OECD Economic Surveys

CANADA

Alexandra Bibbee

OECD Economics Department

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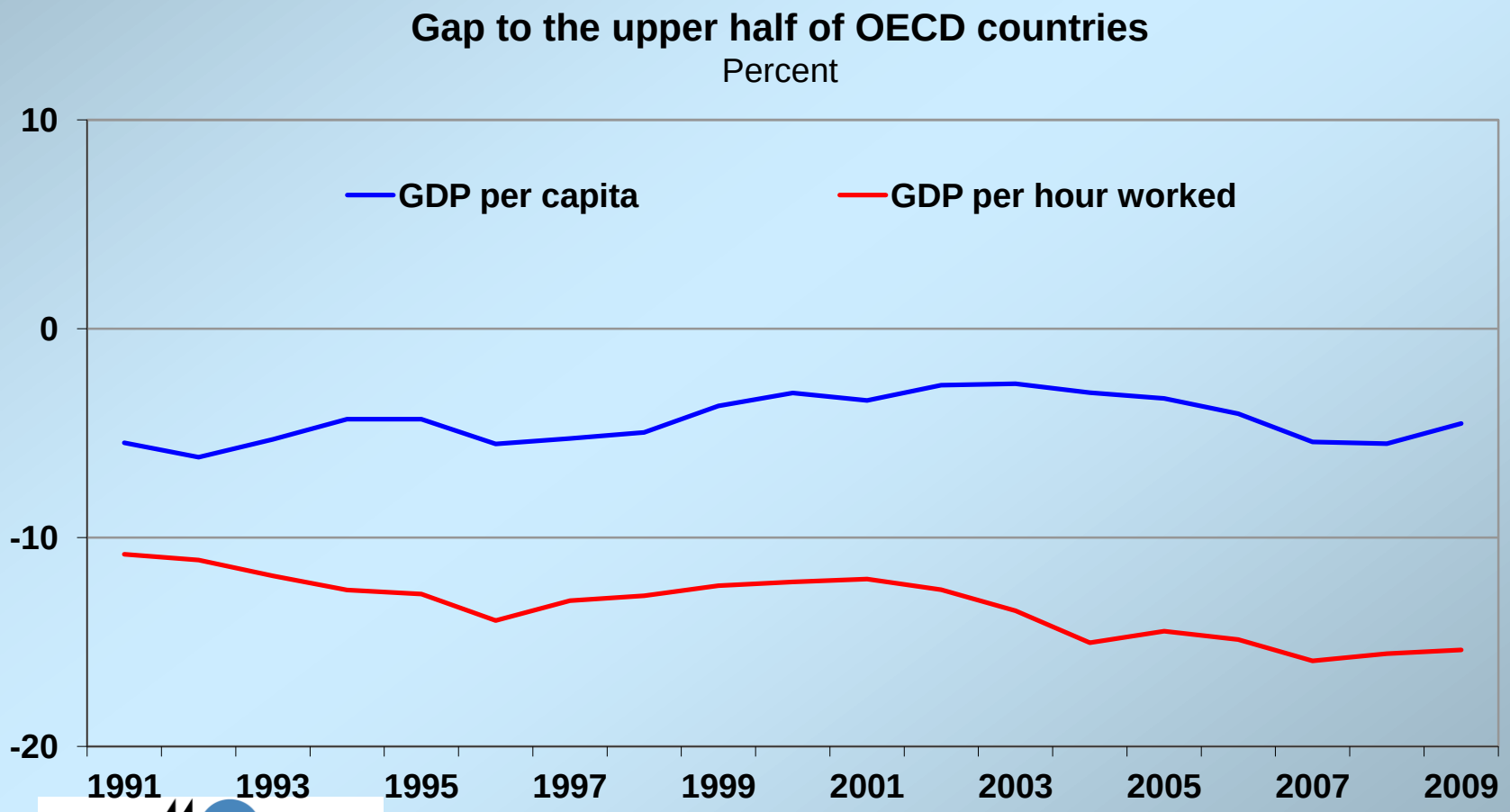
Outline

- Economic and fiscal policy challenges
- Canadian health care in an OECD context
- Key recommendations for health system sustainability
  - A more comprehensive core package + cost sharing
  - Price signals to incentivise efficiency, accountability
  - Information base for quality monitoring and budget prioritisation

The small gap in living standards persists



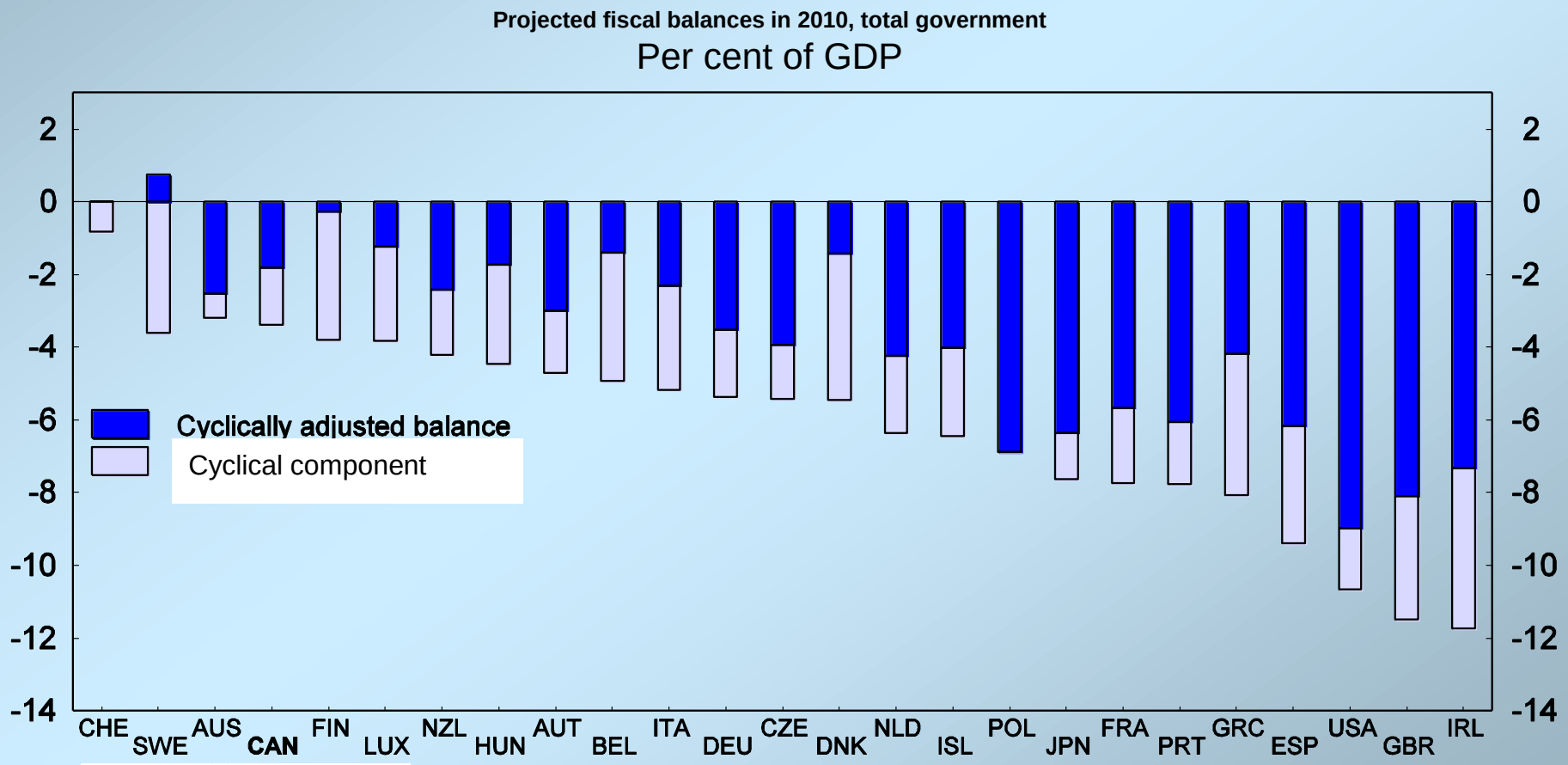
Trend output growth will slow

Estimates and projections of potential output growth

Per cent or percentage points

	Average 1998-2008 (1)	2009	2010	Average 2010-17 (2)	Difference (2) – (1)	2017 level *versus* pre-crisis trend[1]
Newfoundland and Labrador	4.0	1.7	1.1	1.0	-3.0	-22.5
Prince Edward Island	2.2	1.1	0.8	0.8	-1.4	-11.7
Nova Scotia	2.1	0.9	0.8	0.6	-1.6	-12.4
New Brunswick	2.4	1.3	1.1	0.9	-1.5	-12.1
Quebec	2.4	1.6	0.7	0.6	-1.8	-13.9
Ontario	3.0	1.7	1.7	1.6	-1.3	-11.0
Manitoba	2.4	2.4	1.4	1.3	-1.0	-7.7
Saskatchewan	2.2	3.6	1.5	1.5	-0.7	-4.1
Alberta	3.7	2.7	3.3	3.3	-0.4	-4.1
British Columbia	2.9	2.0	1.3	1.1	-1.7	-13.1
Canada	2.9	1.9	1.6	1.6	-1.3	-10.5
***Memo*: Canada (*Outlook* 87)**	2.9	1.8	1.6	1.6	-1.3	-10.4

Canada is in a relatively good fiscal position



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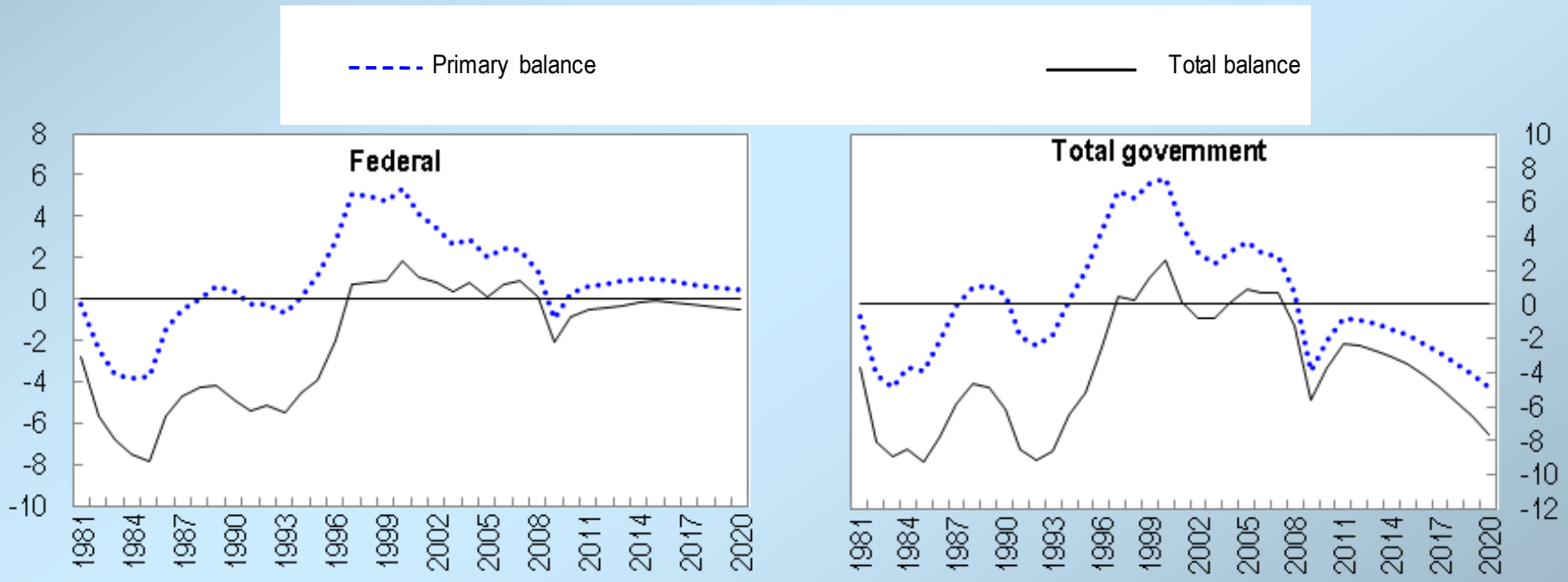
Federal government fiscally sustainable but not total government

Historical and projected baseline fiscal balances, OECD projections

National accounts basis, per cent of GDP



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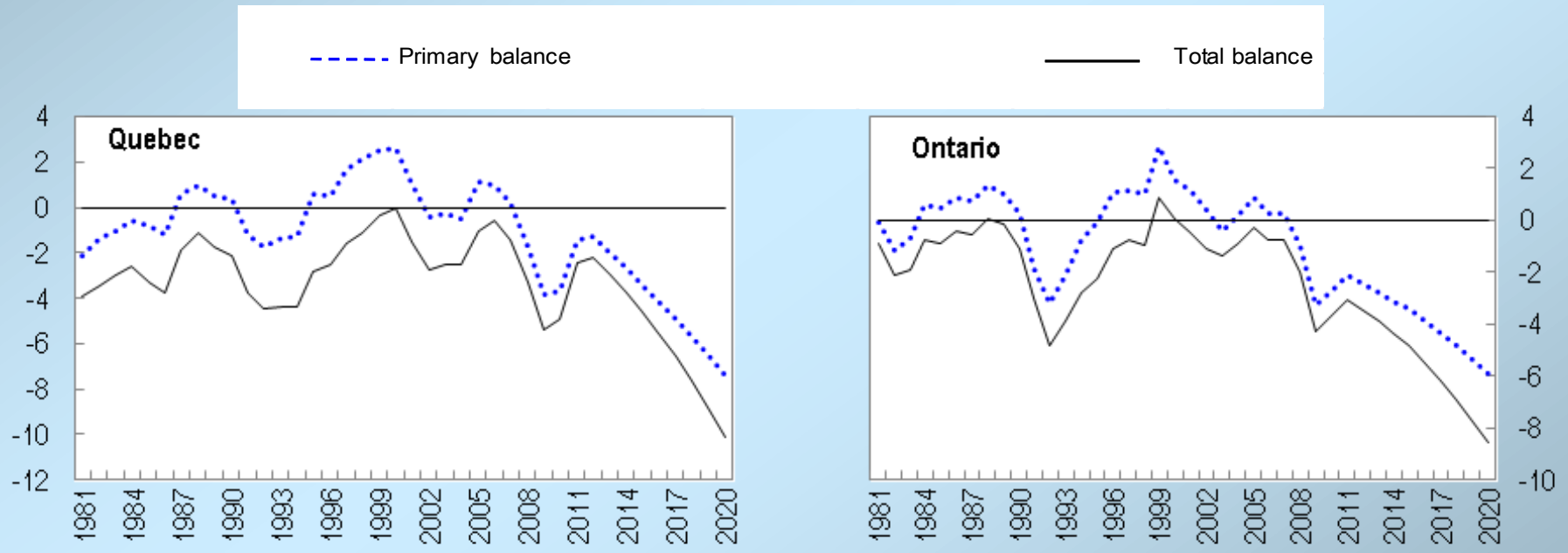
Quebec and Ontario have challenging fiscal outlooks…

Historical and projected baseline fiscal balances, OECD projections

National accounts basis, per cent of GDP



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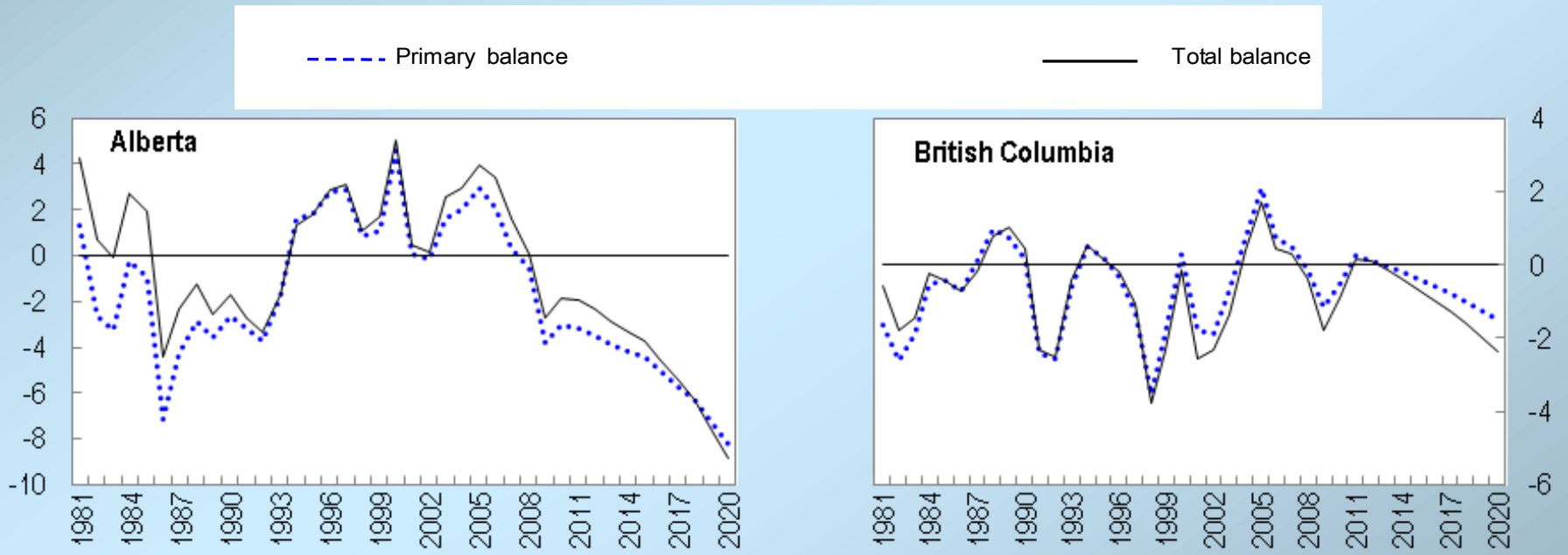
…as does Alberta…

Historical and projected baseline fiscal balances, OECD projections

National accounts basis, per cent of GDP



… and a number of other provinces, especially Newfoundland and Labrador and Prince Edward Island.

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Health care: a growing provincial budgetary burden

	Health expenditure 2008		Average annual change in public health expenditure per capita	Average annual change in own source revenues	Share of public health spending in total programme expenditures	
	Per capita (CAD)	% of GDP				
			1998/2008	1998/2008	1997	2008
Newfoundland and Labrador	5 532	9.0	7.6	10.5	33	39
Prince Edward Island	5 224	15.8	7.5	4.3	33	42
Nova Scotia	5 504	15.1	7.2	6.5	42	48
New Brunswick	5 329	14.5	7.3	4.2	34	42
Quebec	4 654	11.9	5.8	3.4	39	45
Ontario	5 314	11.7	6.3	3.0	49	52
Manitoba	5 560	13.2	6.9	8.9	45	43
Saskatchewan	5 495	8.8	7.2	7.9	45	45
Alberta	**5 795**	**7.2**	**8.3**	**6.0**	**37**	**42**
British Columbia	5 024	11.1	5.4	3.5	38	44
Yukon	7 586	13.2	7.5	5.4	19	22
Northwest Territories	9 564	8.2	6.1	10.8	26	27
Nunavut	11 561	22.8	9.0	7.6	24	29

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Some peculiarities of the Canadian health care system

Medicare

- Drugs, dentistry and community therapies not covered
- No patient co-payments/deductibles (or PHI) allowed

In general

- Lack of cost-saving incentives (DRGs, etc.)
- Gaps in information on performance
- Spends most on prevention and public health

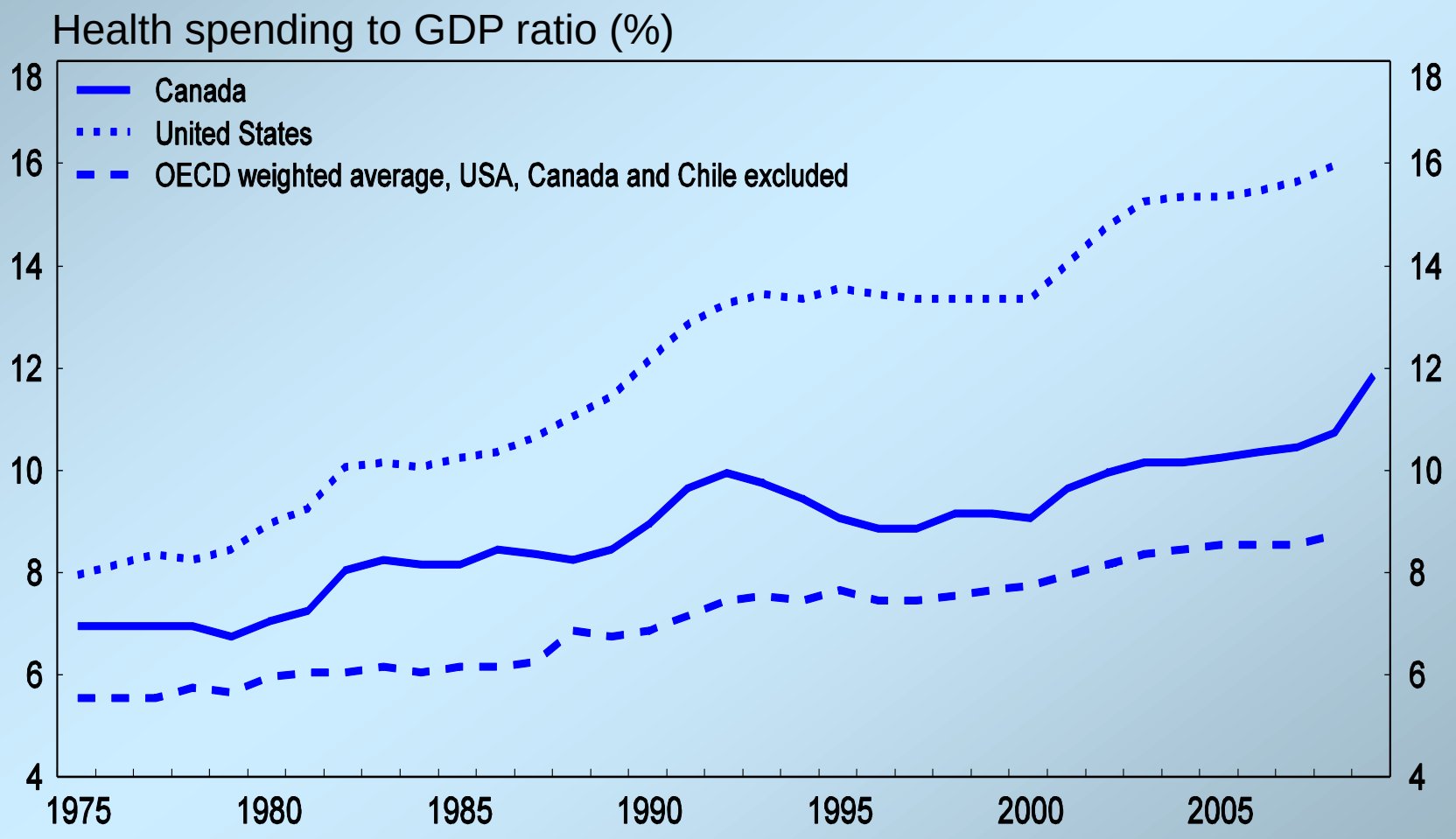
Political economy

- Spending almost entirely decentralised to provinces and below (funding only partially)
- Doctors fiercely independent
- CHA has almost iconic status

Some consequences

- Strong, UK-style equity in Medicare (narrow but deep coverage) *good*
- US-style inequity in non-Medicare (high out-of-pocket and private insurance costs) *bad*
- No possibility of physician “dual practice” (unlike UK) *good or bad?*
- Medicare services effectively firewalled from private competition (unusual), fragmented system *bad*
- Strong macro budget control for Medicare… *good*
- …but weak or no micro price signals (queues) *bad*
- Does the CHA (as interpreted) inhibit innovation?

Health spending trends not sustainable



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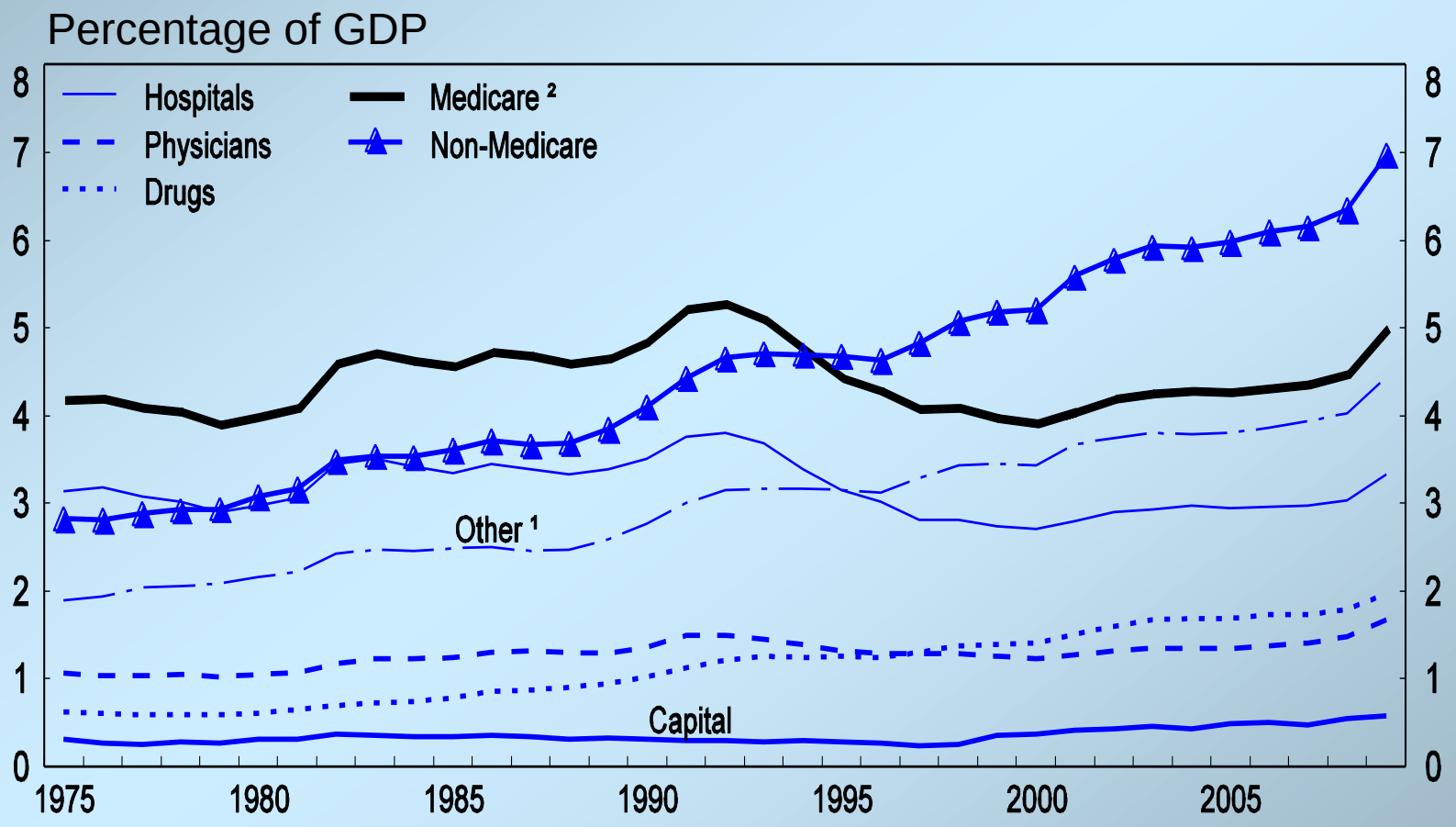
Main pressure points are in non-Medicare



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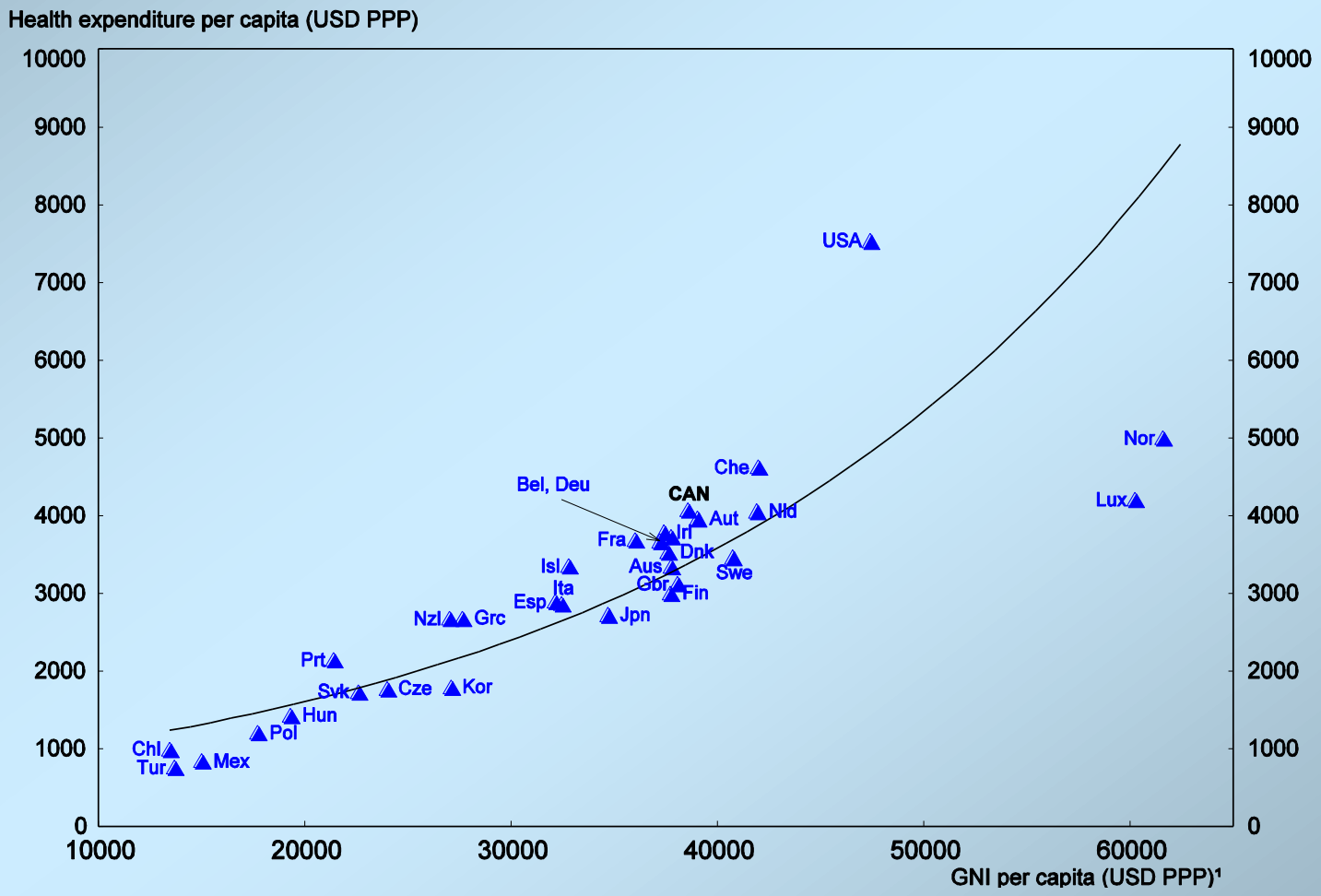
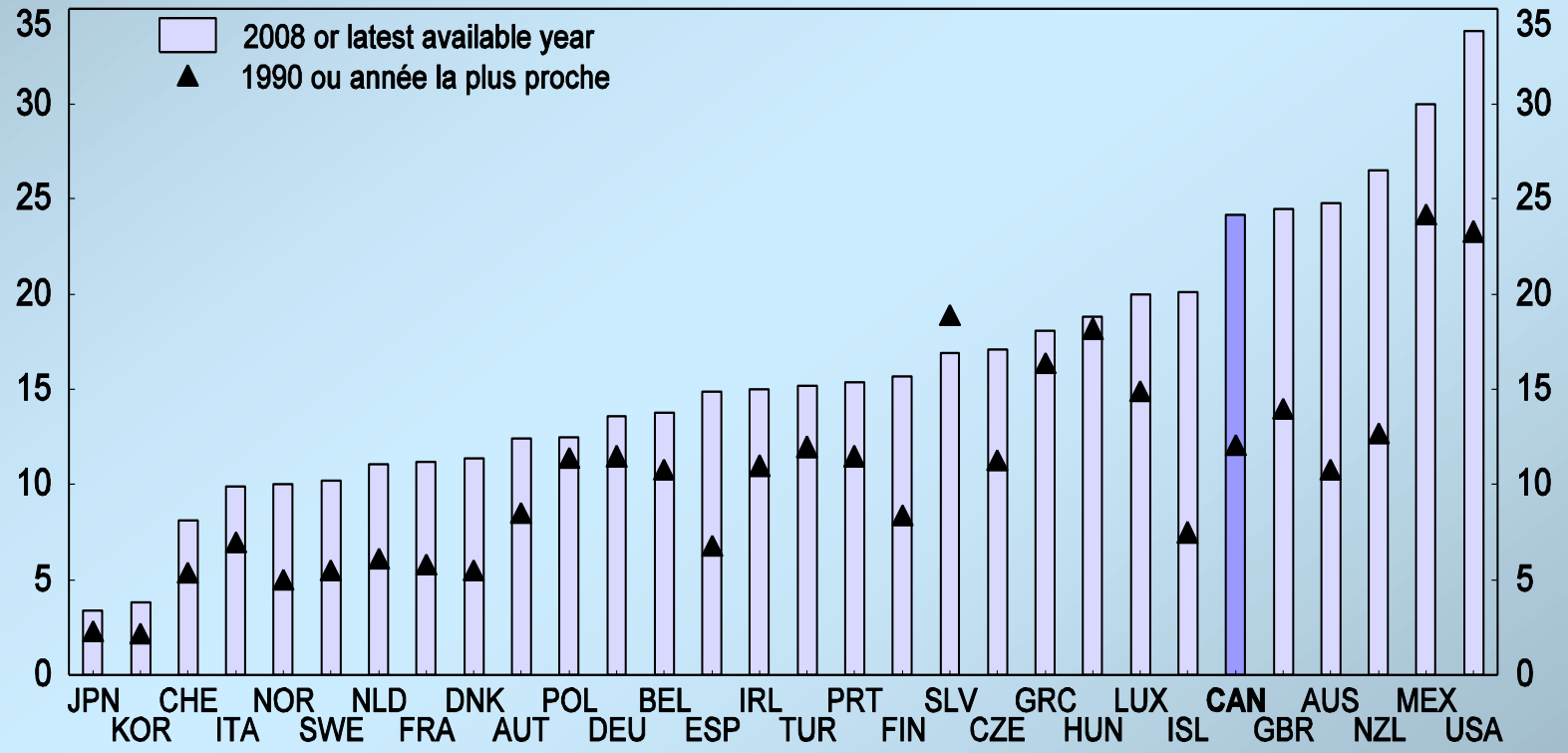
Income is the main driver

2008



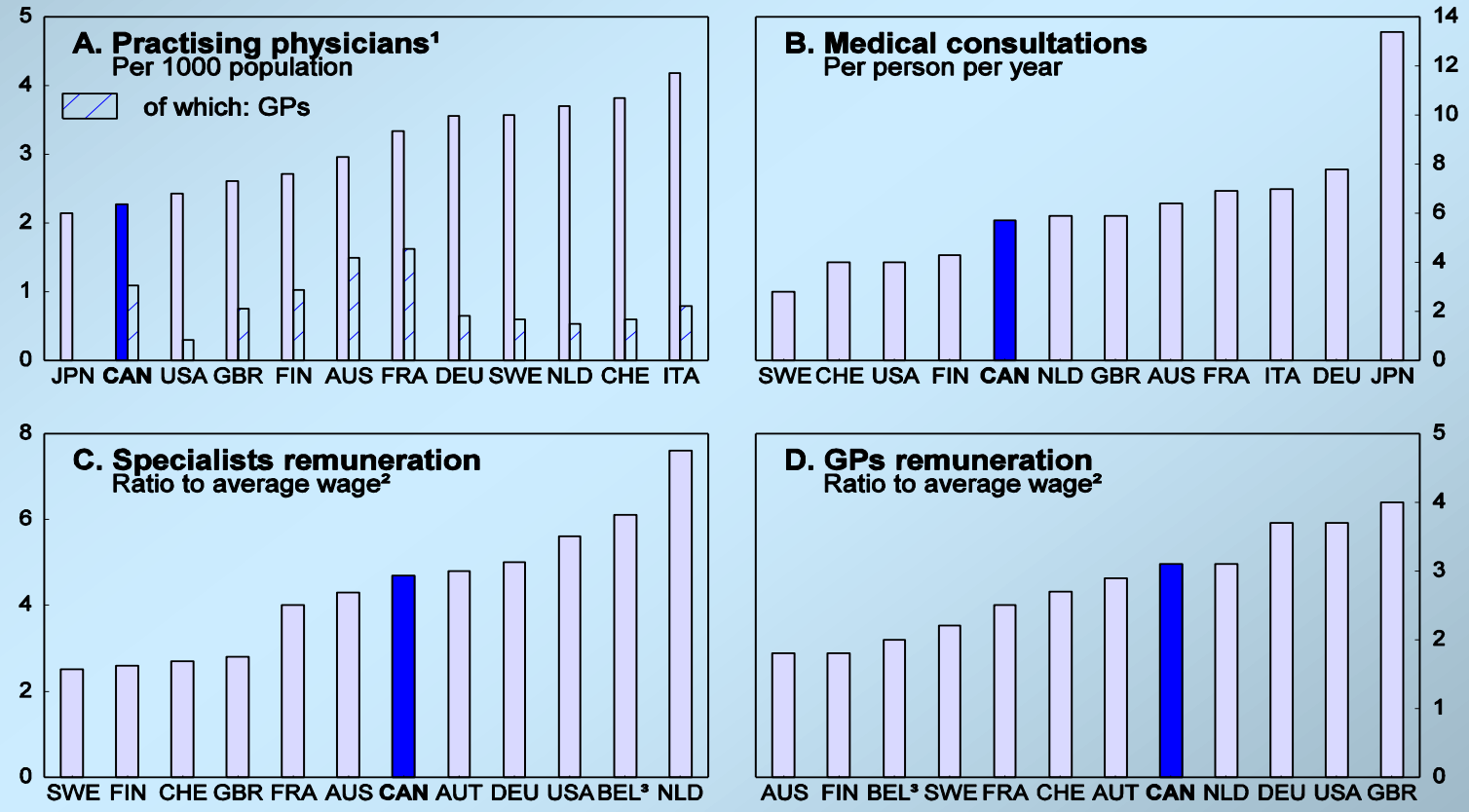
Obesity is a risk factor

Obese population as a percentage of total population



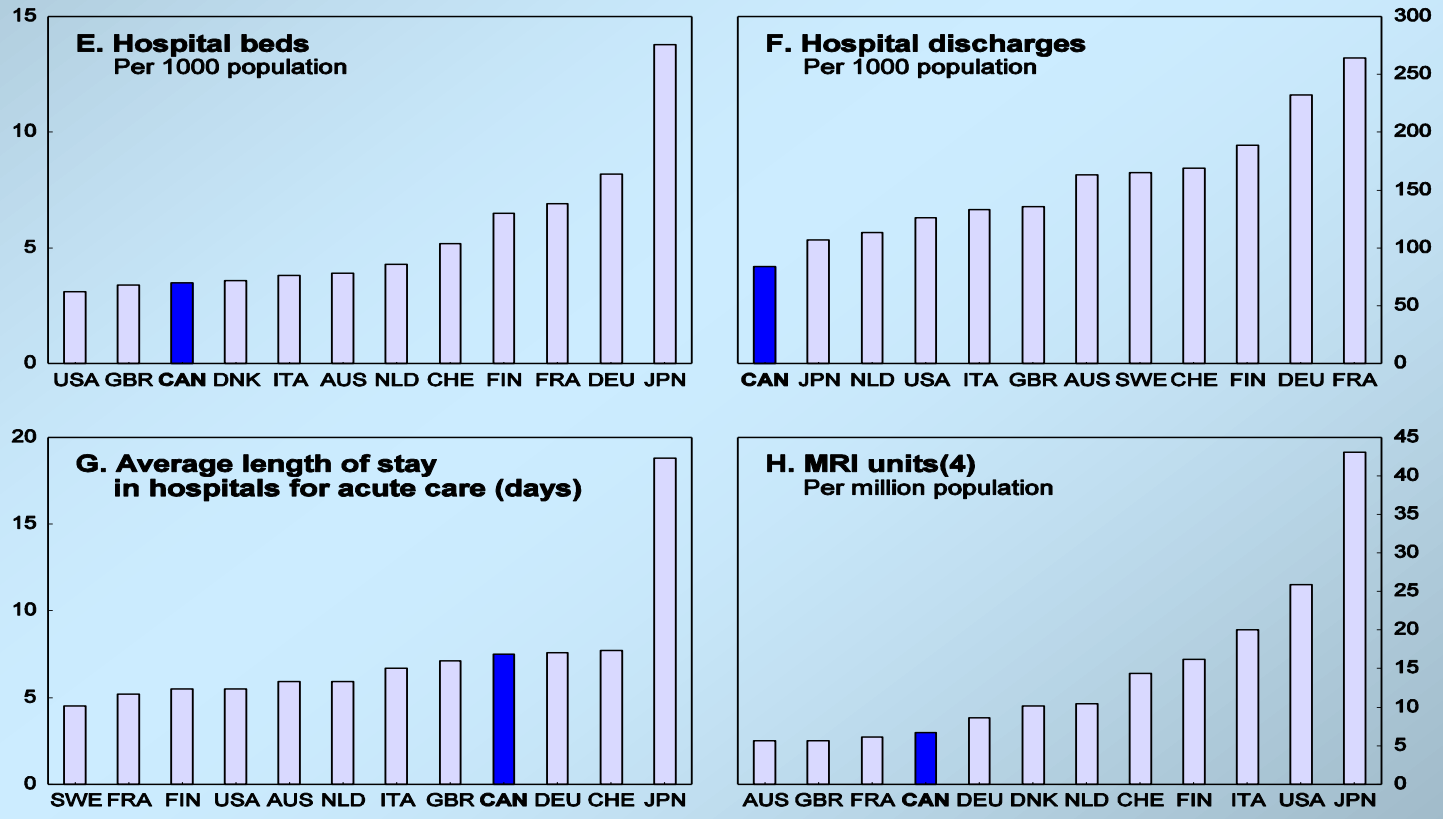
Canada imposes tight capacity constraints

Physicians, 2008



Canada imposes tight capacity constraints (cont.)

Hospitals, 2008



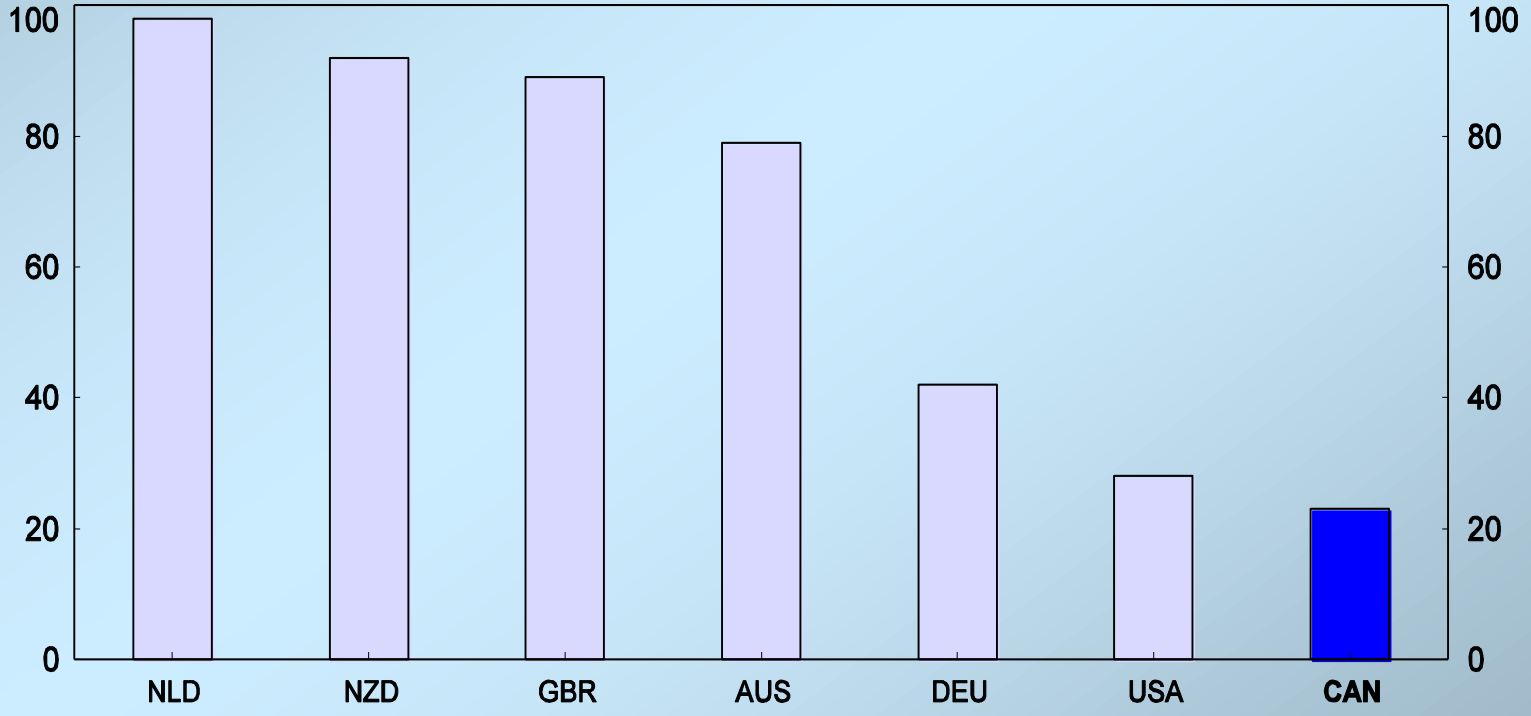
Canada's generic drug prices highest

Average foreign-to-Canadian drug price ratio, 2005

	Non-patented branded	Generic	Patented
Canada	**1.00**	**1.00**	**1.00**
Australia	0.81	0.85	0.78
Finland	0.75	0.49	0.88
France	0.76	0.71	0.85
Germany	0.91	0.84	0.96
Italy	0.73	0.76	0.75
Netherlands	0.72	0.80	0.85
New Zealand	0.64	0.23	0.79
Spain	0.59	0.58	0.73
Switzerland	1.34	0.99	1.09
United Kingdom	0.87	0.80	0.90
United States	2.46	0.65	1.69

Low ICT use in health care suggests missed opportunities

Percentage of primary care physicians using electronic medical records, 2006



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Quality indicators are mixed

Age-sex standardised rates, 2007

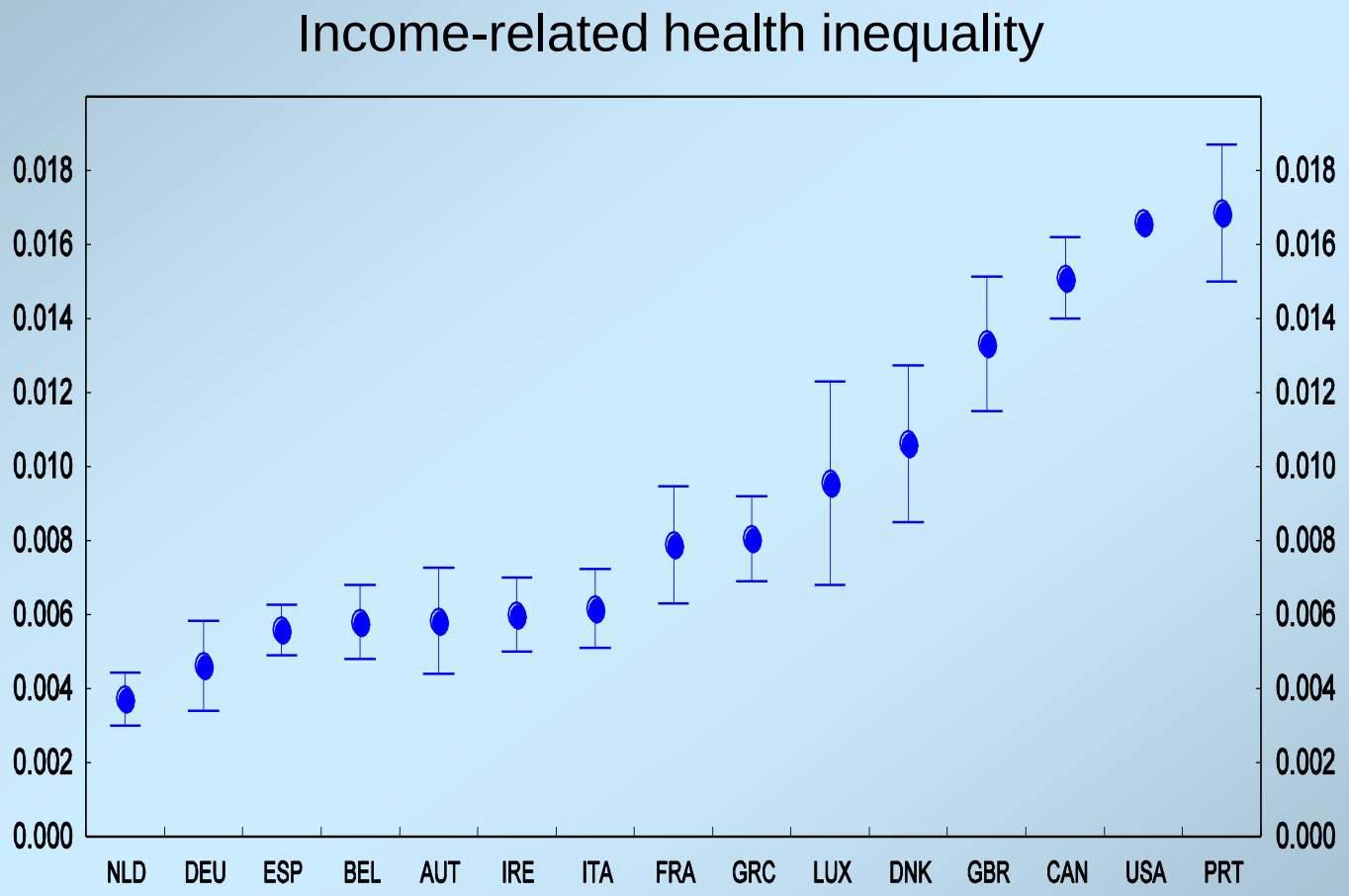
Indicator	Rank within OECD	Canadian data	Highest and lowest in sample (per cent)
Breast cancer 5-year survival rates (2002-07)	3 out of 16	87.1%	(90.5; 61.6)
Cervical cancer 5-year survival rates (2002-07)	2 out of 14	71.9%	(76.5;50.1)
Colorectal cancer 5-year survival rates (2000-05)	6 out of 16	60.7%	(67.3; 38.1)
In-hospital mortality rate within 30 days, stroke			
Hemorrhagic stroke	9 out of 19	23.2%	(30.3; 9.5)
Ischemic stroke	17 out of 19	7.6%	(9.0; 2.3)
In-hospital mortality rate, myocardial infarction	13 out of 19	4.2%	(8.1; 2.1)
Reduction in in-hospital case- fatality within 30 days after admission for stroke, 2002-07			
Hemorrhagic stroke	4 out of 13	5.5%	(0.5; 33.8)
Ischemic stroke	2 out of 13	1.6%	(0.4; 39.8)
Asthma admission rates (population aged 15 and over)	2 out of 22	18 per 100 000	(17;120)
Prevalence of diabetes (population aged 20-79, 2010)	20 out of 22	9.2%	(10.8; 1.6)
Amenable mortality	6 out of 19	76.8 per 100 000	–

Canada ranks poorly in patient satisfaction

The Commonwealth Fund Health Survey, 2010 update

	Netherlands	United Kingdom	Australia	Germany	New Zealand	Canada	United States
Overall ranking	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Quality care	2	3	4	5	1	**7**	6
Effective	3	1	2	6	5	**7**	4
Safe	1	2	6	3	4	**5**	7
Co-ordinated	2	3	4	7	1	**5**	6
Patient-centred	6	7	2	3	1	**5**	4
Access	1	2	6.5	3	4	**5**	6.5
Cost-related problem	2	1	6	3.5	5	**3.5**	7
Timeliness of care	1	4	6	2	3	**7**	5
Efficiency	3	1	2	5	4	**6**	7
Equity	1	2	4	3	6	**5**	7
Long healthy and productive lives	4	6	1	3	5	**2**	7
Health expenditure per capita, 2008	USD 4 063	USD 3 129	USD 3 353	USD 3 737	USD 2 683	**USD 4 079**	USD 7 538

Health still depends heavily on socio-economic status



Public burden set to grow

Public health and long-term care spending as a per cent of GDP

	2005	2050	
		Cost-pressure	Cost-containment
I. OECD cross-country projections			
Canada	**7.3**	**13.5**	**10.8**
France	8.1	13.4	10.8
Germany	8.8	14.3	11.8
Italy	6.6	13.2	10.7
Japan	6.9	13.4	10.9
United Kingdom	7.2	12.7	10.0
United States	7.2	12.4	9.7
OECD average	6.7	12.8	10.1
II. Canada: domestic projections			
Robson (2009)	7.5[1]	12	-
Lee (2007)	7.5[1]	12.5	8
Brimacombe *et al*. (2001)	2.2% annual growth in real per capita expenditure,1999-2020		
Di Matteo and Di Matteo (2009, Alberta)	1.9-6.1% annual growth in real per capita expenditure, 2007-30		
TD Economics (2010, Ontario)	6.5% annual growth in health expenditure, of which 2% real per capita, 2010-30		

Health care reform recommendations

Promote cost awareness and accountability

- Demand side price signals
  - Eliminate zero patient cost sharing for core services by imposing co-payments and deductibles, potentially adjusted for social benefit of the service.

- Supply side efficiency incentives
  - Devolve integrated, formula-based budgets for hospital, physician and pharmaceutical services to RHAs.
  - Introduce an element of capitation or salary for doctor payment with fees regulated by RHAs.
  - Move to activity-based (*e.g.* DRG) budgets for hospital funding.
  - Contract with private and public hospitals on an equal footing, *via* setting service prices.
  - Allow competition to drive generic drug prices to internationally comparable levels.

- Federal role
  - Base federal funding to provinces on rules and envision tax points in lieu of cash transfers.
  - Clarify the CHA to facilitate provincial experimentation with private entry of hospital services and mixed public/private physician contracts.
  - Impose value-for-money conditions on the CHT.

Health care reform recommendations (cont.)

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Promote access and choice

- A comprehensive and affordable core package:
  - As finances permit, include essential pharmaceuticals, home care and therapy services in a revised public core package.
  - Define the core package by use of marginal benefit/cost analysis, constrained by budget situation, with perhaps graduated co-payments (in lieu of delisting).

- A role for private health insurance (PHI):
  - Consider PHI for core services with consumer choice for risk/coverage mix.
  - Regulate PHI to prevent cream-skimming and adverse selection (cont. Europe).
  - Remove tax exemptions for employer PHI benefits, and tax supplemental PHI progressively.

Health care reform recommendations (cont.)

Promote quality and innovation

- Accelerate ICT applications in health care, starting small-scale if necessary.
- Encourage provinces to provide better health-system analysis and performance data, e.g. by federal conditioning of CHT.
- Charge a pan-Canadian, independent agency with monitoring and analysis of health-care quality, allowing benchmark competition.