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Bending the cost curve: Ontario

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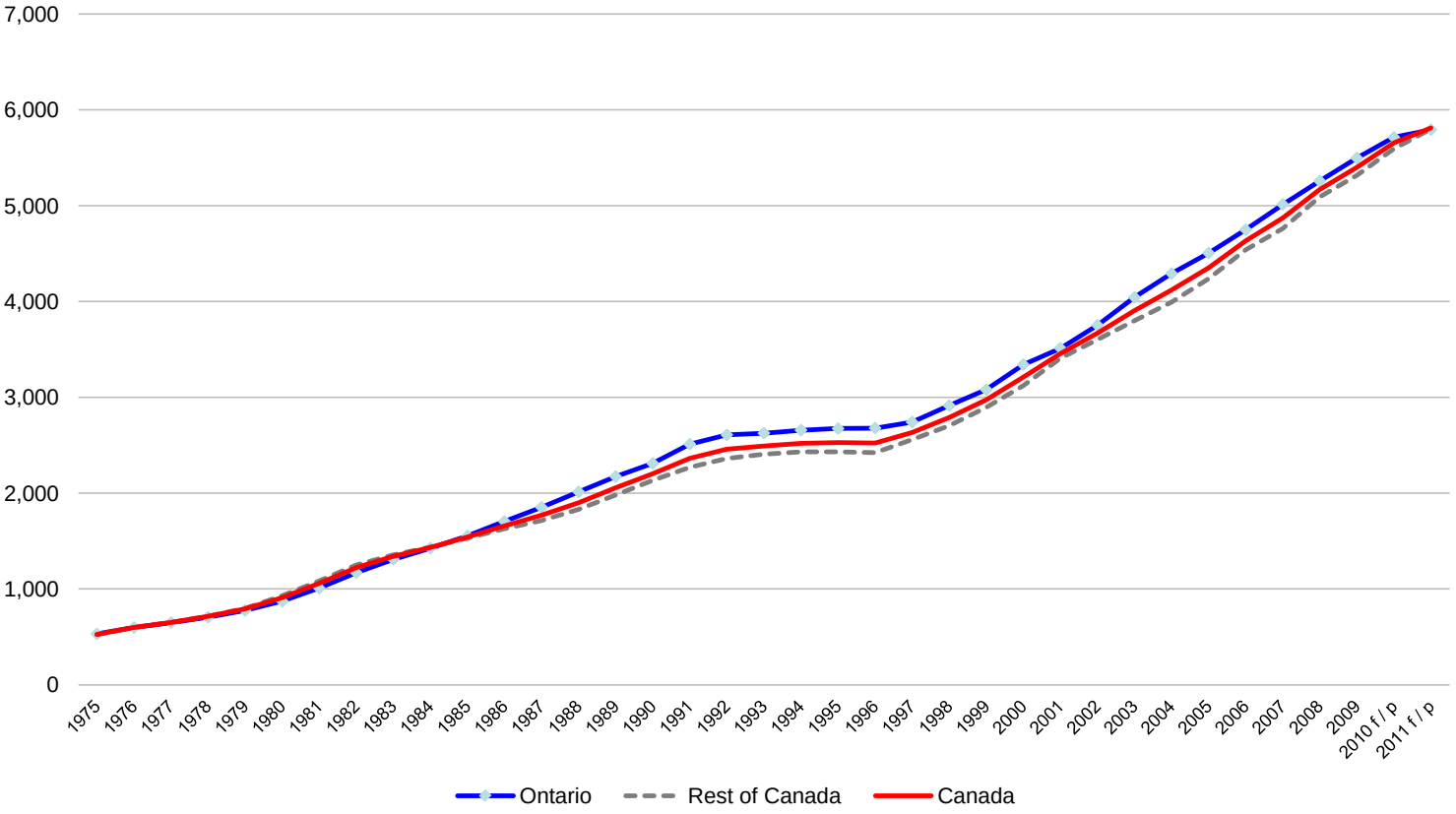
Big picture

- 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
- Thanks to:
  - Christopher Kuchciak and Ruolz Ariste for clarification
  - Owen Adams, Adalsteinn Brown, Sarah Caldwell, Michael Hillmer for helpful comments
- They are not responsible for our interpretations!

Total health spending per capita in Ontario, Canada, and the rest of Canada, 1975-2011, current dollars



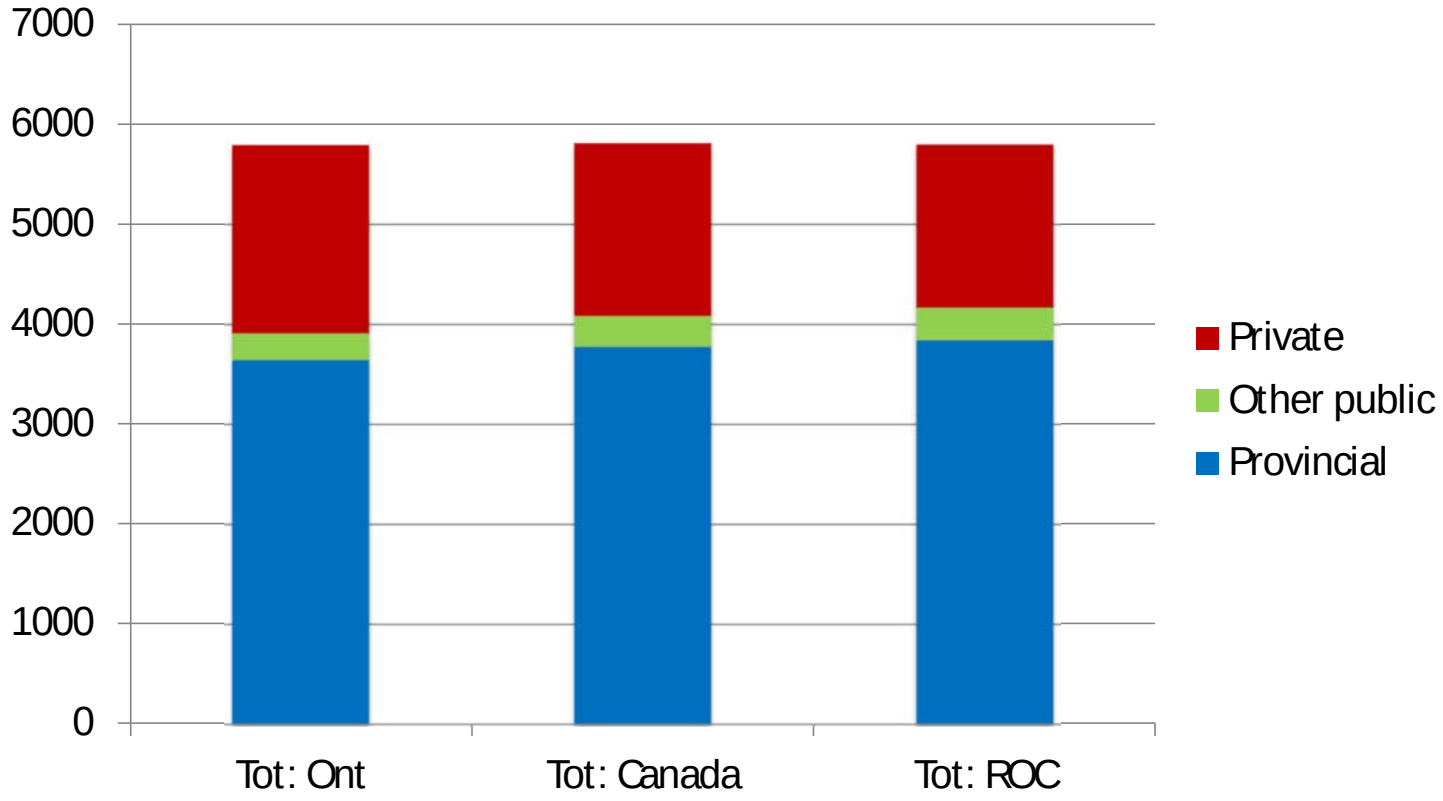
Breaking it down: Source of funds

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

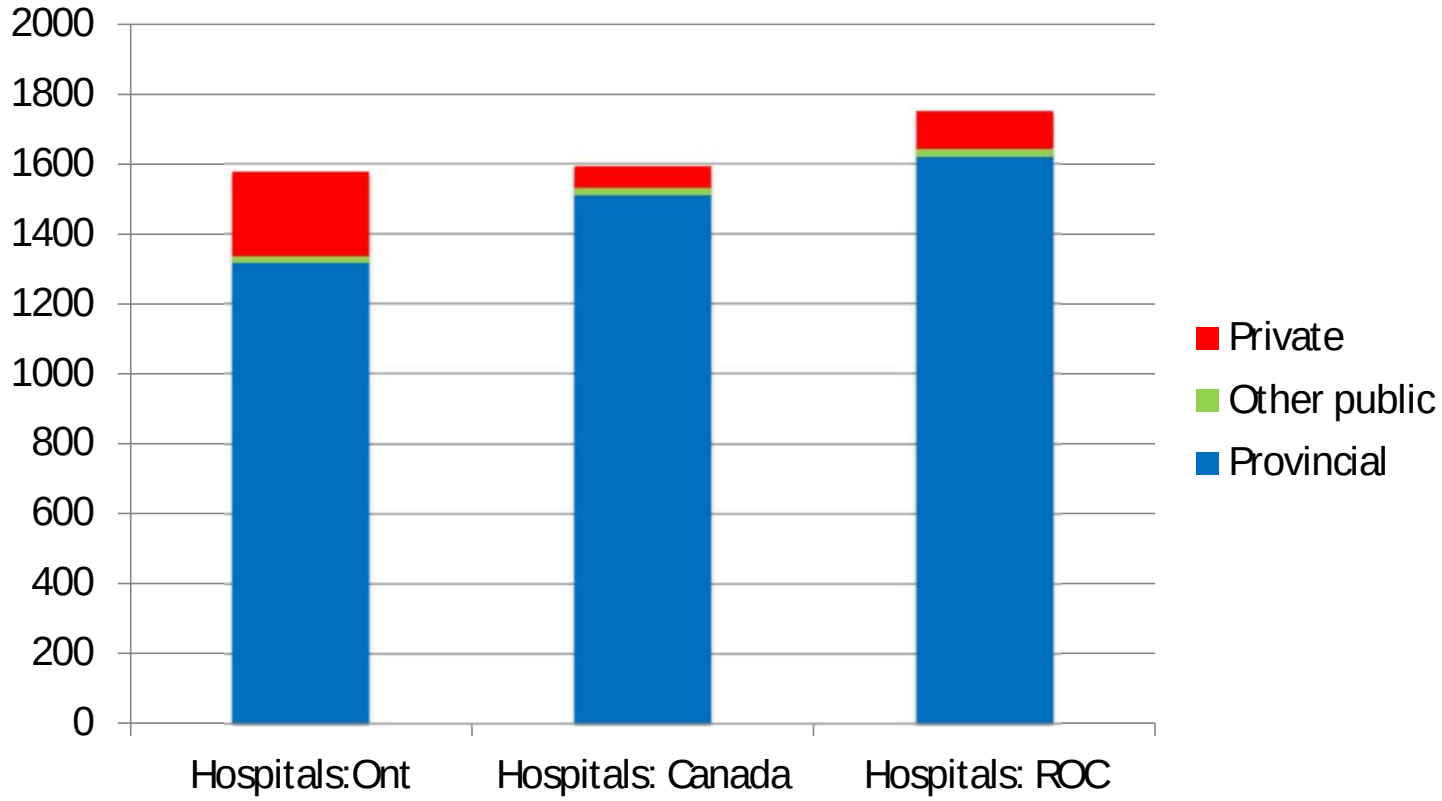
Breaking it down: Use of funds

- Hospitals
- Other institutions
- Physicians
- Drugs – Prescription
- Public Health
- All other
  - Drugs –non-prescription
  - Other professionals
  - Administration
  - Capital
  - Other health spending

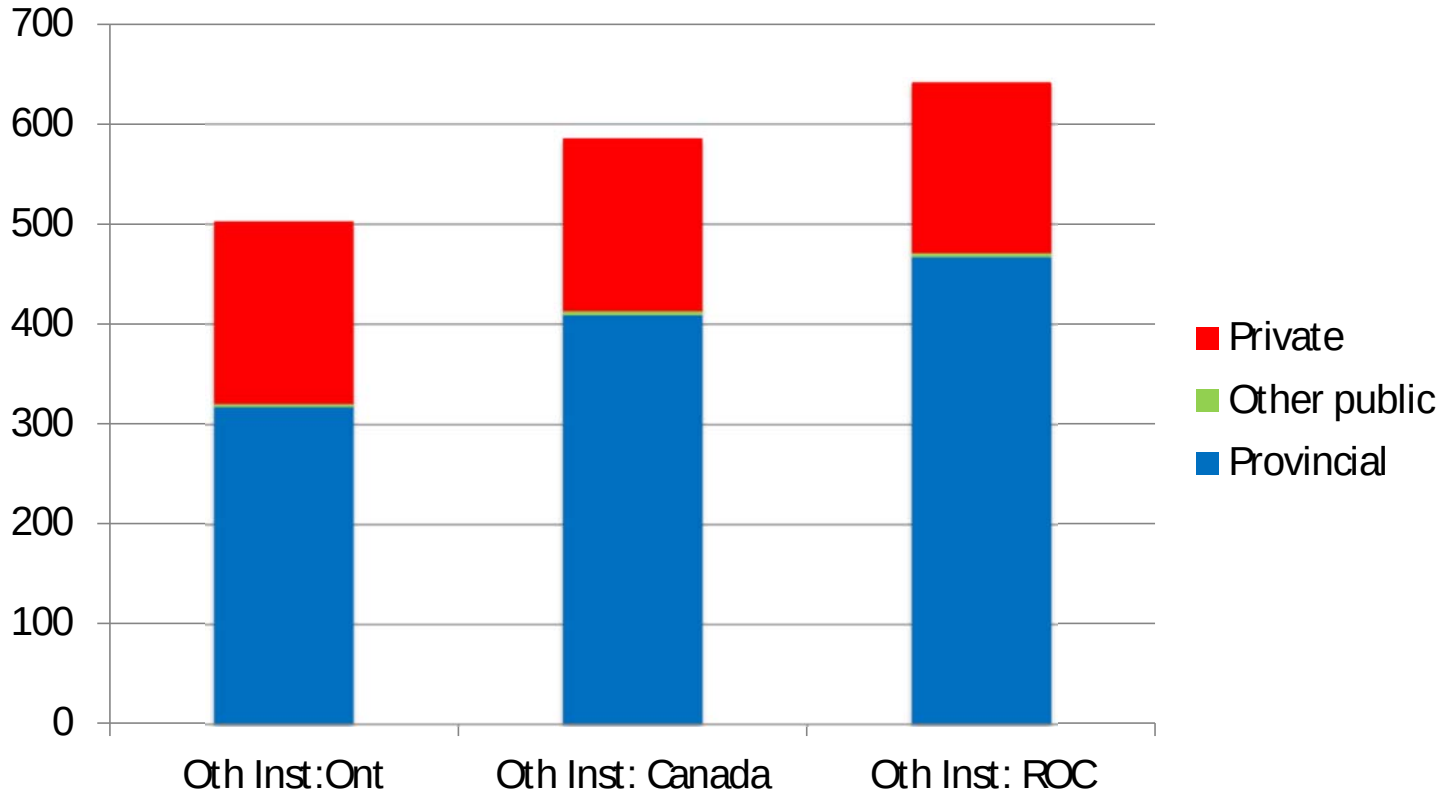
Spending per capita, 2011
Total



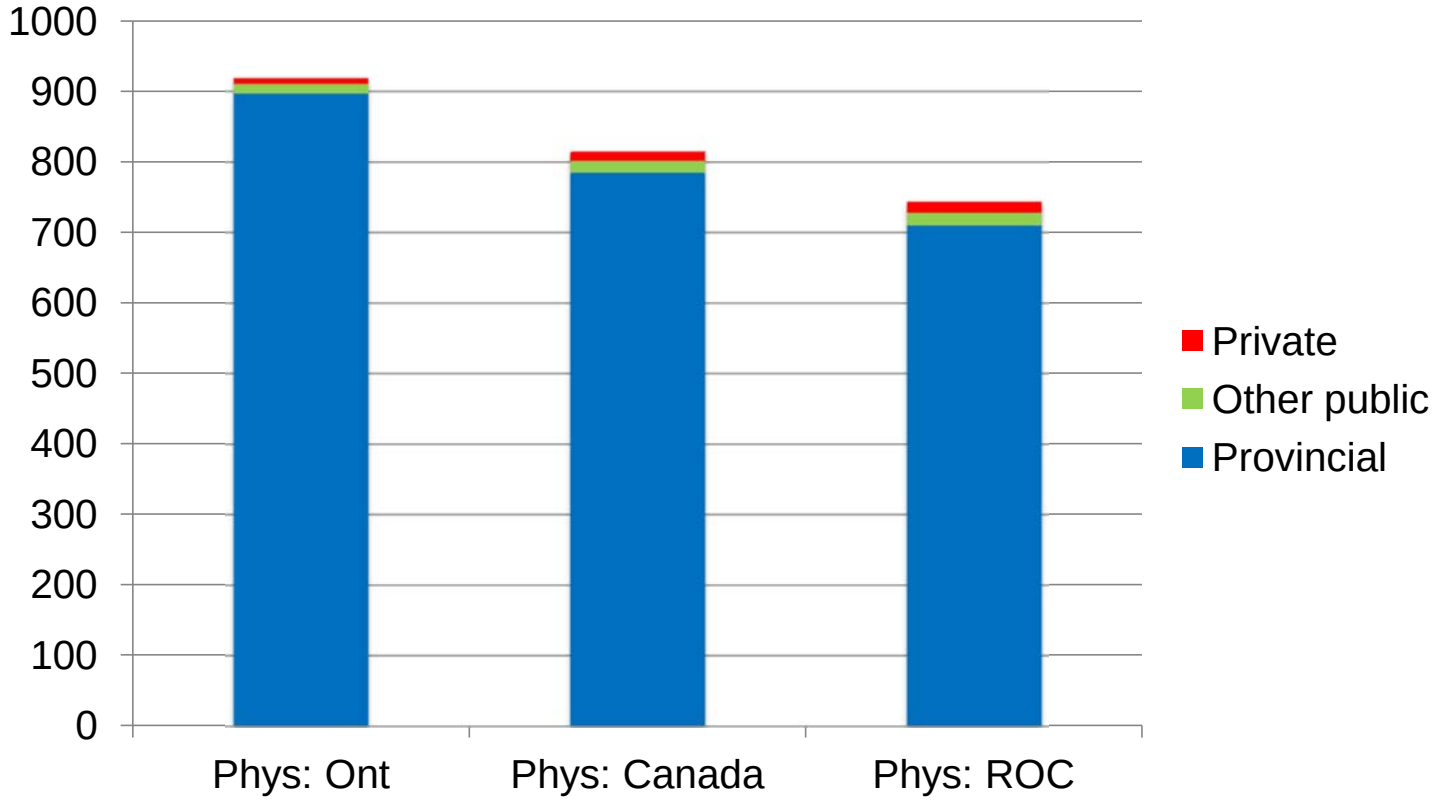
Spending per capita, 2011 Hospitals



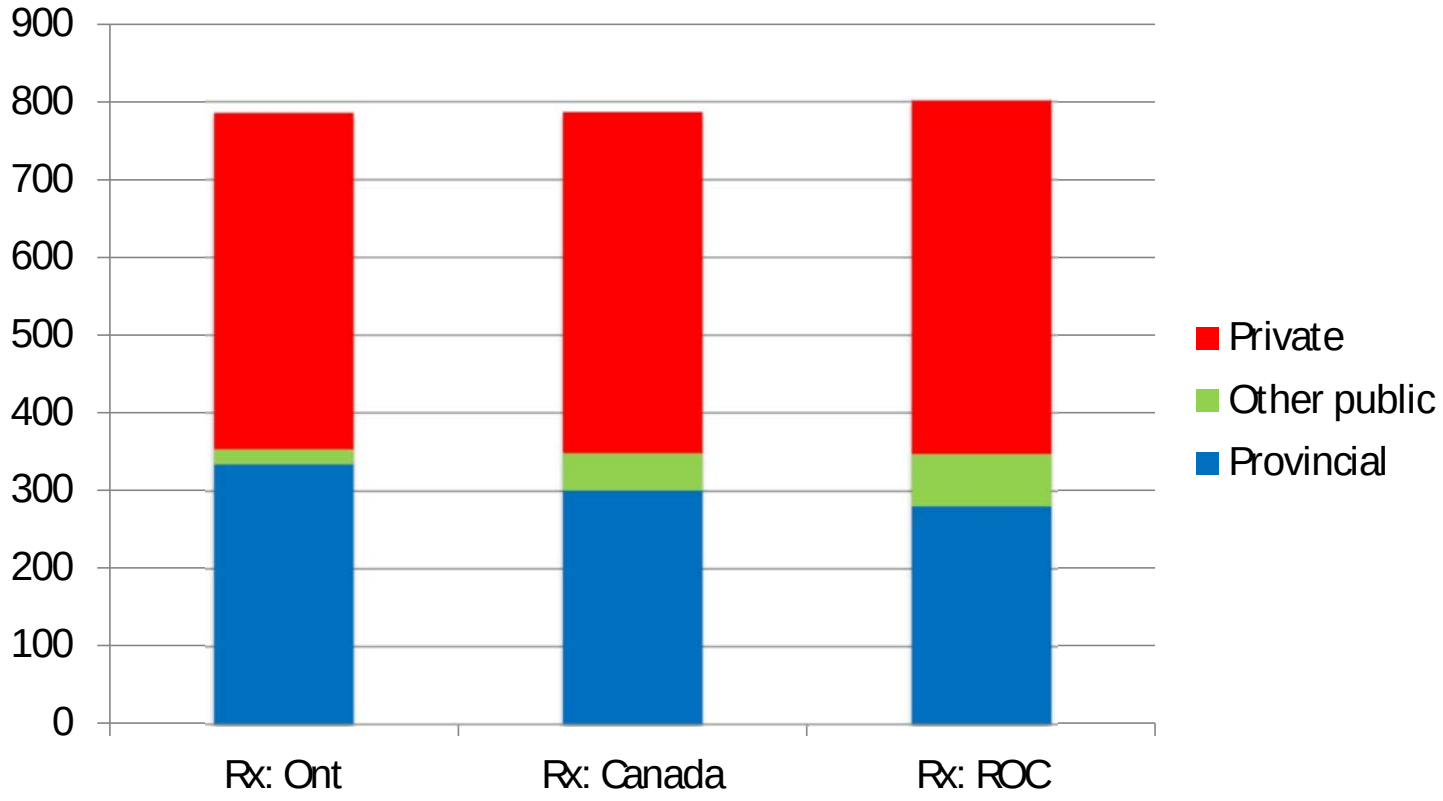
Spending per capita, 2011
Other Institutions



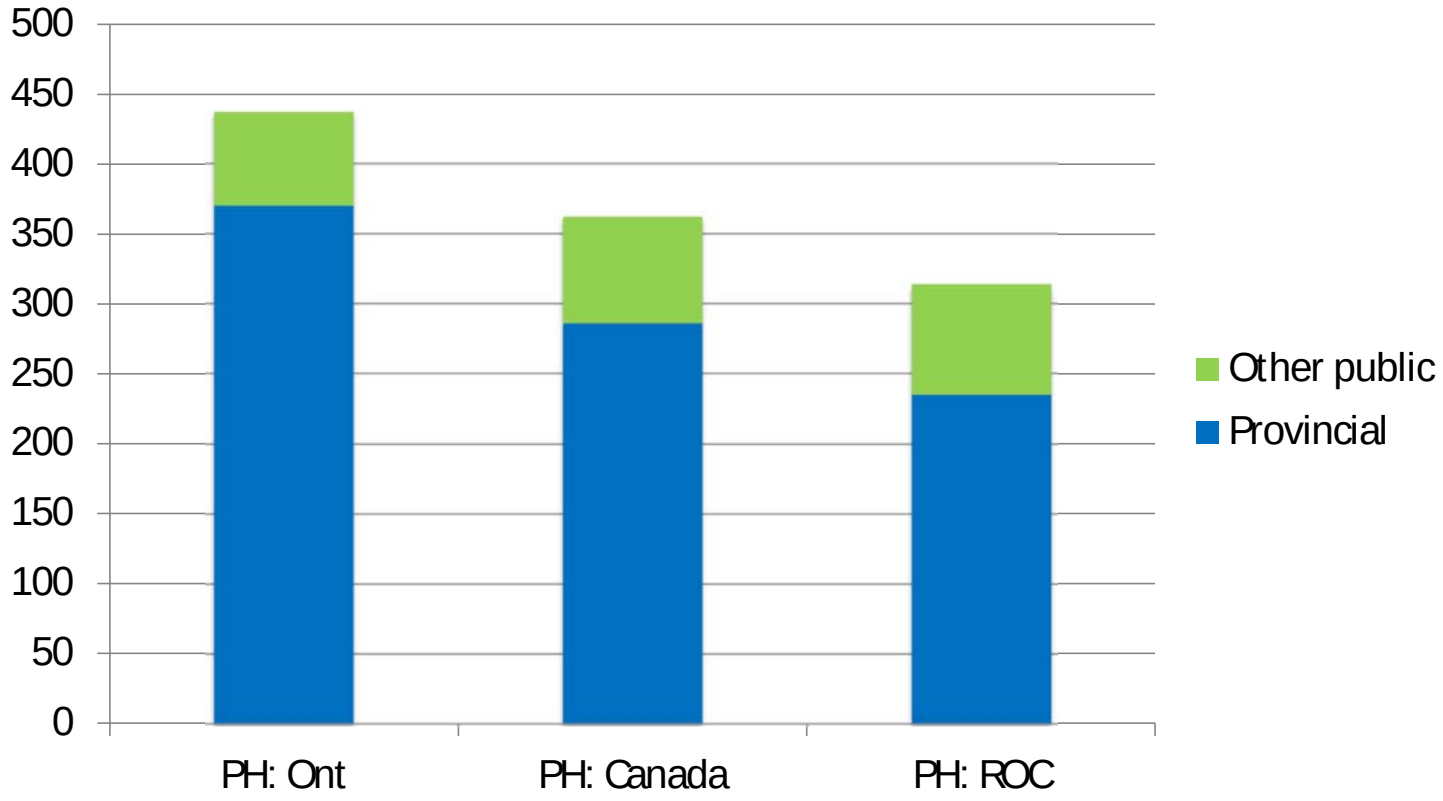
Spending per capita, 2011 Physicians



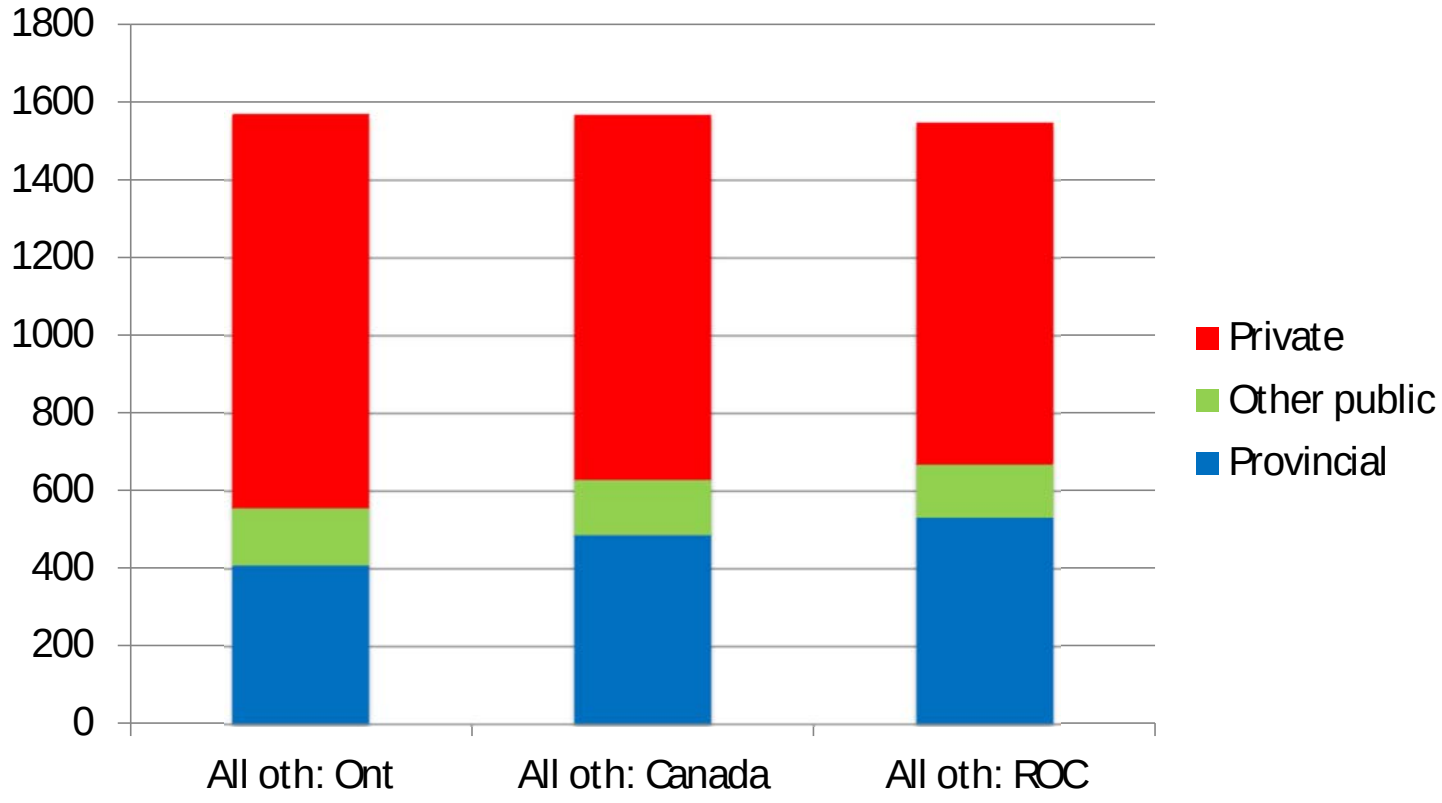
Spending per capita, 2011 Prescription Drugs



Spending per capita, 2011 Public Health



Spending per capita, 2011
All Other



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)
  - Source: Henry et al, *Payments to Ontario physicians from Ministry of Health and Long-Term Care sources 1992/93 to 2009/10*. Toronto: ICES, 2012

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