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Lessons from Canada

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IHPME

What is the Canadian system?

- Trick question: There is no Canadian system
- Under Canada's constitution (1867), health care is a provincial responsibility
- There is considerable variation both between and within provinces
- One size does not fit all
- But there are commonalities

Canada does not have "Socialized Medicine"

- It has a system of public financing of certain categories of health services ("single payer")
- These services are delivered by private (albeit often not-for-profit) providers

So, Canada also has "Medicare"

- It calls its system of publicly-financed hospital and medical insurance "Medicare"
- It is very similar to US Medicare (but without co-pays or deductibles for insured services)

Reasons for reform?

- Recognition that:
- People were not as healthy as they could be.
  - 1918 flu pandemic (“public health”)
  - People unable to enlist in WWII because health status too poor
  - Etc.

Reasons for reform?

- Recognition that:
- Providers could not always be paid for providing necessary care
  - During depression, physicians were often paid in chickens (if at all)
  - Hospitals had bad debts
  - Shortage of providers in rural areas
  - Patients often faced financial hardships

History?

- Many failed attempts to achieve national program (battles over fed-prov powers)
- Federal government did provide some targeted federal funds (National Health Grants program) for specific provincial initiatives (e.g., public health activities to combat TB, training personnel, building new hospital facilities, etc.)

The provinces take action

- Saskatchewan took the lead in 1947 and introduced publicly funded insurance for hospital care
- Alberta and B.C. followed in 1950
- In 1957 the federal government passed the Hospital Insurance and Diagnostic Services Act (HIDS) providing federal cost-sharing if provinces chose to provide single-payer hospital insurance
- All provinces did so by 1961

Hall Commission

- Under Conservative government of John Diefenbaker, Justice Emmett Hall set up a Royal Commission to investigate next steps.
- Hall Commission found, as of 1961, 10.7 million Canadians had some form of medical care insurance, and 7.5 million did not. Only 42.6% of doctors bills were paid through insurance.

Next step – Physician care

- Saskatchewan took its savings from receiving federal contributions and introduced publicly funded coverage for physician services (1962)
- Following a physician strike, they agreed that their physicians would remain private providers (as opposed to using an NHS model)

The federal government follows

- 1966 Medical Care Act provided federal cost sharing for single-payer provincial insurance plans for physician services
- All provinces had set up eligible programs by 1971

Common features in all provinces

- Full coverage for all medically necessary care delivered in hospitals, or by physicians
- All Canadian residents are covered
- No co-pays or deductibles for insured services to insured persons
- Patients can choose their providers

Cost sharing models have evolved over time

- Current model (since ca 1977)
- federal funds for provincial programs paying doctors, hospitals, social services and post-secondary education were merged into a mix of block grants and tax points; they go directly into provincial budgets but some can be withheld if province does not meet *Canada Health Act* conditions

These programs are popular

- All legal residents had coverage
- Hospitals and physicians had fewer bad debts
- Administrative costs were lower
- It is so popular that:
  - It has basically not changed since its introduction
  - Main pressure has been to extend it to other services

Variation across provinces

- Services delivered outside hospitals by non-physicians may be covered, but do not have to be
  - Dental care, rehab, outpatient pharmaceuticals, mental health, long term care, etc.
  - Some people have private insurance for these services – model resembles US (not universal, can be co-pays and deductibles, etc.)

Public hospitals in Canada are (were?) not public

- They are charitable, not for profit organizations
  - Many founded by religious groups
- Which happen to receive much of their funding from public sector sources (government)
- But manage their own affairs
  - Although subject to various "accountability" provisions which may shift them closer to the quasi-public category
- Their employees are not civil servants

Why is single payer helpful?

- Savings on administrative expenses
- Better coverage
- Minimizes risk selection issues

Risk selection (1)

- Health care costs are often large and unpredictable (people need insurance)
- Health care costs vary
  - E.g., U.S. National Medical Expenditure Study showed:
  - Bottom 50% used 3% of resources
  - Top 50% of spenders used 97% of resources
  - Which group would a smart insurer rather write policies for?

Risk selection (2)

- Our work with Manitoba data showed much the same pattern

Distribution

- Take population
- Compute health expenditures for each member of population
- Arrange from low to high
  - Categorized (percentiles? Deciles? Vingtiles?)
  - Show top 1% separately (caution: “double counting” - since these people also in top 5%)

Distribution

- If spending is equal, then:
  - Top 1% will account for 1% of spending
  - Bottom 50% will account for 50% of spending
  - And so on

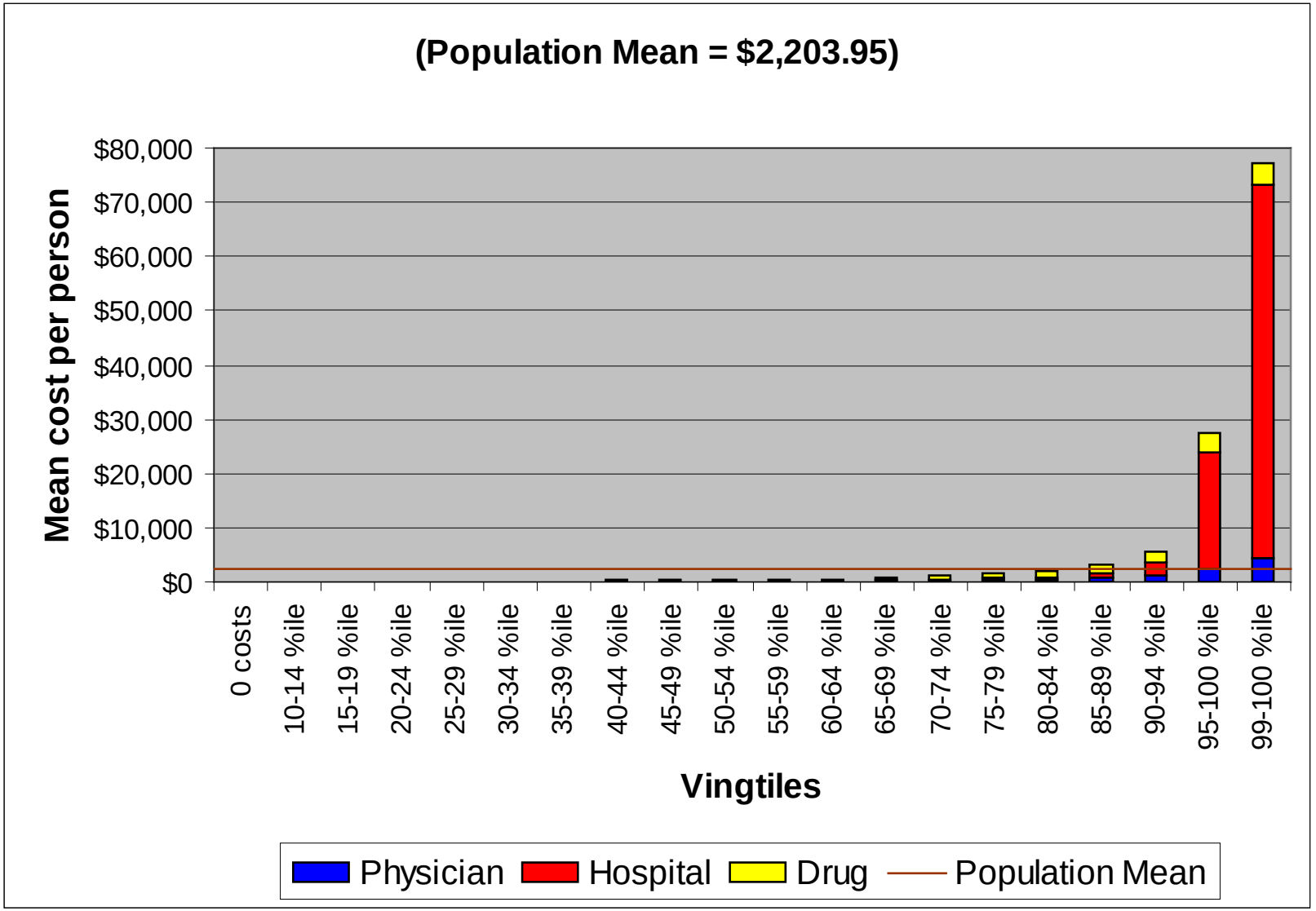
Deber, Roos, Forget et. al. studied Manitoba

- Kenneth C. K. Lam did in-depth analysis for his PhD
- This work done by Raisa B. Deber, Kenneth C. K. Lam, Leslie L. Roos, Evelyn L. Forget, Gregory S. Finlayson, and Randy Walld
  - Through Manitoba Centre for Health Policy, Faculty of Medicine, University of Manitoba
  - Funded by CIHR Fund Number: 4597

For more information:

- Deber, Raisa and Lam, Kenneth Cheak Kwan, Handling the High Spenders: Implications of the Distribution of Health Expenditures for Financing Health Care (2009). Available from http://papers.ssrn.com/abstract=1450788

Mean Total Expenditures for the Full Population by Vingtiles in Manitoba, Fiscal 2005-2006



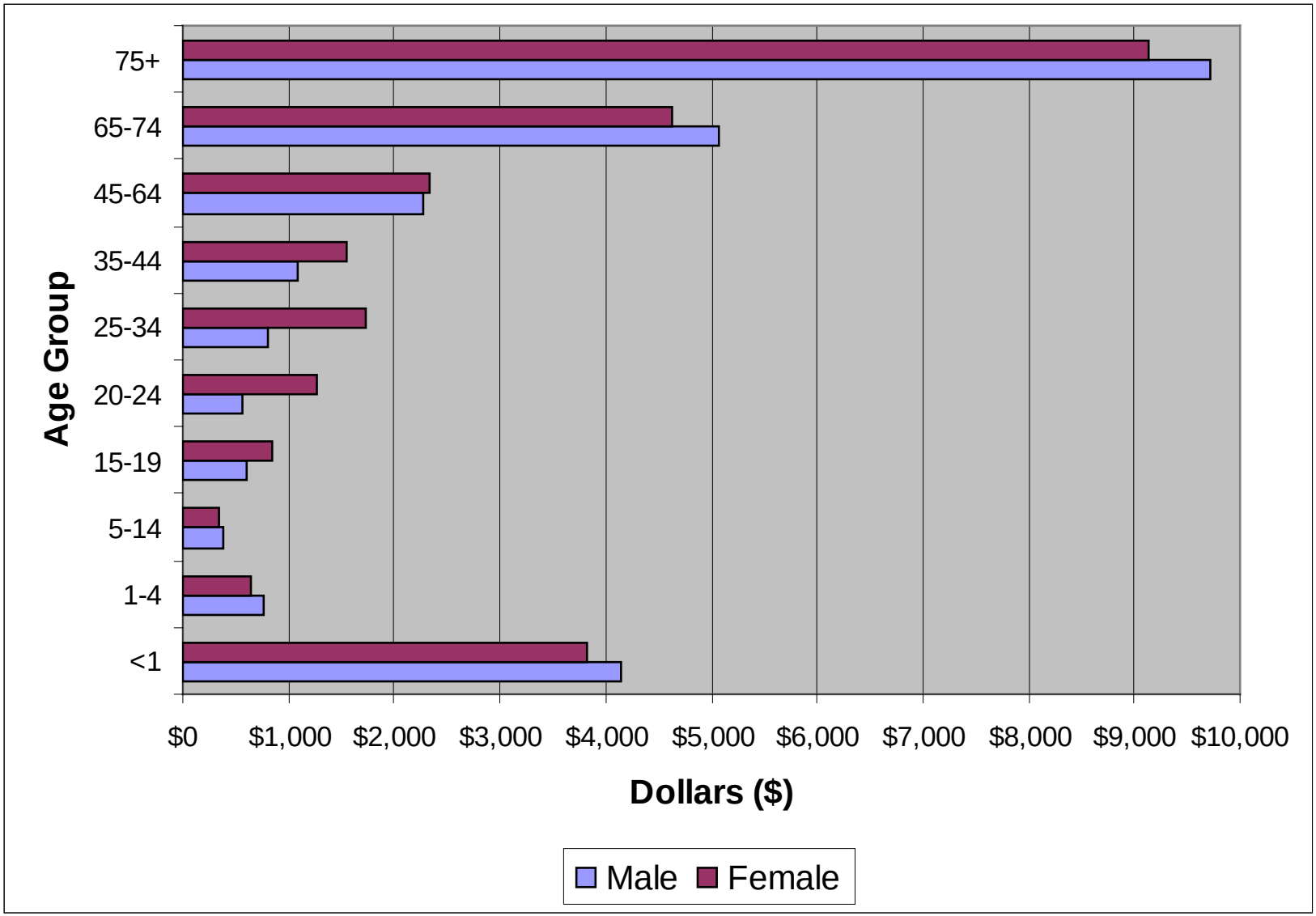
Distribution by Sub-Category of Expenditures for the Full Population, 2005-06

Subcategory	Mean	% <Mean	Share: Top 1%	Share: Bottom 50%
Physician	$391.22	70%	11.21%	9.51%
Hospital	$1,277.99	90%	53.81%	0.00%
Pharmaceutical	$534.74	70%	7.71%	2.38%
Total Expenditures	$2,203.95	85%	35.06%	2.27%

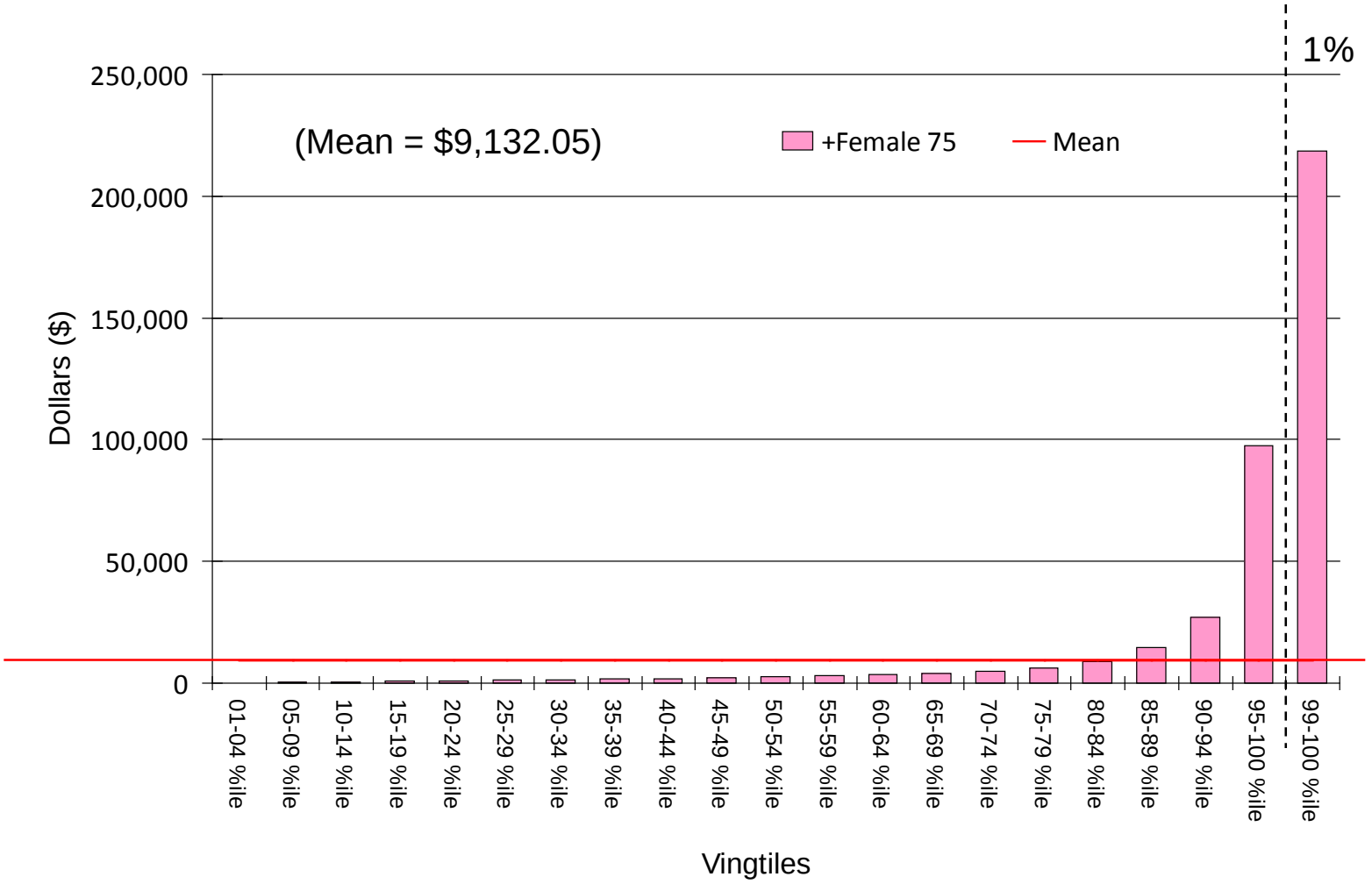
What should funders do?

- Considerable variation in costs
- Is it sufficient to control for age and sex?

Mean Total Expenditures for all Age-Sex Grouping, 2005-06



Mean spending by vingtile for females Age 75+, Manitoba, Fiscal 2006



Given how skewed costs are..

- Which group would a smart insurer rather write policies for?
- Please note: Age-sex adjustment alone is insufficient
  - In every age group, 80-90% of individuals had costs for physician + hospital care below the mean for that group

Another argument against market competition

- When is consumption based on demand, as opposed to being based on need?
- Strong case for single payer coverage for care that you should not get (or want) unless you need it, but should get (and want) if you do.

For necessary care, Canada has found that single payers are preferred because:

1. Savings from administrative costs (contrast Canadian and US hospitals)
2. Eliminates risk selection issues
3. Payer can drive tougher deals with providers (which providers obviously don't like)

Why not two-tier care?

- Assuming the existence of a publicly-funded tier, there is no market for privately-funded care unless the publicly-funded system is inadequate, or perceived to be inadequate

What does this tell us?

- We need to distinguish between goods and services which you are “entitled” to if you “need” them, regardless of your ability to pay, and those for which a market might be appropriate
- Public financing is more cost-effective for the first category of goods and services
- For other goods, there is room for a market, recognizing that this means people who cannot afford those items will not receive them

Canada Health Act

- Requires coverage based on:
  - Where care delivered (in hospital)
  - Or by whom (physicians)
- Provincial/territorial governments can go beyond this
- But they are not required to

What happens when we move out of hospitals?

- These services move beyond Medicare
- No longer a requirement to include them within public financing
  - Even though many are undeniably “medically necessary” (e.g., prescription drugs for cancer treatment)

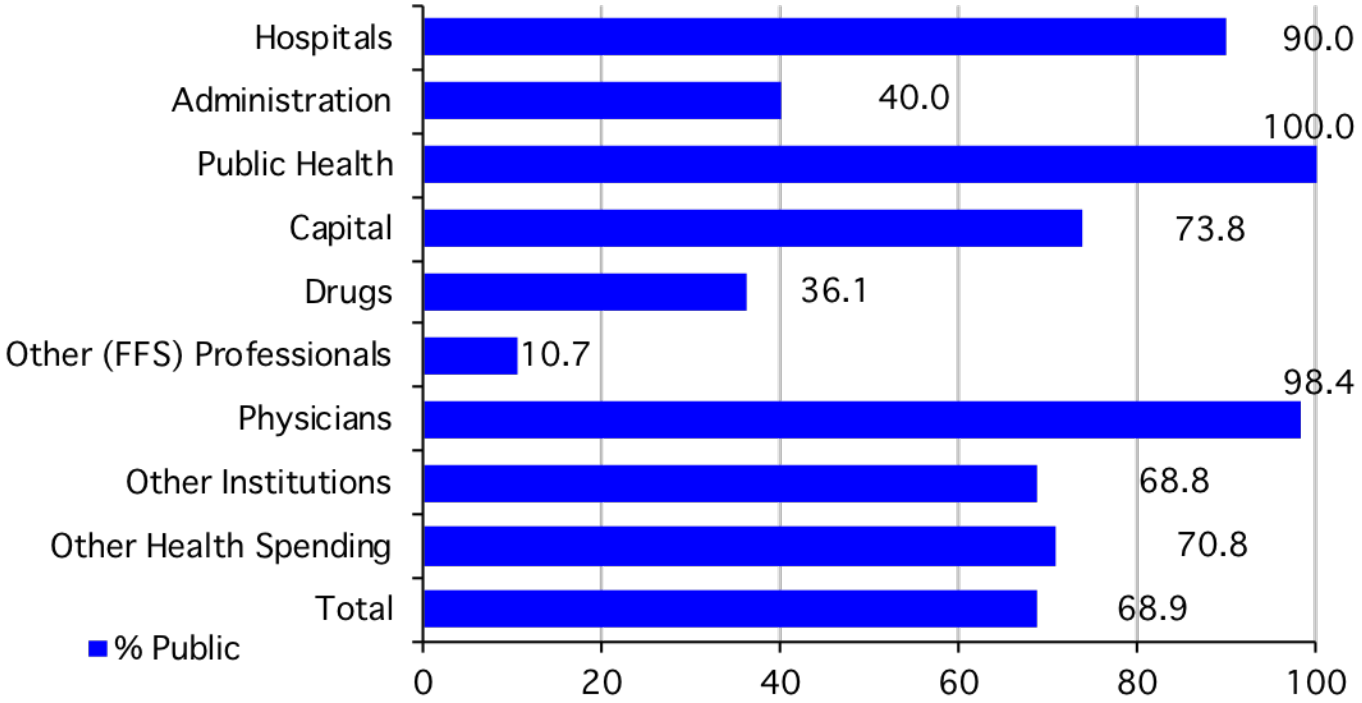
Current policy tension

- Pressure on hospitals (“hallway medicine”) because patients would have to pay for some services once they are discharged
- Pressure on governments to decide whether they wish to extend coverage to non-physician services delivered in community (including pharmacare, home care, mental health, rehab, etc.)

A few more observations

- On levels of spending
  - in Canada and
  - internationally
- On “shares” (federal/provincial)
- On delivery

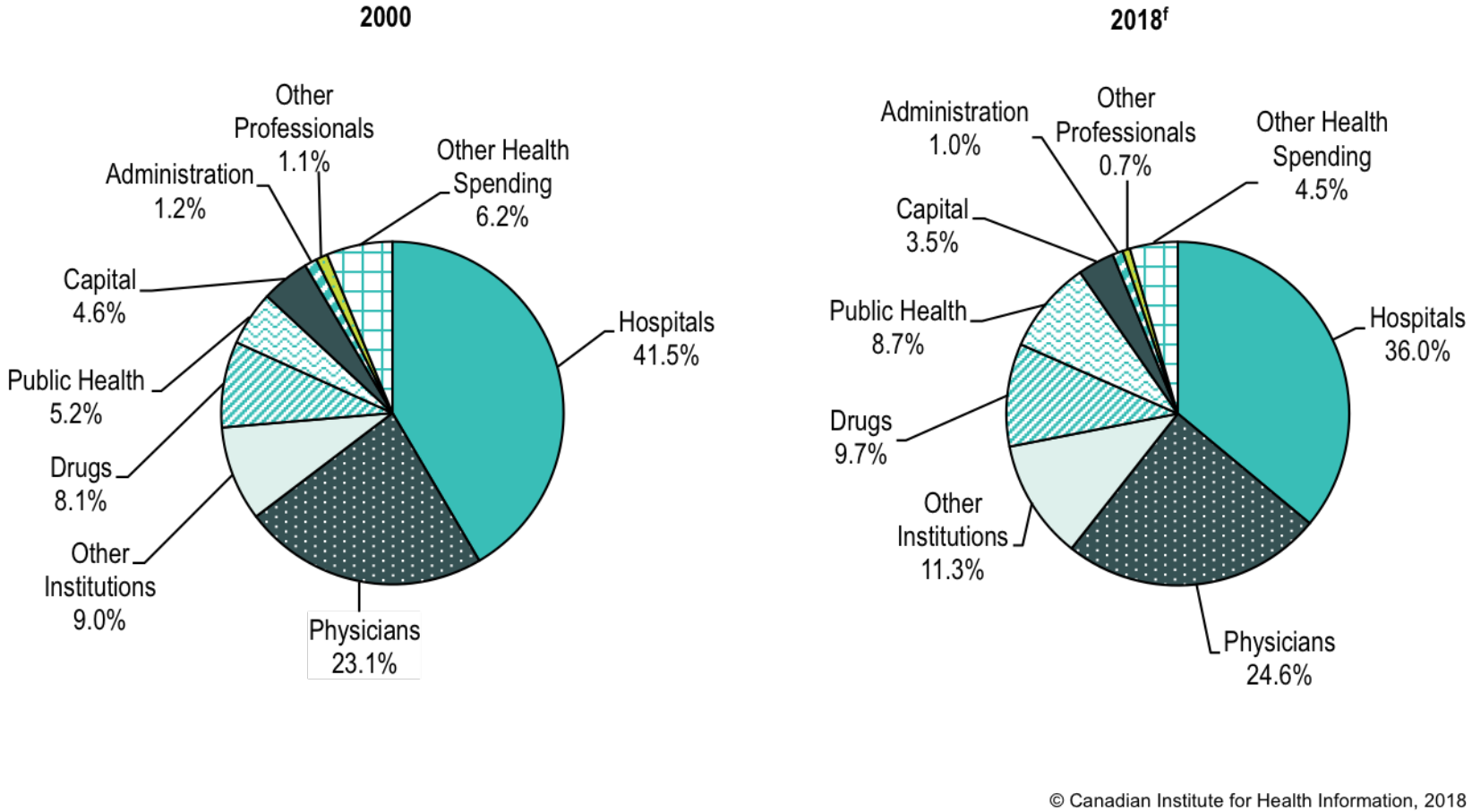
Public share of expenditure Canada 2018 (forecast)



Source: CIHI National Health Expenditure Trends, 1975-2018

Ontario

Category shares of provincial government health spending



Note
f: Forecast.
Source
Table D.4.6.2 (Series D), National Health Expenditure Database, CIHI.

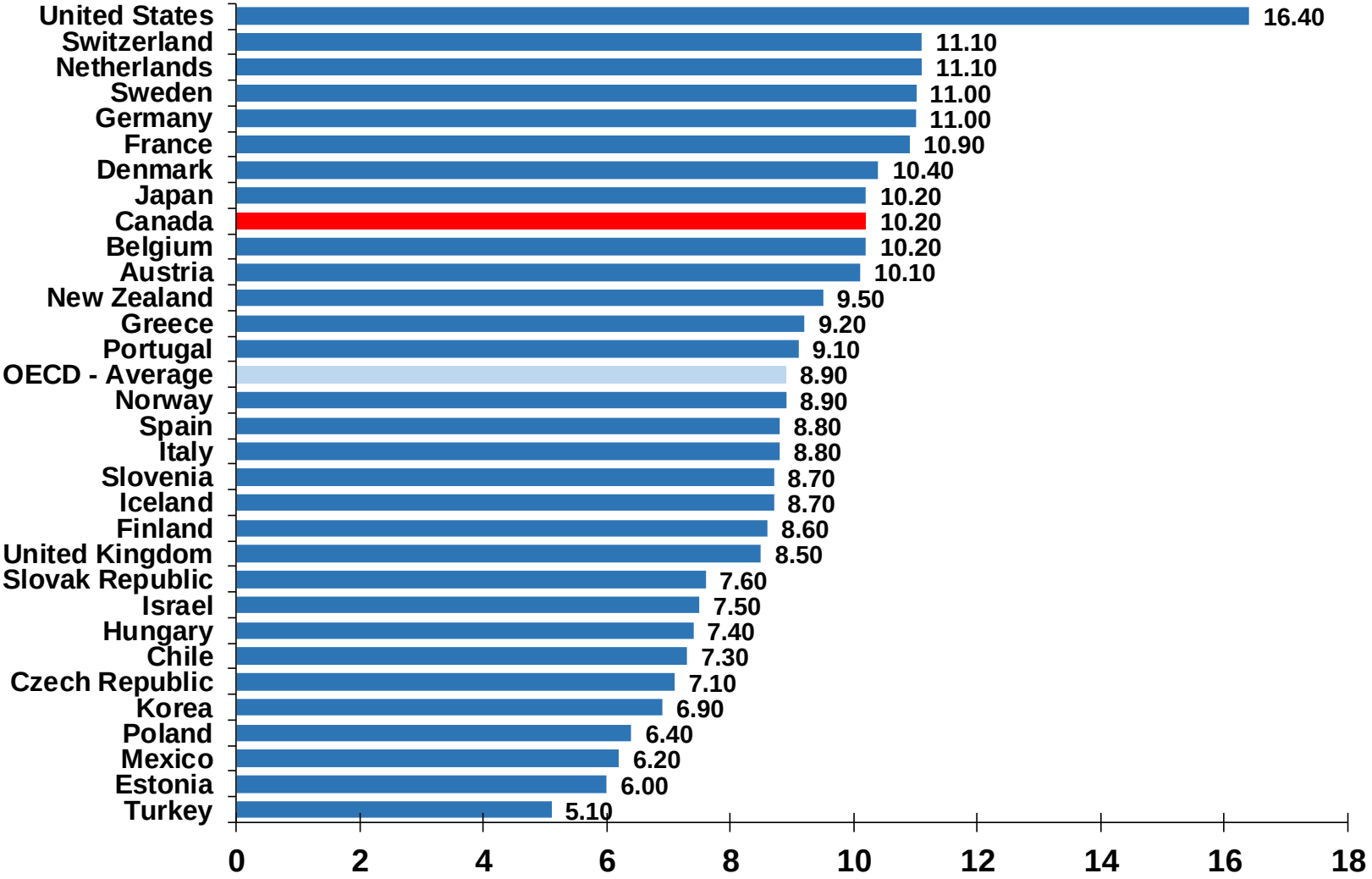
Canada's public share of spending is relatively low

- Looking at the OECD developed countries:
- Canada's public share is consistently below the OECD average
- Canada ranked 14 (of 22) in 1975, 19 (or 22) in 1997, 23 (of 29) in 2003, 22 (of 35) for 2015, and 24 (of 36) for 2017.

Are we spending too much?

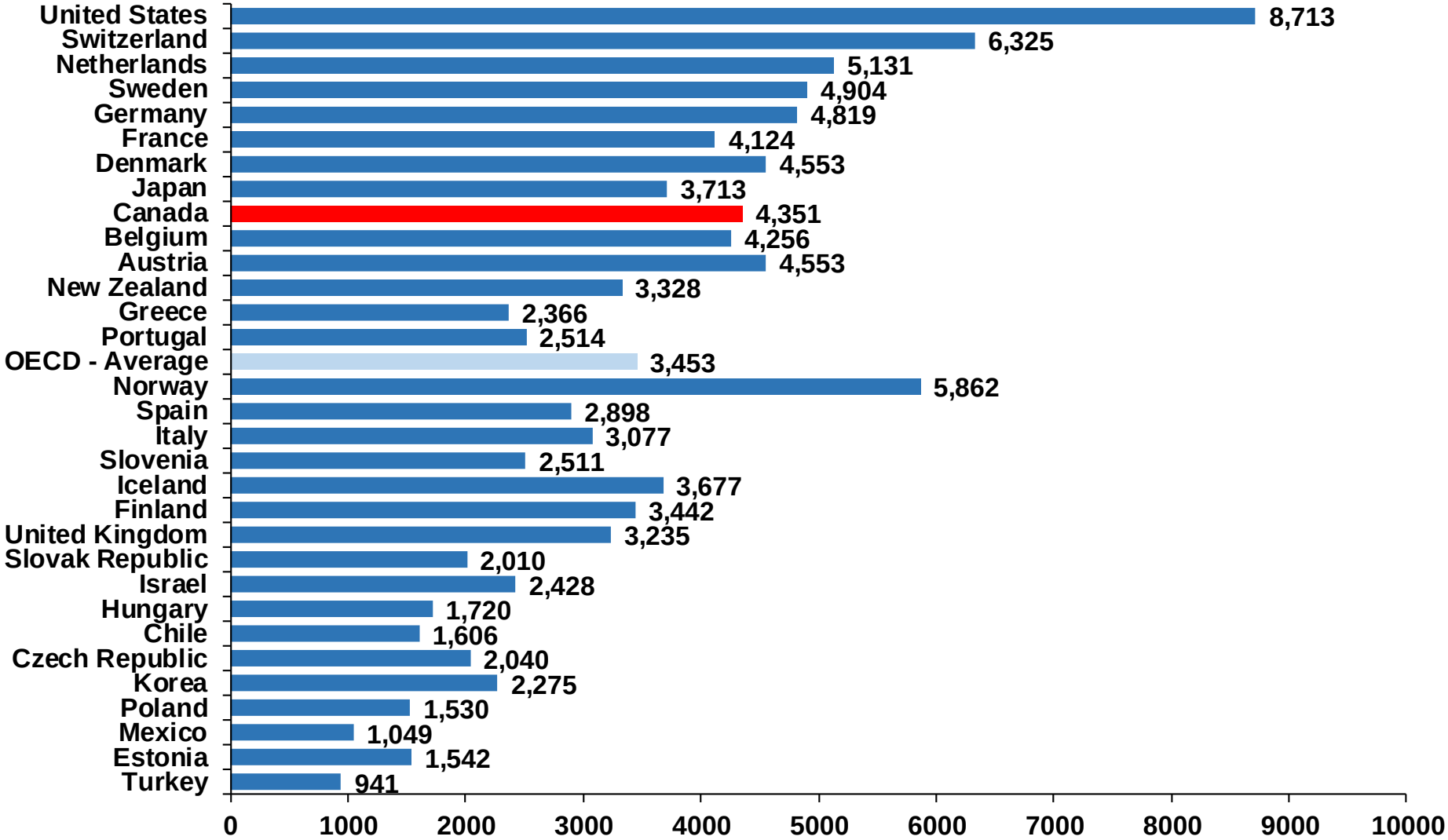
- Contrary to current rhetoric:
  - Canadian health spending is not particularly high in international terms

Comparative Data: 2013
Health Expenditures as % of GDP



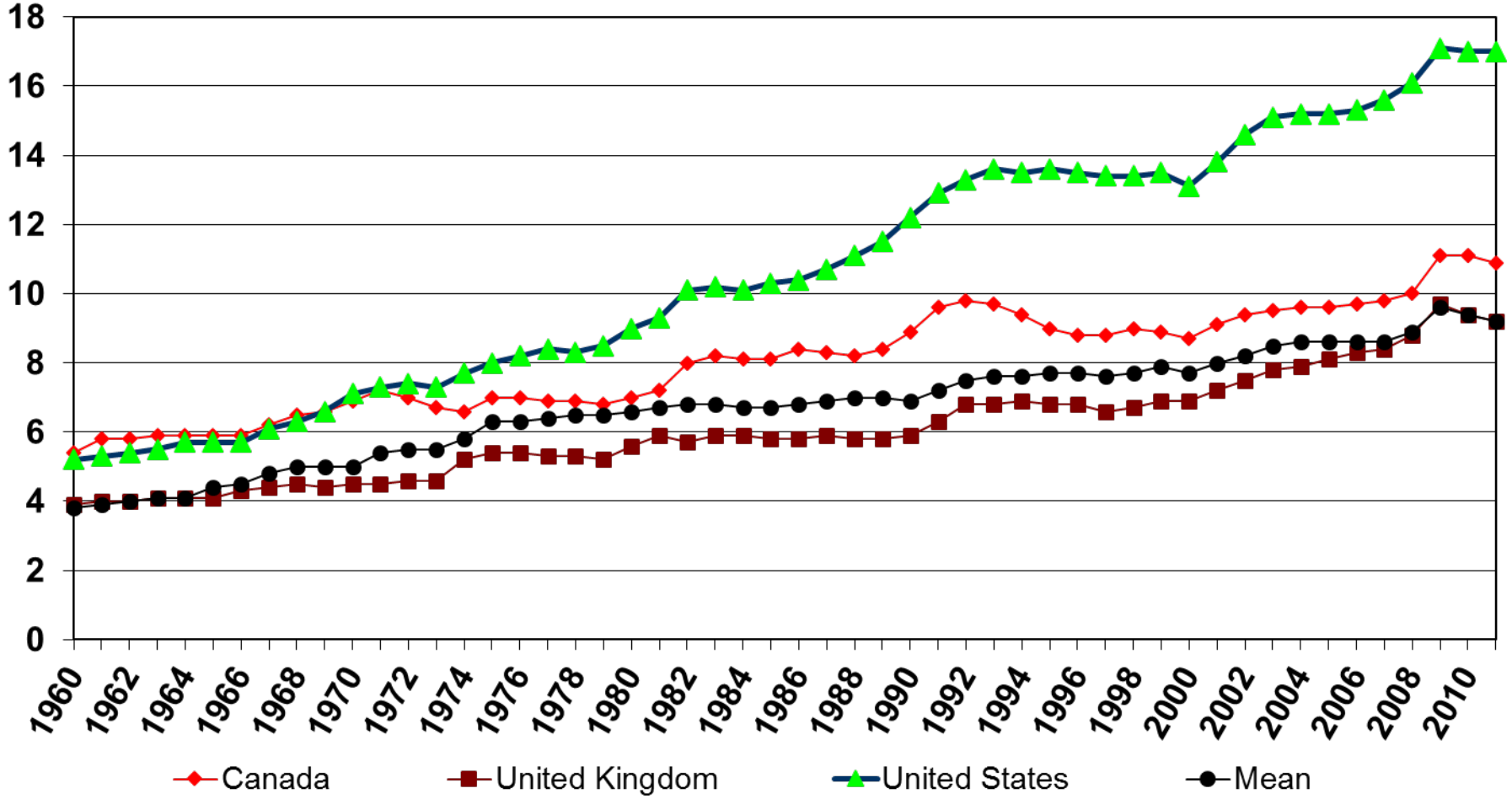
Source: OECD Statistics 2015 (stats.oecd.org)

Comparative Data: 2013 Health Expenditures per capita, US$ PPP



Source: OECD Statistics 2015 (stats.oecd.org)

As the economy improves/falters, the ratio of spending to GDP falls/rises



Source: OECD Statistics 2015 (stats.oecd.org)

Why the perceived crisis?

- Until recently, public spending has not even kept up with inflation and population growth, let alone aging, new technology, and wage pressures
- Public spending is concentrated in certain sectors
- Private-sector spending has been increasing more rapidly than public-sector spending, putting pressure on payroll (e.g., for pharmaceuticals)
- People keep talking about a crisis

Accessibility issues include:

- Need to address ensuring timely access to quality services (waiting list issues)
- Need to address financial barriers from care which escapes from comprehensiveness definition (ranging from home care and pharmaceuticals to transportation issues arising from regionalization)
- Need to address non-financial barriers to obtaining needed care
- Continuing issue of what constitutes reasonable compensation for health care workers

What's broken?

- Public financing and not-for-profit delivery seem to work relatively well
- Biggest problem is allocation
  - No single best model; trade off efficiency and responsiveness?
  - Incentives are often perverse
  - Few built-in mechanisms to ensure appropriateness of care delivered
  - Fortunately, despite this, most providers do a good job, even if this may not maximize their own incomes

Who should pay?

- What is the responsibility of society?
- What is the responsibility of voluntary organizations (including faith-based groups)?
- What is the responsibility of individuals and their families?
- Not a questions of evidence, but of values

My policy assumption: There is no quick fix

- Policy choices are often about trade-offs
- As Wildavsky noted:
  - One rarely solves complex policy issues
  - One usually replaces one set of problems with another set
  - The mark of success is whether you prefer the new problems to the old ones

For more information

- Deber, Raisa B. *Treating Health Care: How the Canadian System Works and How it Could Work Better*. University of Toronto Press, 2018

Good summary of Canada's system

- Marchildon, Greg. *Canada*, 2013
- University of Toronto Press.
- Also available from European Observatory on Health Systems and Policy
- http://www.euro.who.int/__data/assets/pdf_file/0011/181955/e96759.pdf?ua=1