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Funding Healthcare in Canada: The Pitfalls and Opportunities

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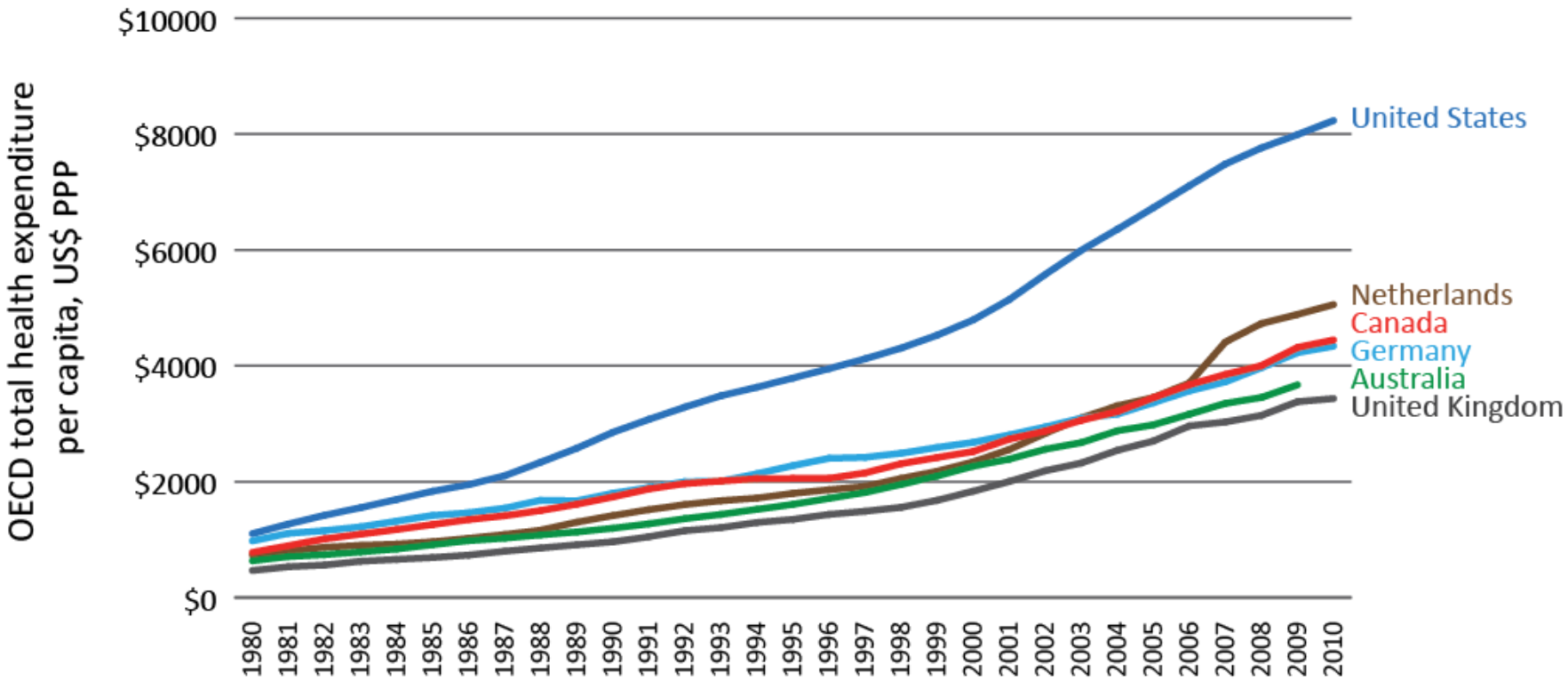
Health spending per capita, OECD, 1980-2010



Source: OECD

Overview

- 2014:
  - Spending on healthcare in Canada was estimated to be $214.9 billion
  - Over $6,000 per Canadian
- Health is ~47% of provincial government's budget
  - Hospitals are the largest and most costly segment of the Canadian healthcare system
  - Crowding out other sectors of public spending: Education

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Current State of Funding:

- Sector-based
- Government/HAs pour in money: Unclear value

Overview: Silos

- Global Budgets for Hospitals
  - Pay for all the services delivered by the hospital irrespective of the volume and type of care delivered
  - Cost containment and opaque
  - No incentive for increasing access
    - Decreasing wait times and discouraging early discharge
    - Alternate level of care: no ‘push’ and no ‘pull’
  - Predictable budgets and cost certainty

Overview: Silos

- Physician Payment
  - Fee-for-service payments based on fee schedules
    - Paid by provinces directly
    - By-pass hospitals and regions
  - Incentive for increasing volume of services
  - No incentive for increasing effectiveness or quality
  - No alignment with population need

Overview: Silos

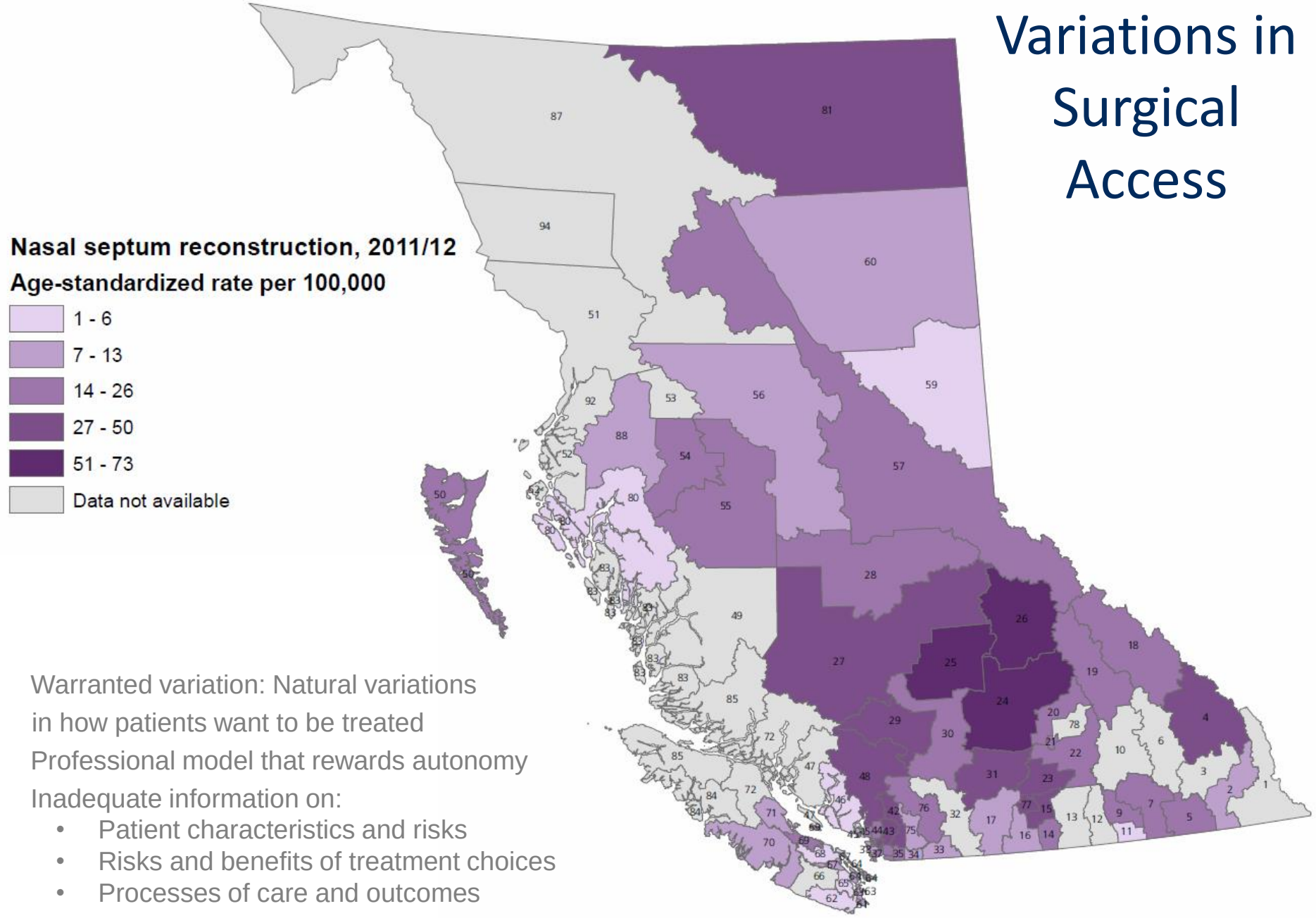
- State of Affairs:
  - Hospital budgets have increased ~5%, each year, for the last decade
  - Wait times have not improved despite significant expansion of $ and capacity
    - Why is this? Elasticity of supply?
  - Significant political and health policy issue

Overview: Silos

- Recent, but not new, findings rank Canada's performance among the worst of 11 OECD countries in:
- Safety and coordination of care
- Timely communication between sectors
- Access to specialists and elective surgery
- Poor access to off-hours primary care

	Australia	Canada	France	Germany	Netherlands	New Zealand	Norway	Sweden	Switzerland	United Kingdom	United States
Able to get Same/Next Day Appointment When Sick	65%	45%	62%	66%	72%	78%	45%	57%	93%	70%	57%
Very/Somewhat Difficult Getting Care After-Hours	59%	65%	63%	57%	33%	38%	45%	68%	43%	38%	63%
Waited Two Months or More for Specialist Appointment[a]	28%	41%	28%	7%	16%	22%	34%	31%	5%	19%	9%
Waited Four Months or More for Elective Surgery[b]	18%	25%	7%	0%	5%	8%	21%	22%	7%	21%	7%

Variations in Surgical Access



- Warranted variation: Natural variations in how patients want to be treated
- Professional model that rewards autonomy
- Inadequate information on:
  - Patient characteristics and risks
  - Risks and benefits of treatment choices
  - Processes of care and outcomes

Source: BC Ministry of Health, 2014

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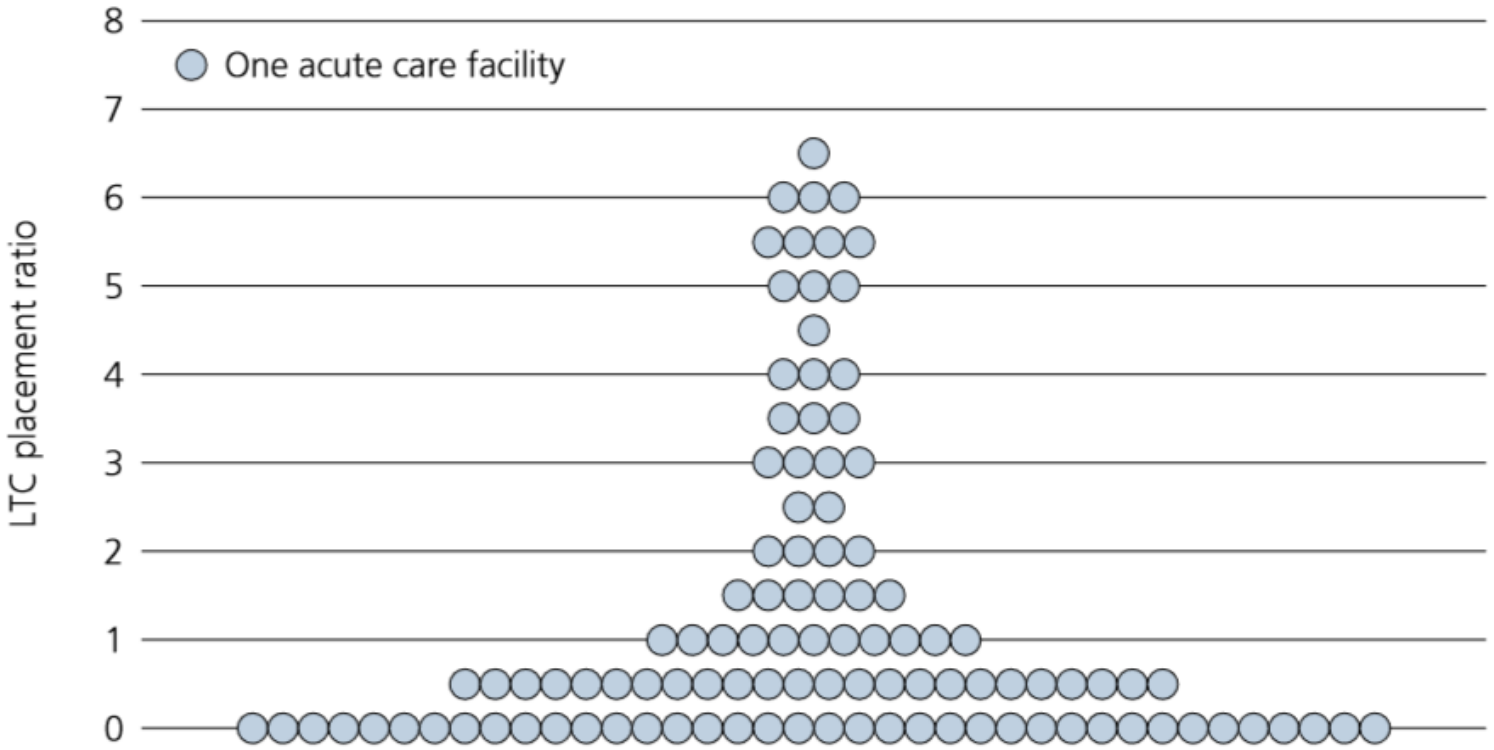
Variations in Access and Quality

Quartile	Hospital	Hospital Adjusted Rate per 100
Lowest	Surrey Memorial Hospital	49.4
	Burnaby Hospital	60.6
	Kelowna General Hospital	62.2
	Royal Columbian Hospital	63.3
	Abbotsford Regional Hospital and Cancer Centre	70.8
	Langley Memorial Hospital	75.2
Highest	Victoria General and Royal Jubilee Hospital	90.6
	Penticton Regional Hospital	91.6
	Nanaimo Regional General Hospital	91.7
	Kootenay Boundary Regional Hospital (Trail)	93.5
	St. Joseph's General Hospital [BC]	95.6
	Campbell River and District General Hospital	97.4

Highest and lowest rates of hip fracture surgery within 48 hrs
Source: BC DAD data from 2011/2012

Variations Across the Continuum

Adjusted ratio of placement to LTC for hospitalized medical patients, Alberta



Source: Sutherland et al, 2013

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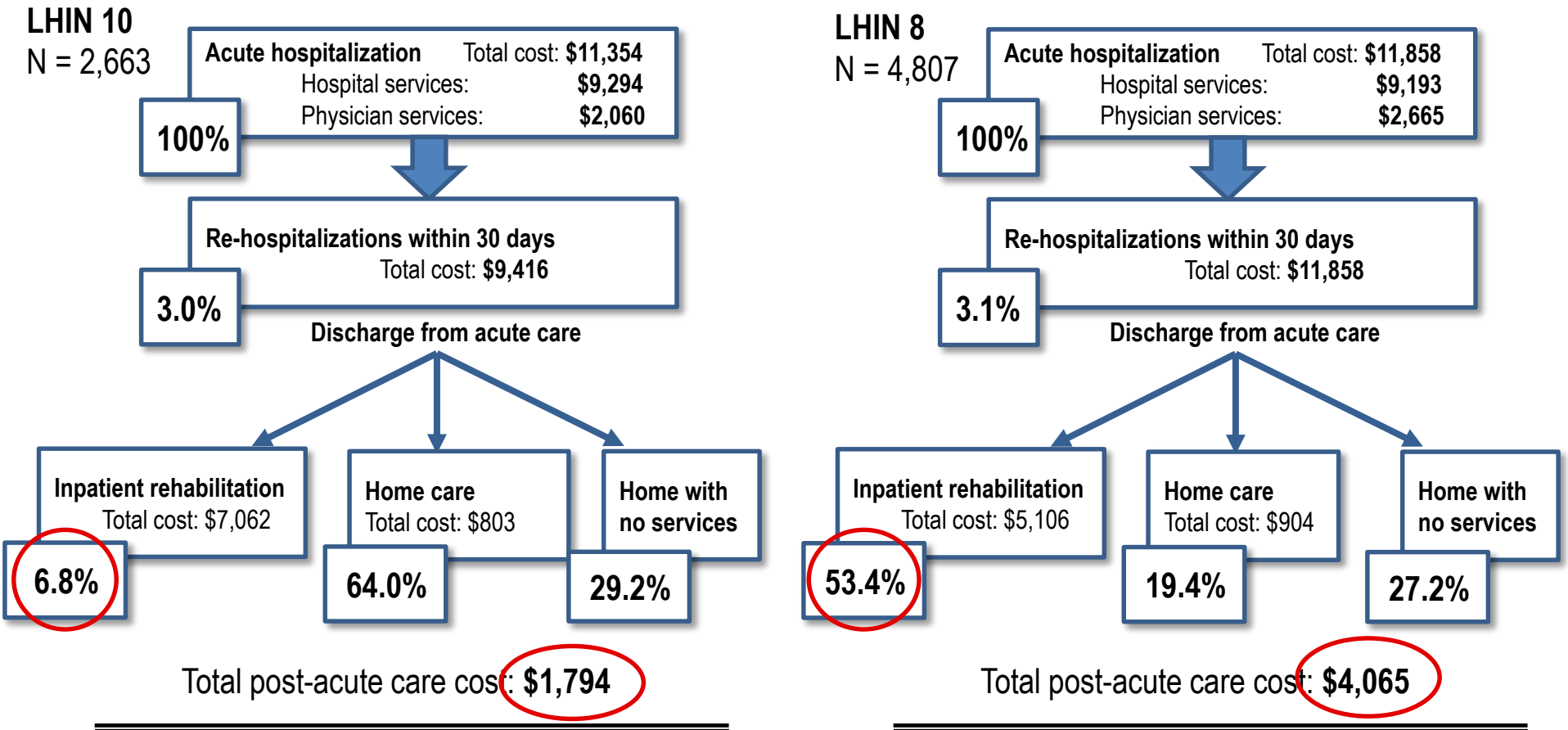
Variations Across the Continuum



Source: Hellsten, 2013

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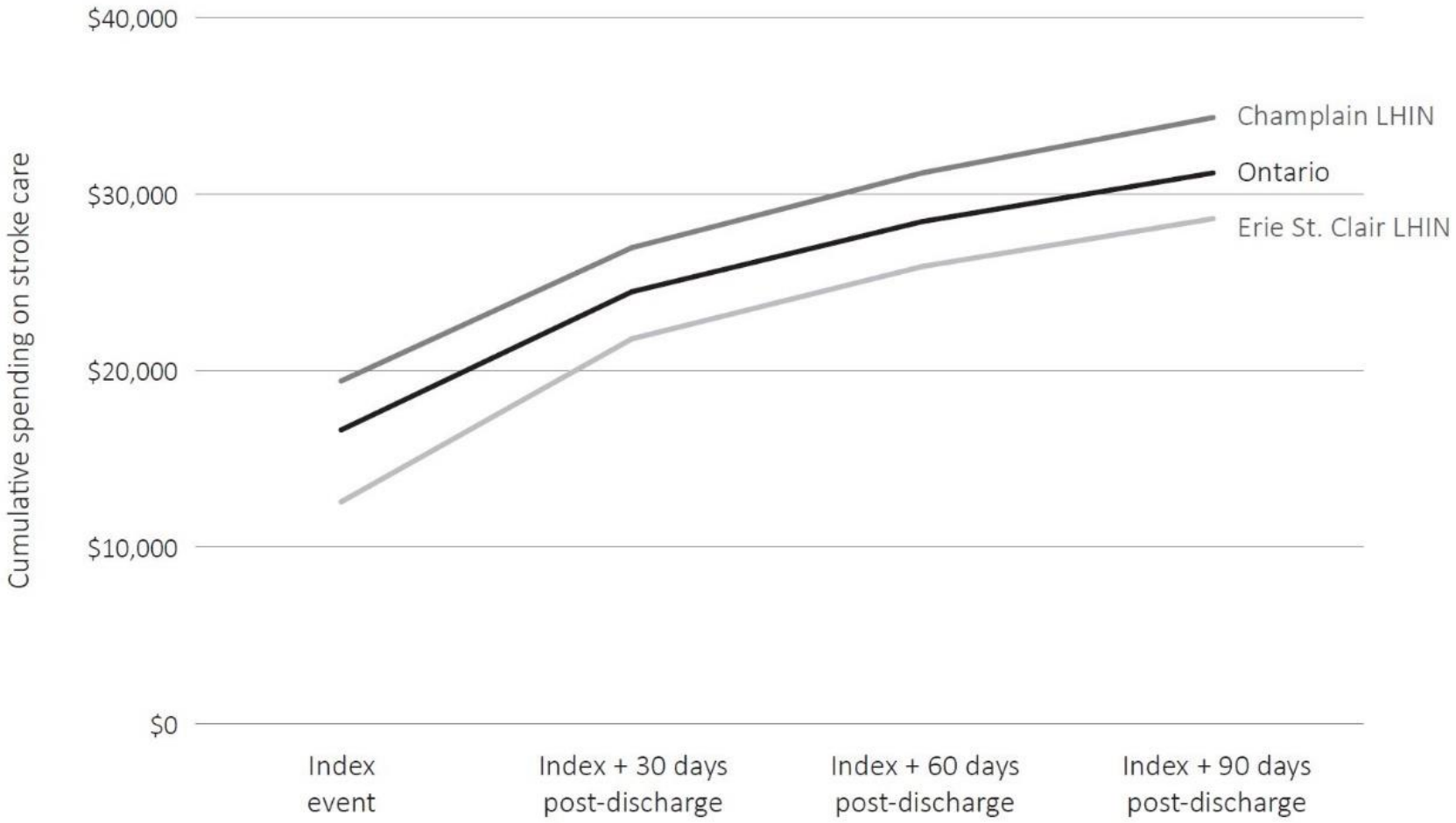
Variations Across the Continuum



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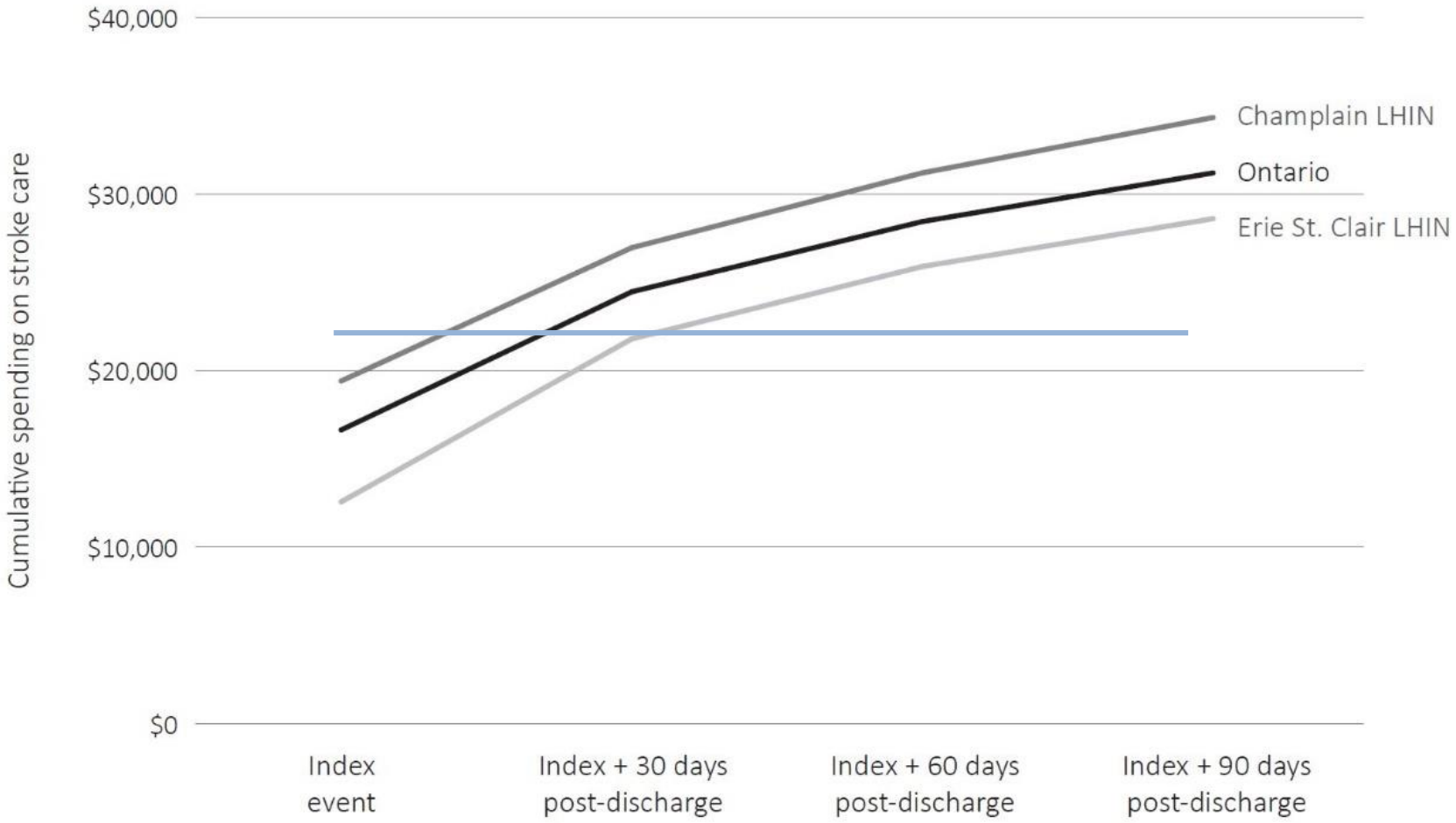
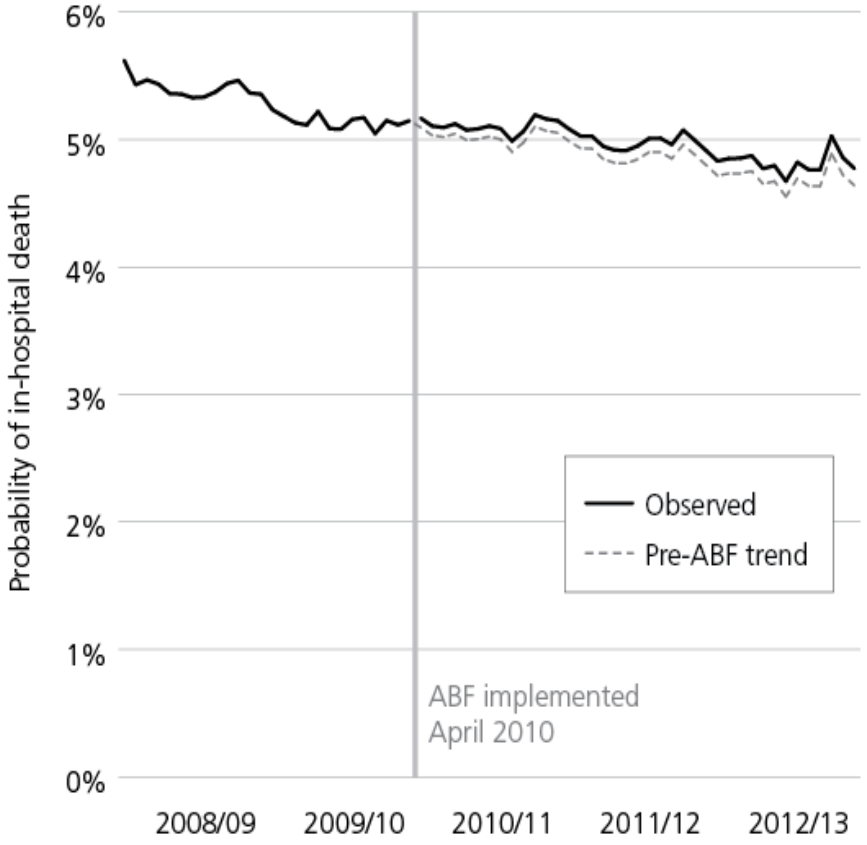
Variations Across the Continuum

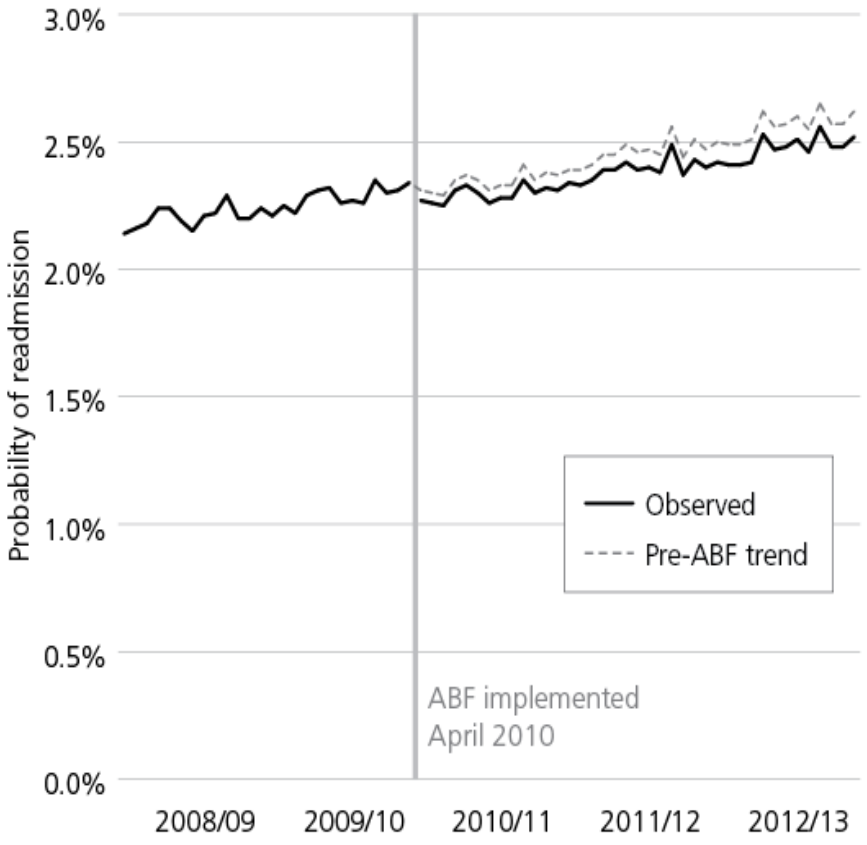


Overview

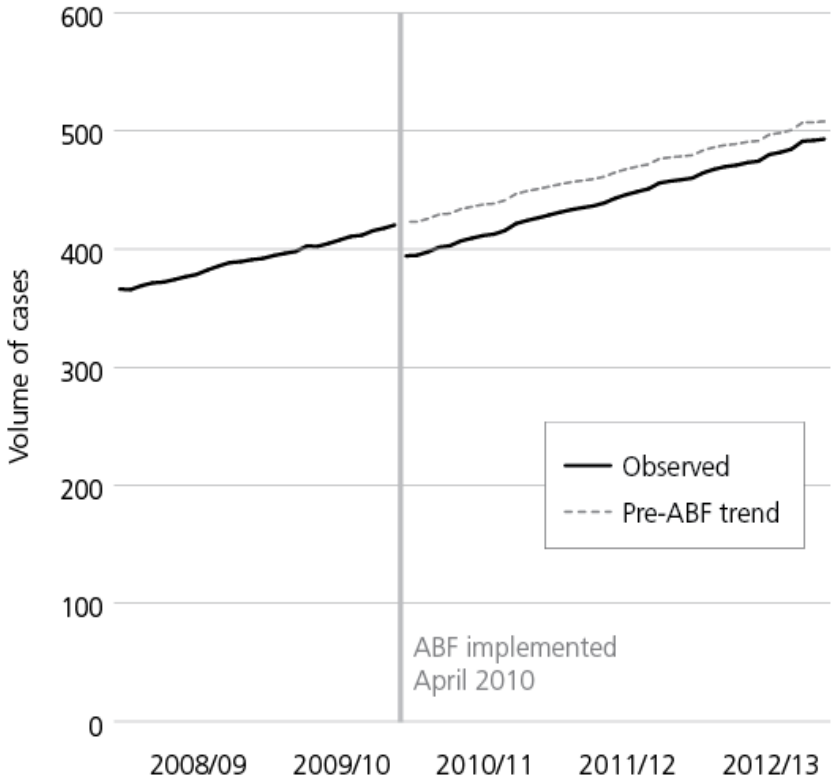
- Glaring problems – easy to see, hard to fix
- Provider payment reforms:
  - Implemented activity-based funding for hospitals
    - A single amount for each patient's type of care during hospitalization (per case)
  - Pay-for-performance for decreasing Emergency Department waits
  - Marginal pricing models for surgical treatment

Activity-based Funding: The BC Experiment

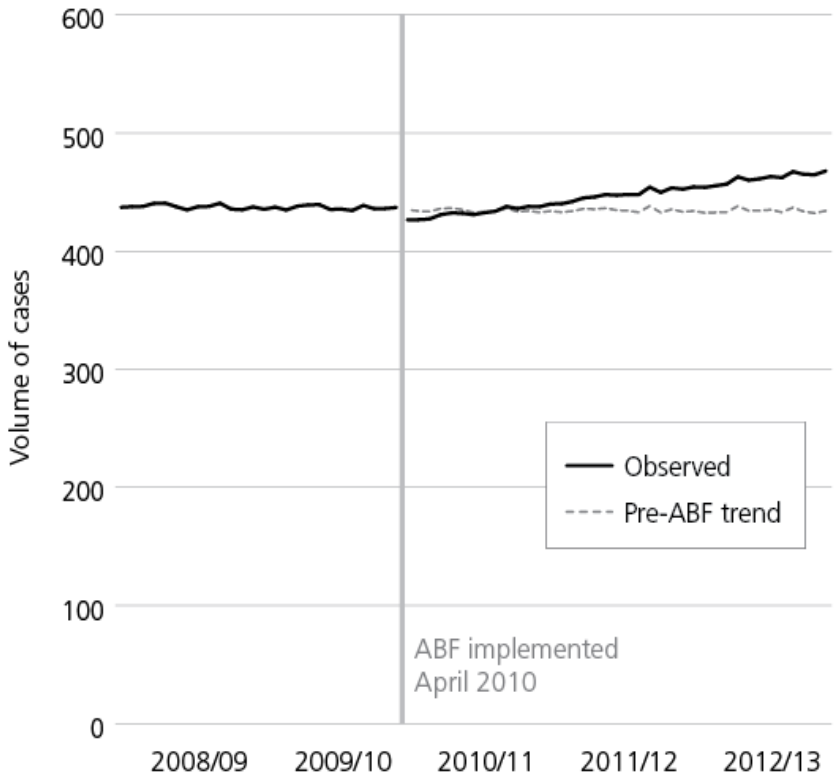




Activity-based Funding: The BC Experiment



Medical



Surgical

Activity-based Funding: The BC Experiment

- Why are the results from hospitals in BC different from those reported in other countries?
  - Three year horizon of the program limited hospital's response to the incentives, such as expanding capacity
  - Less than 20 percent of hospital's government revenues and a no-loss provision
  - Hospital-focused with no commensurate changes in the post-acute care sector

Pay-for-Performance

- Program:
  - Incentives to decrease ED wait times
- Incentives:
  - Percentage of patients attaining wait time thresholds equates to incremental hospital funding
  - Small financial incentive, renewed annually
- Results:
  - No change observed in ED wait times

Marginal Pricing Surgical Treatment

- Program:
  - Attempt to unlock marginal surgical capacity within hospitals
- Incentive:
  - Government (agency) provided a price for each surgery
- Results:
  - Price was less than hospitals' marginal cost in most scenarios regarding excess capacity
  - Joint replacements were profitable in all scenarios

Marginal Pricing Surgical Treatment

- Pricing is absolutely important!

Inpatient surgery case mix title	Hospital average cost	Marginal Cost in Canadian $ Scenario				HSPO price Gov't $$
		One	Two	Three	Four	
Sinus intervention	$2709	$721	$1701	$2173	$2595	$800
Non-complex hernia repair	$3026	$654	$1888	$2499	$3020	$900
Complex hernia repair	$4446	$987	$2792	$3717	$4459	$1300
Shoulder/rotator cuff intervention	$3308	$655	$1895	$2550	$3067	$1000
Shoulder replacement	$8845	$3388	$6165	$7598	$8703	$2500
Unilateral hip replacement	$9800	$3322	$6880	$8526	$9820	$10,000
Unilateral knee replacement	$8734	$2708	$6035	$7599	$8813	$8900
Revised knee replacement w/o infection	$10,930	$3836	$7695	$9498	$10,908	$11,100
Revised knee replacement with infection	$12,588	$3688	$8535	$10,725	$12,437	$12,800

Source: Sutherland, 2015

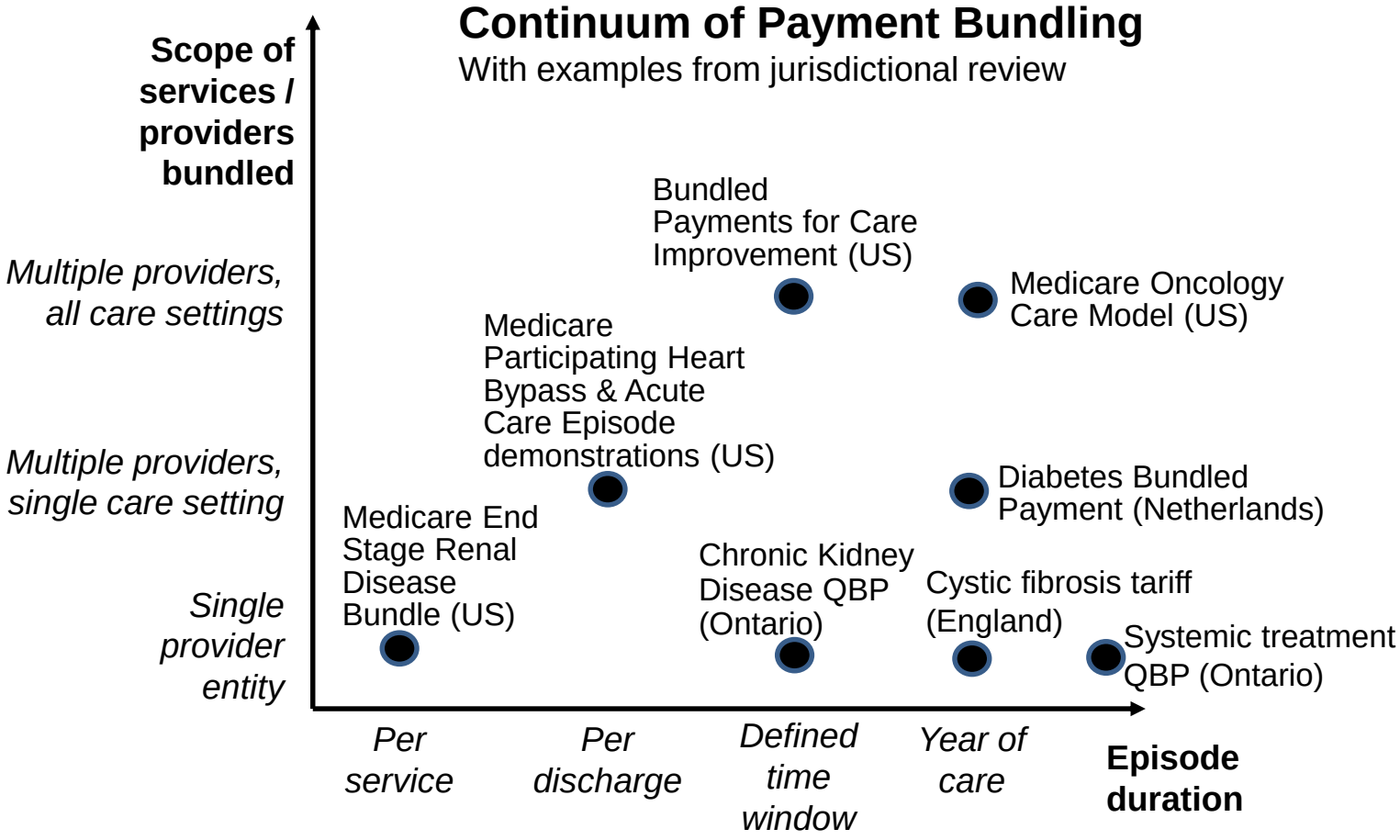
Current State

- Little or no effect in BC
  - Many possible reasons and barriers; Hospital focused
  - Disconnected from physicians, long-term care and community-based care
- Ontario and Quebec are now implementing funding policy changes
- *We make our system more costly and ineffective - and, likely, poorer quality, than necessary*

The current international consensus is to encourage integrated models of care using financial incentives

Lever	Quality	Fragmentation	Effectiveness
Funding Policy	Value-based Purchasing and Non-Payment	Episodes of Care	Episodes of Care
		Meaningful Use of EHR	Meaningful Use of EHR
Organization and Delivery System	Accountable Care Organizations	Accountable Care Organizations	Accountable Care Organizations
		Medical Home	Medical Home
System-Level	Cross Sector Data Standardization Patient Outcomes and Experience		

Contrasting Approaches to Improving Value



Key Take-Aways

- Some integrated funding and delivery models already occur in provinces
  - Chronic kidney disease, Cancer
- Focused on clinical areas with high variability in spending, quality or effectiveness
  - Mixed methods review found many knew where problems existed + data validation
  - Unwarranted variation amenable to change

Key Take-Aways

- Known Barriers:
  - Information sharing between sectors
  - Privacy
  - Labour contracts and scopes of practice
  - Physician relationships
  - Measuring outcomes that matter to patients

Summary

- At limit of silos? Integrated funding models are coming
  - Our system is similar to others undergoing change
  - Provinces hold policy levers
- Many templates to choose from
  - ACOs, episodes, year of care, etc, built on fee-for-service
- Many opportunities! Barriers are well known.

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