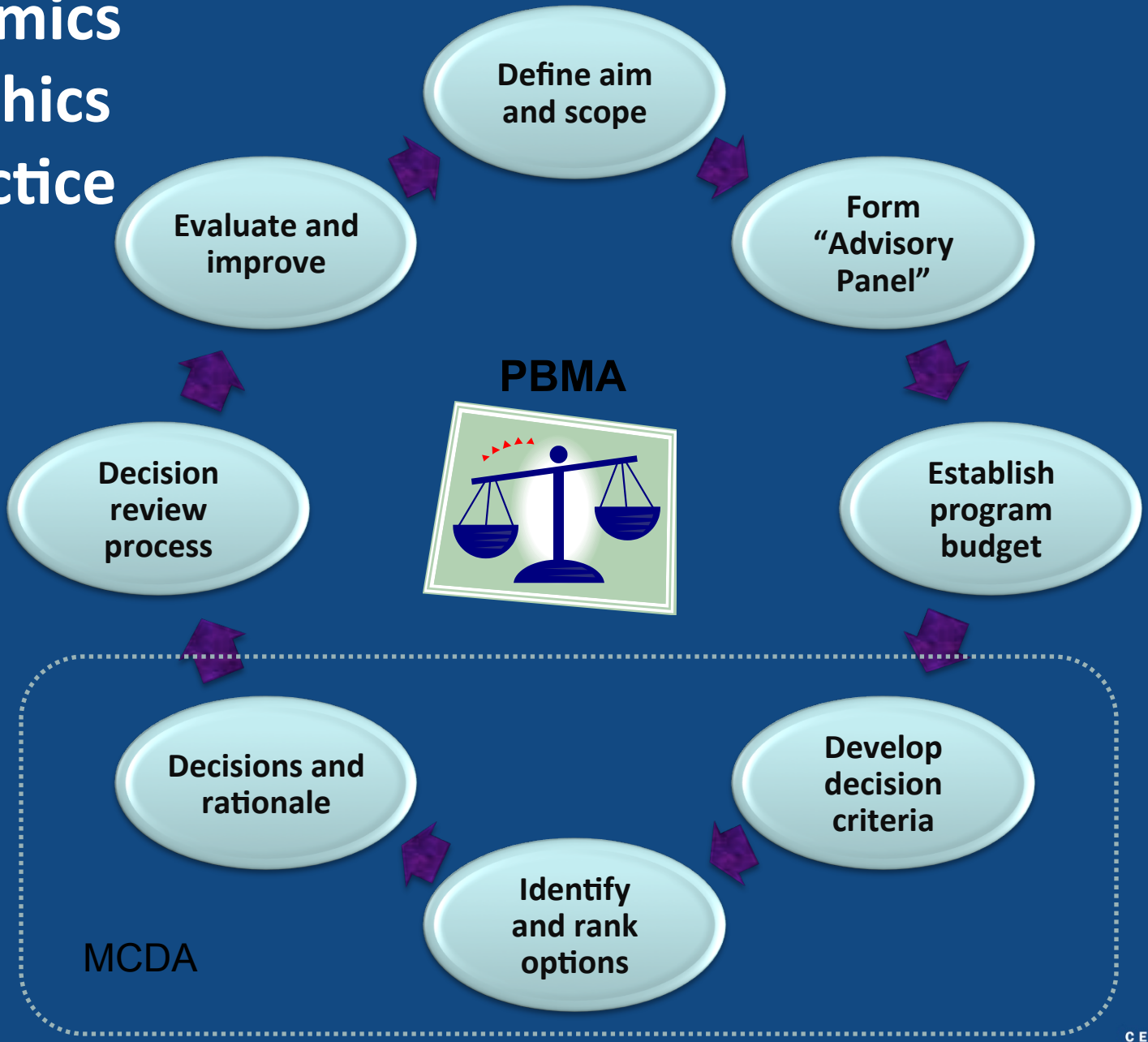
Economics and ethics in practice



[Mitton and Donaldson 2004]

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Key Concepts

- Shifting or re-allocating resources based on comparison against pre-defined criteria
- Incentives to encourage participation
- Clinicians and managers working together
- Ethical conditions built in
- Tool that supports decision making

[Peacock et al. BMJ 2006]

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Take home #4

- Methods are available to assist decision makers in making difficult choices
- Has to be based on public values
- Physicians have a key role to play
- Big stakes both in terms of $$$ and equity

- But note it doesn't involve reform and it likely doesn't win many votes

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The best investment ever

- Social determinants have a greater impact on population health than health care per se
  - Poverty reduction
  - Early childhood education
  - Affordable housing

[Evans and many, many others]

Take home #5

- Best use of limited resources unequivocally lies OUTSIDE of health care system

Summary

- We spend a lot on health care in Canada
- Overall we do not do too badly on the international comparison front
- More reforms and ideology get us nowhere
- The answer is to accept scarcity and employ explicit methods to better manage existing resources
- The consequence of this is that there will be winners and losers which can be hard to accept
- Ultimately, non-health care investments provide greater benefit overall

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Discussion

- Does an ‘economic way of thinking’ compete with Christian values of social justice, equity or empathy?
- In ‘having to make choices’ some people will be worse off --- what does this say for the Christian?
- Economics is known as the ‘dismal science’ but today’s reality is one of resource constraints --- what should a ‘Christian perspective’ on resource allocation be?

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