Bending the cost curve: Ontario

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Big picture

- How much are we spending?
- Can we afford it?
- Where is the money going?
- Who pays for what?
- How does this compare, within Canada, and internationally?
- What policy initiatives are being tried to bend the cost curve?
Data?

- Our charts/tables compare:
  - Ontario
  - Canada
  - ROC - “rest of Canada” (average of remaining 9 provinces, excluding territories, weighted by population size)

- Data provided by CIHI

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- They are not responsible for our interpretations!
Total health spending per capita in Ontario, Canada, and the rest of Canada, 1975-2011, current dollars
Breaking it down: Source of funds

- **Public - Provincial/territorial governments**
- **Other public**: includes
  - Federal direct
  - Municipal
  - Social security
- **Private**: includes
  - Out-of pocket
  - Private insurance
  - Non-consumption
Breaking it down: Use of funds

- Hospitals
- Other institutions
- Physicians
- Drugs – Prescription
- Public Health
- All other
  - Drugs – non-prescription
  - Other professionals
  - Administration
  - Capital
  - Other health spending
Spending per capita, 2011

Total

- Private
- Other public
- Provincial

Tot: Ont

Tot: Canada

Tot: ROC
Spending per capita, 2011
Hospitals

- Private
- Other public
- Provincial
Spending per capita, 2011
Other Institutions

- Private
- Other public
- Provincial

Oth Inst: Ont  Oth Inst: Canada  Oth Inst: ROC
Spending per capita, 2011
Physicians

- Phys: Ont
- Phys: Canada
- Phys: ROC

- Private
- Other public
- Provincial
Spending per capita, 2011
Prescription Drugs

- Private
- Other public
- Provincial
Spending per capita, 2011
Public Health
Spending per capita, 2011
All Other

[Bar chart showing spending per capita for different regions and categories.]

Legend:
- Private
- Other public
- Provincial
As always
Nuances include…

- **How are things classified?**
  - When care moves out of hospitals, may change categories

- **What costs are being captured?**
  - E.g., home care provided by other than health professionals is not in NHEX framework
Canadian wrinkle - Canada Health Act

- Sets terms provinces must meet to get federal money
- Requires coverage of ‘necessary care’
- But definition based on:
  - Where care delivered (in hospital)
  - Or by whom (physicians)
- Governments can insure beyond this
- But they are not required to
- I.e., not linked to “what” but to “where” and “by whom”
More nuances

- **Who is paying for what?**
  - Total spending? Public spending? Provincial government spending?
    - In Ontario, municipal governments spent $44 per capita in 2011, compared to $12 in ROC
    - Higher public spending may not represent higher total costs
      - E.g., Prescription drugs may partially represent shift from hospital line?
      - Public coverage for certain drugs (e.g., chronic disease control) may yield lower total costs, better outcomes

- **Who is generating which costs?**
  - Health care costs may be skewed, particularly for hospital costs
  - Per capita costs may accordingly be misleading
First law of cost containment

- Easiest way to contain costs is to shift them to someone else
What is Ontario doing?

- We focus on three initiatives:
- Hospitals
- Physicians
- Long term care
Hospitals

- Fewer beds
  - Canada had 3.2 hospital beds per 1,000
    - Reduced from 6.8 in 1981 and 5.8 in 1991.
    - Curative (acute) beds – 1.7 in 2009 (source: OECD)
  - Ontario had 2.4 (source: CIHI MIS database)
    - Average for other provinces (excluding Quebec) 3.1
    - Range 2.7 (BC) to 4.3 (Newfoundland)
  - Major cuts in bed capacity (almost 40% since 1990)
  - 2011, Ontario’s per capita spending by provincial government 2011, compared to $1620 in ROC (only Quebec spent less, at $1298)
Shift from hospitals

- Provide care where most effective?
  - Independent health facilities?
  - Home care?
  - Primary care?
- But – backlash (note wait time/access agenda)
Will it work?

- Jury is out:
  - Much low hanging fruit already picked
  - Shift from global budgets to activity-based payments may increase volume, and hence costs
  - Encouraging initiative – focus on appropriateness rather than just volume
Physicians

- Costs relatively high
- Ontario paid them more money:
  - Ontario paid doctors approximately $8 billion in 2009/10
  - More than twice what they had received in 1992/93 (in unadjusted dollars)
Why?

- More doctors (37% of increase)
- Higher average payment per physician (63% of increase)

- Some of this was catch up (mean payment per physician had been at or below inflation 1992/93 to 2004/05)
- Some was planned (‘access agenda’)
- Note changes in primary care (alternative payment models)
Watch this space

- Ontario has $15 billion deficit
- Wants to curb public expenditure
- 2012 – unilateral changes to OHIP fee schedule (goal, save $338.3/year)
- Many directed towards overused / overpaid specialty services
- Negotiations break down (but have resumed)
Long term care

- Home care:
  - Acute care substitution
  - Long-term care substitution
  - Prevention/maintenance

- Particular focus: Alternate Levels of Care (ALC) in hospitals
- Note Ontario shift in focus: from LTC to acute care substitution
Policy implications?

- Mixed
Truism

- If we cannot afford something universally from a single payer
- We cannot afford it universally from multiple payers at higher cost!
- “Sustainability” thus means deciding what we allocate on the basis of need
- And what on the basis of ability/willingness to pay
- Important caveat - we need mechanisms to make sure that the single payer plays fair
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 question of evidence, but of values
Penny wise pound foolish?

- Shifting some costs may make total costs worse, give worse outcomes, and increase inequity
- Cutting unneeded services may give lower costs and better outcomes
- Appropriateness a key factor!
Unhelpful conclusion

- One size won’t fit all
- There is not a single problem
  - There are big differences in what problems are seen to exist, across jurisdictions, across clinical issues, across client groups
Better questions

- What are we actually spending?
- Can we afford it?
- Is it a good use of money?

- How much do we want to pay providers?
- Can we pay more attention to appropriateness?
- Question is left as an exercise for the public!
Final thoughts

- Medicare is as sustainable as we want it to be
  - Roy Romanow
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