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Canada's Health Care System: Targets & Levers for Policy Change

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The Arthritis Society
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Health Policy 101

- Skate to where the puck's headed

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Canadian Medicare

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Canadian Medicare: A Sacred Trust

- Medicare defining characteristic of Canadian identity
- Top policy issue for Canadian public and governments
  - **Medicare supported on ethical and economic grounds**
- Tommy Douglas, father of Medicare, voted “greatest Canadian” in 2005

Medicare = Health Care Funding

- Public Financing/Private Delivery
  - 10 separate provincial health care insurance programs cost-shared with federal government under minimal conditions (Medicare principles)
  - Public payment for services provided by private fee-for-service physicians and not-for-profit hospitals

National Health Care Systems in Comparison

	Public Financing	Private Financing
Public Delivery	National Health Service (e.g., UK)	---
Private Delivery	Public Insurance (e.g., Canada)	Private Insurance (e.g., US)

Medicare Principles

- *Universality*: The plan must entitle 100% of the insured population (i.e. eligible residents) to insured health services on uniform terms and conditions

- *Public administration*: The health insurance plan of a province must be administered and operated on a non-profit basis by a public authority accountable to the provincial government

Medicare Principles

- *Accessibility*: The plan must provide, on uniform terms and conditions, reasonable access to insured hospital and physician services without barriers

- *Portability*: Residents are entitled to coverage when they move to another province within Canada or when they travel within Canada or abroad

Medicare Principles

- *Comprehensiveness*: The plan must insure all medically necessary services provided by hospitals and physicians

The Limits of Medicare

- Medicare *does require* coverage for …
  - "Medically necessary" hospital and doctor services
- Medicare *does not require* coverage for …
  - Even medically-necessary services provided outside of hospitals or by other providers (e.g., home and community care, pharmaceuticals, rehab)

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International Trends

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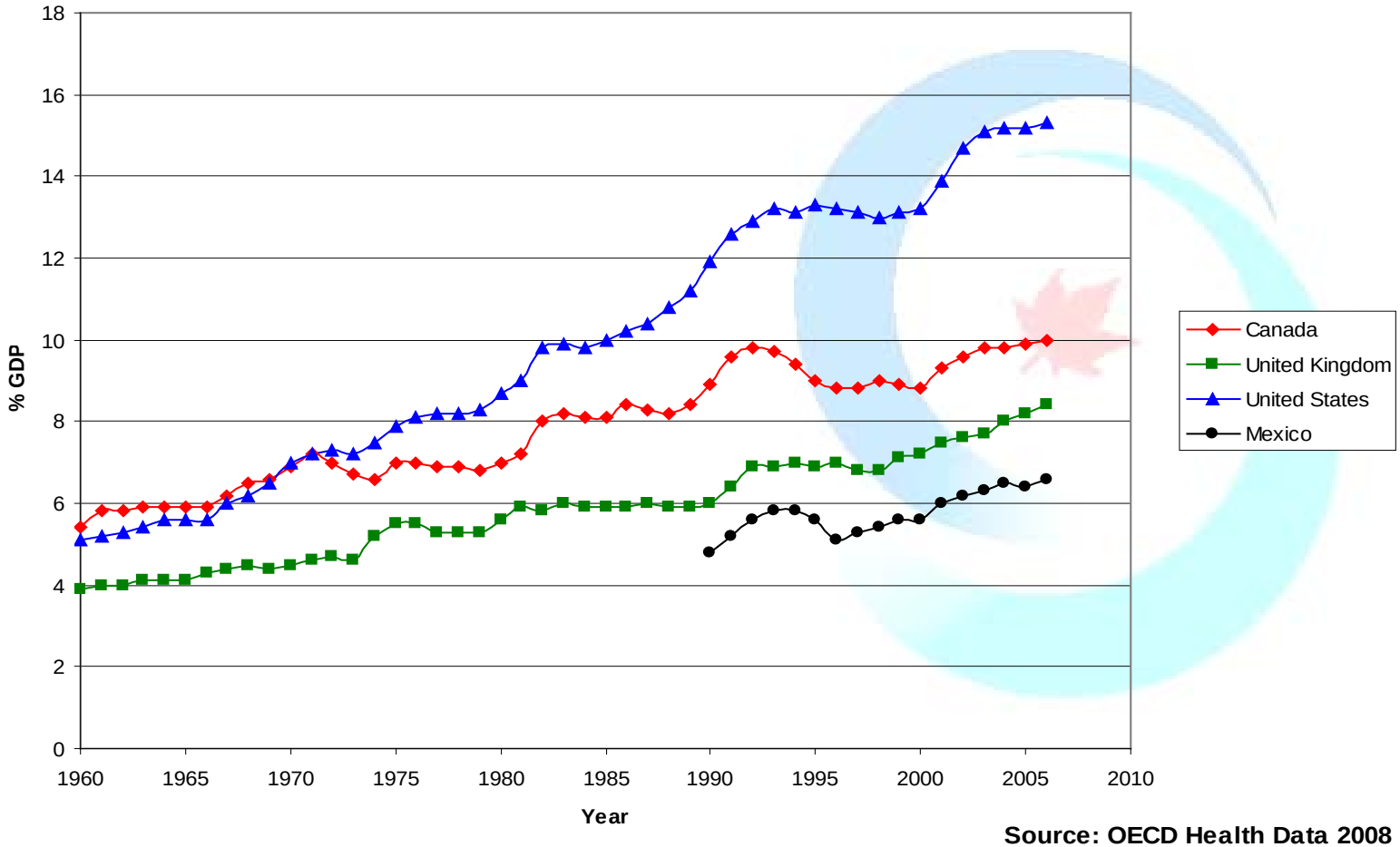
Health Care Expenditures are Rising (% GDP)



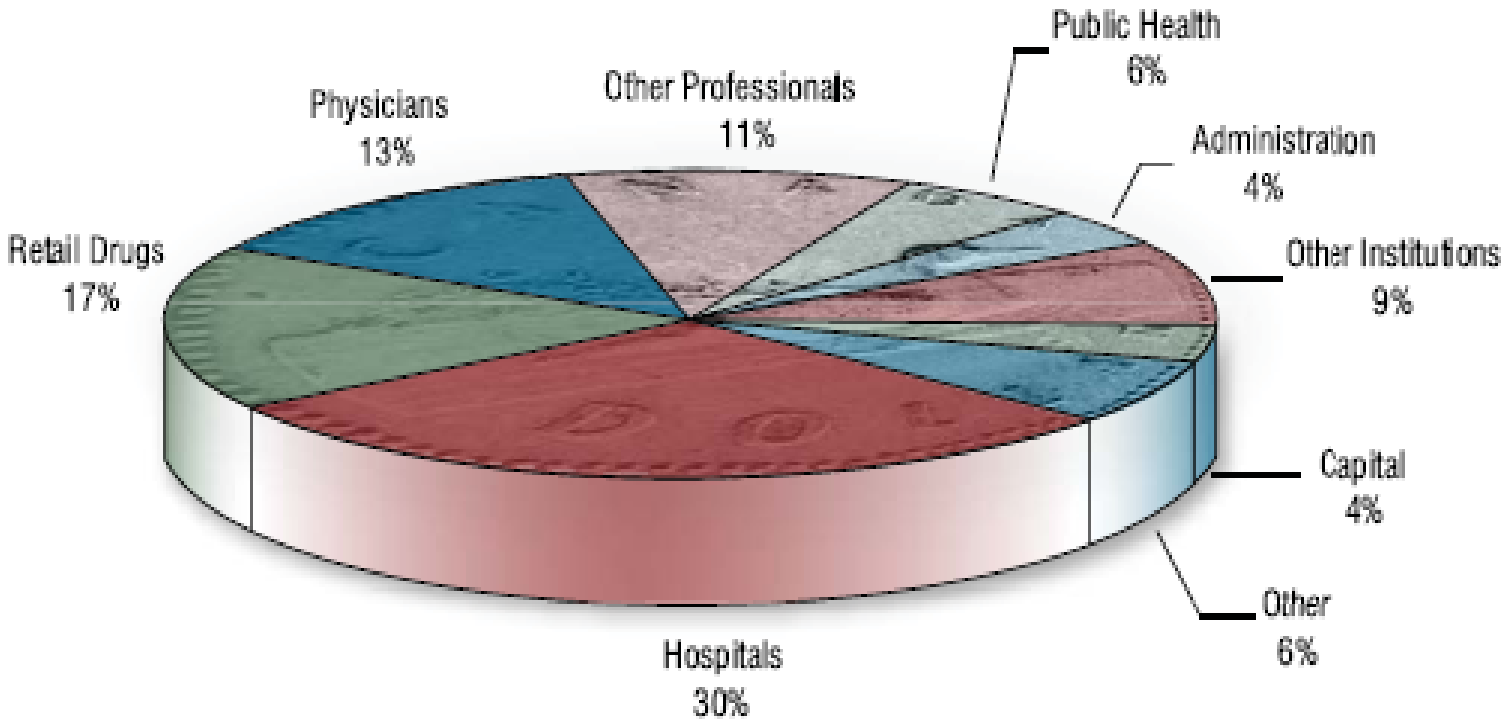
Source: OECD Health Data 2008

Key Cost Drivers
(OECD, 2008)

- Aging populations
- Increasing public expectations
- New and more expensive medical technologies and treatments (esp. drugs)

Still a Curative Focus
(2007)

Distribution of Health Spending

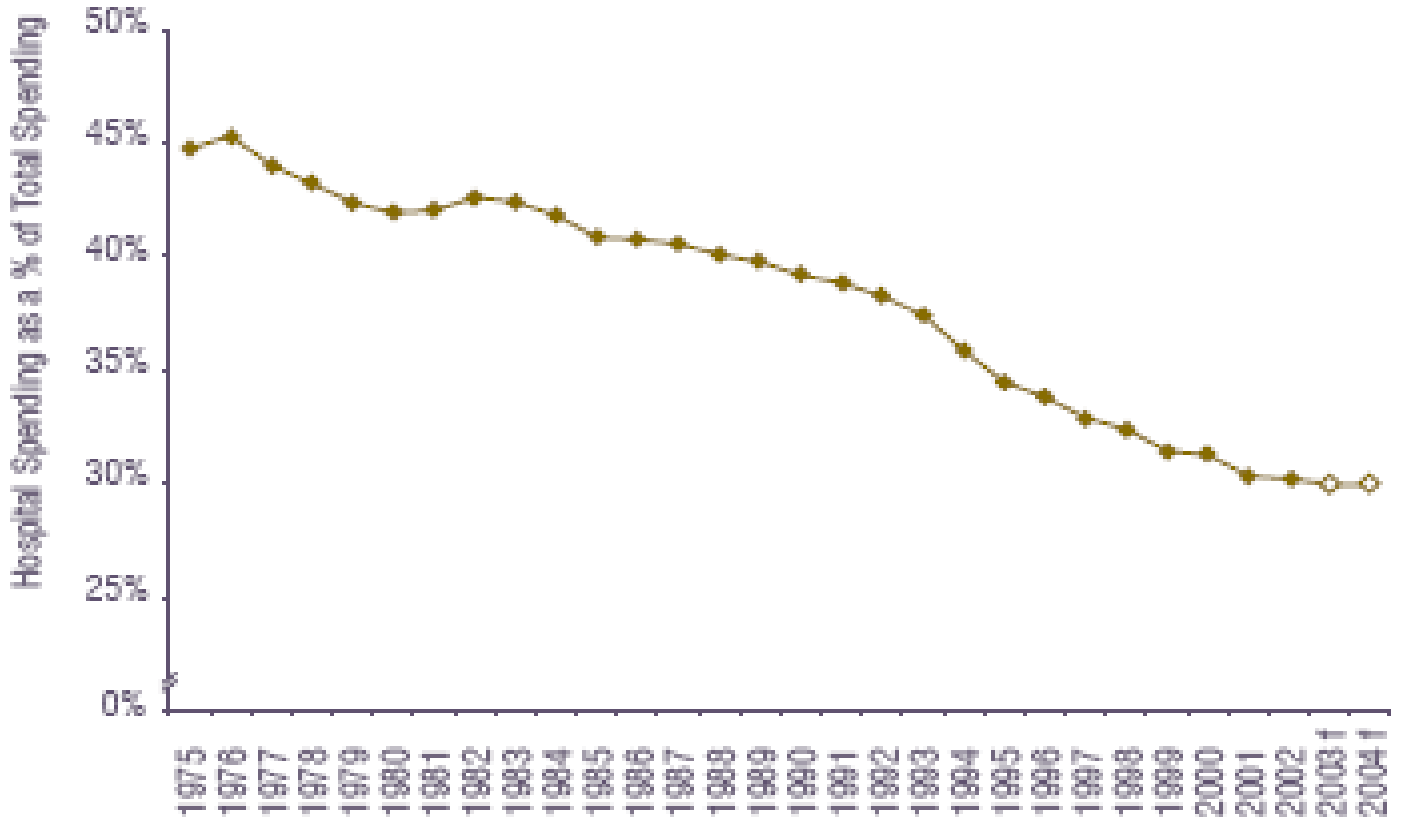


But … Spending Patterns Are Changing

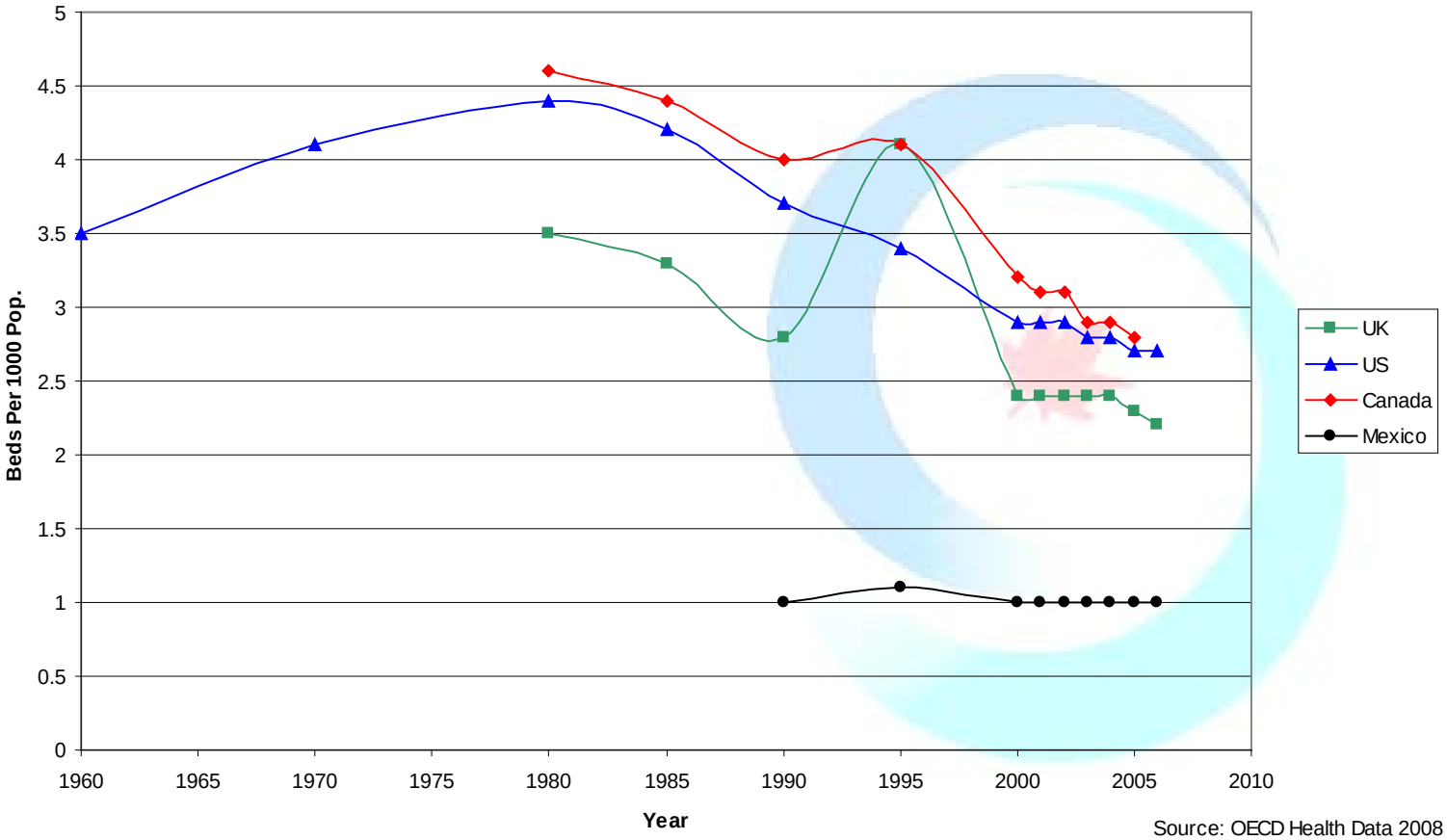
- Hospitals still account for largest, but declining, share of health dollars
  - In 2005 record $42.4 billion
  - However, hospital % declined from 44.7% (1975) to 29.9% (2007)

- Key factors:
  - More out-patient and community care
  - More rapid rises in other sectors (e.g. pharmaceuticals)

Hospital Spending As Percentage of Total Health Care Spending (CIHI, 2005)

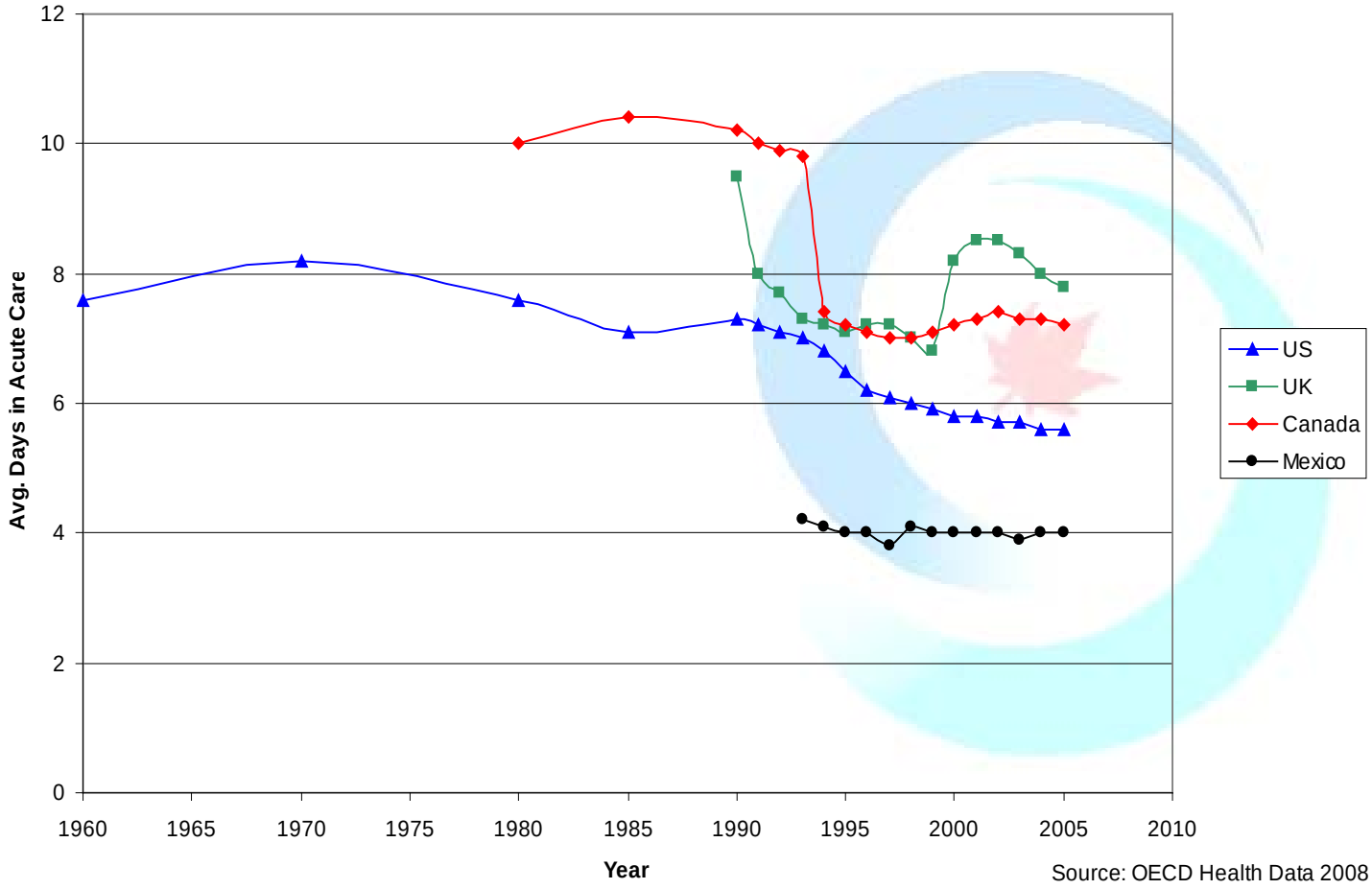


Acute Care Beds, Per 1000 Population (1960-2006)



Source: OECD Health Data 2008

Average Length of Stay in Acute Care, Days (1960-2005)



Source: OECD Health Data 2008

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Toward System Integration: Ontario's Local Health Integration Networks (LHINs)

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Ontario's Health Care System, 1990s

- Fragmented/siloed
  - Hospitals, home care, community supports, doctors, drugs, residential long-term care
  - Each with different legislation, funding, regulations, eligibility

Ontario's Health Care System, 1990s

- Costs of fragmentation
  - Difficult for vulnerable individuals (including growing number of older persons) to access most appropriate care
  - Incentives for providers to "cost-shift" through earlier discharges, unnecessary referrals, tighter eligibility requirements, service restrictions
  - Incentives for funders to control costs through capped budgets, de-listing insured services, unwillingness to cover new procedures

Mandate

- 14 LHINS responsible for planning, funding and monitoring care within geographic regions
  - LHIN budgets set by province
- Unlike regional health authorities in other provinces
  - No direct care provision
  - Hospitals (and other providers) maintain independent governance structures

Improving System Performance

- Reduce inappropriate hospital ED use
  - Ambulance crews now trained to assess whether a hospital admission is needed
  - Geriatric Emergency Management (GEM) nurses in hospitals redirect non-medical admissions to community care
- Reduce hospital ALC bed rates
  - Link to LTC and home and community care to facilitate timely discharge

Improving System Performance

- Reduce hospital use for Ambulatory Sensitive Conditions
  - Asthma, Angina, Congestive Heart Failure, Hypertension, Epilepsy, Diabetes, Chronic Obstructive Pulmonary Disease
- Shorten LTC wait lists
  - Provide integrated home and community care

Ontario's Aging at Home Strategy

- Four year, $1.1 billion program introduced in 2007
  - "to enable people to continue leading healthy and independent lives in their own homes."
  - Reverses policy of capping H&CC while building residential long-term care (LTC) beds (e.g. nursing homes)

Ontario's Aging at Home Strategy

- Includes ...
  - Professional home care services (e.g. nursing)
  - Community supports such as meals, transportation, shopping, friendly visiting, snow shoveling, adult day programs, caregiver support

Balance of Care

- Analyzed LTC wait lists in 9 LHINs
- Using very conservative assumptions, estimated 25%-50% of those on LTC wait lists could be supported safely, cost-effectively at home
- "Lower level" supports key
  - E.g., transportation, nutrition, medications management, housekeeping, social engagement, caregiver support

Balance of Care

- Little evidence for fragmented services
- Targeted, managed home & community care within an integrated continuum consistently meet individual & system goals
  - Maintain the health, well-being and autonomy of individuals and caregivers
  - Contribute to system sustainability

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Observations

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Medicare's Second Stage

- First stage of Medicare
  - Funding universal access to hospital and doctor care without regard to economic means
- Second stage of Medicare
  - Provide an integrated continuum of health and social services so that people get the care they need, when they need it, in a cost-effective way which contributes to system sustainability

Making the Case

- Much of the action now shifted to regional (LHIN) level

- Medicare fundamentals remain:
  - Top line: individuals and caregivers
  - Bottom line: cost-effectiveness & system sustainability

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