Bending the Healthcare Cost Curve: The Fiscal Sustainability of Public Healthcare in Canada

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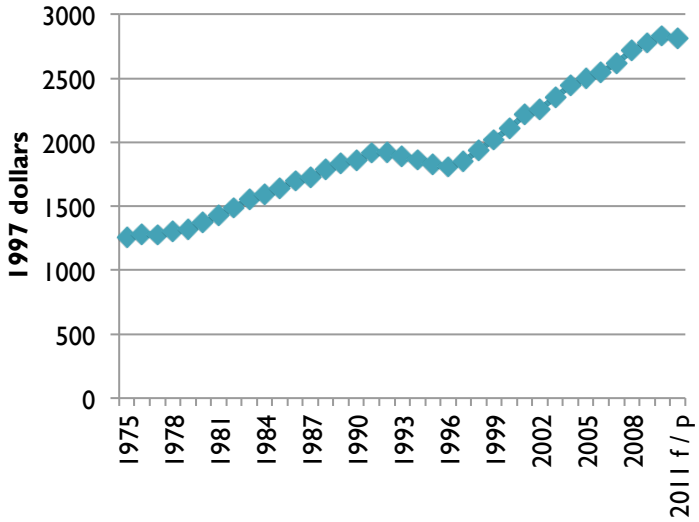
The Issues

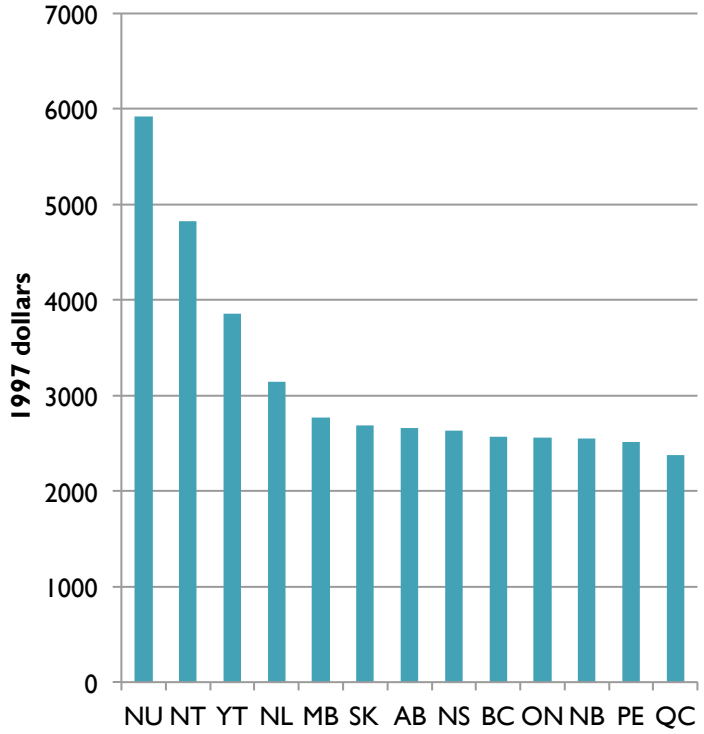
Real Per Capita Public Health Care Expenditures (1997 dollars), Canada, 1975-2011 (Source: CIHI)



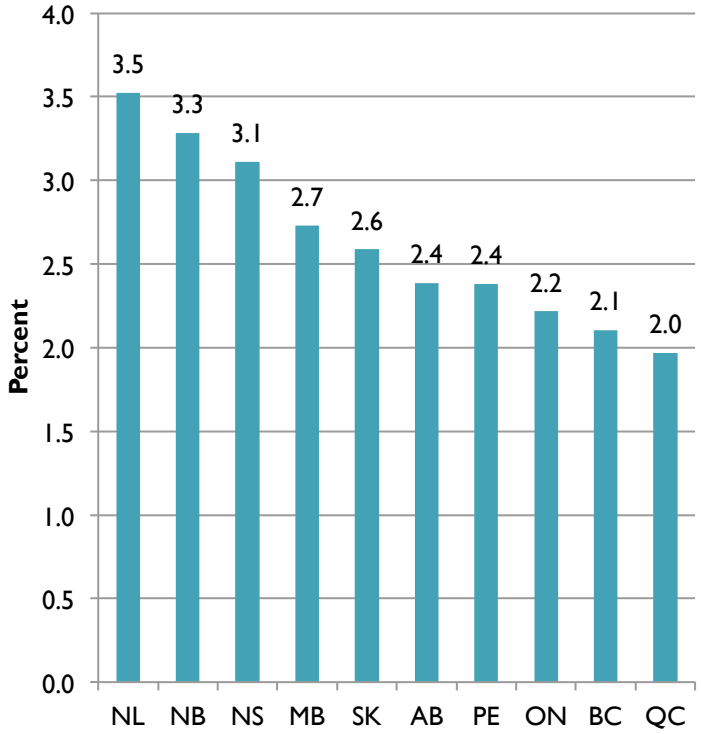
- Fiscal sustainability a persistent policy issue
- Public sector healthcare spending for 2011 is forecast by CIHI at 141 billion dollars (increase of 3.0 percent in 2011 and 6.0 percent in 2010).
- Since 1975, real per capita government health spending in Canada rose at an average annual rate of 2.3 per cent – faster than growth in real per capita GDP (1.3%) or government revenues (1.7%).

Some Historical Provincial Evidence

Ranked Real Per Capita Provincial/Territorial Government Health Spending, 2009 (1997 dollars, Data Source: CIHI)

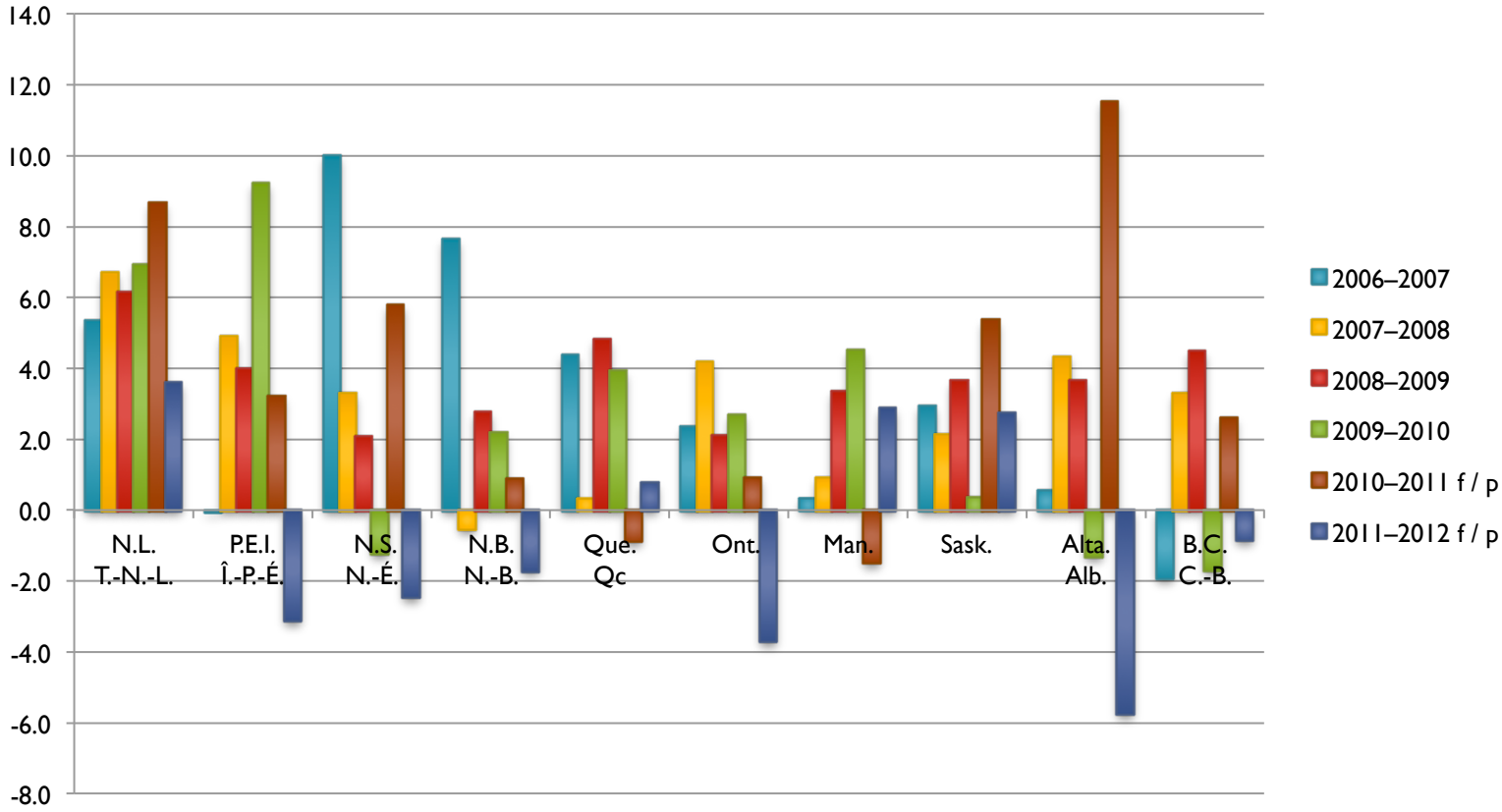


Average Annual Growth Rate of Real Per Capita Provincial Government Health Expenditure: 1975-2009



Some Evidence that Growth Rates are Moderating But Not Enough

Growth Rate of Real Per Capita Provincial Government Health Spending: 2006-2012 (Data Source: CIHI)



Defining Sustainability

- Sustainability of health seems to mean many things to many people:
  - Maintaining a quality healthcare system, fair access to healthcare, affordability
  - *Health spending cannot rise faster than resource base indefinitely.*
  - ***Fiscal sustainability* means having the money to pay for what you want to do both at present and in the future**

Measuring Fiscal Sustainability

- **General macro indicators of healthcare expenditures**
  - m1: Is government healthcare expenditure-to-total government expenditure ratio rising?
  - m2: Is government healthcare expenditure-to-GDP ratio rising?
- **Indicators of affordability:** ***compare healthcare expenditure real per capita growth rates (h) to resource base growth measures (r):***
  - r1: growth of real per capita provincial GDP
  - ***r2: growth of real per capita total provincial gov. revenues***
  - r3: growth of real per capita federal cash transfers
- **Indicators of healthcare spending unduly restricting the availability of funds for other government expenditures:** compare healthcare expenditure growth rates (h) to government expenditure growth measures (g):
  - g1: growth of real per capita provincial gov. total expenditures
  - g2: growth of real per capita provincial gov. program expenditures
  - g3: growth of real per capita provincial program expenditures net of health

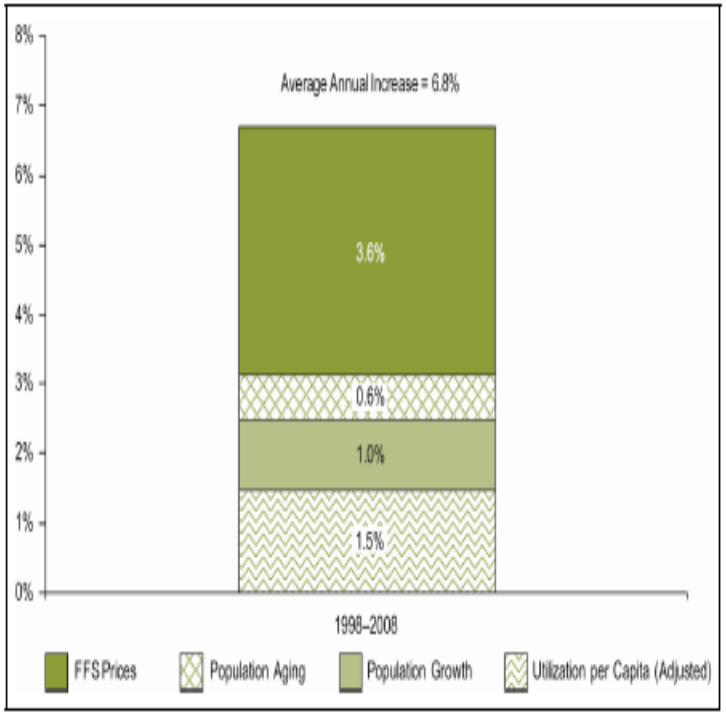
If h>r and h>g, there is a ***potential sustainability problem***.

CIHI Health Care Cost Drivers: The Facts (2011)

- ***At 7.4 percent annual growth, period from 1998 to 2008 saw public-sector health spending grow at more than double the rate of revenue growth.***
- Growth Contributors:
  - Population 1%
  - Population Aging 0.8%
  - General Inflation 2.8%
  - Other 2.8%
    - Technology, service utilization, health sector specific inflation (eg. labour costs).

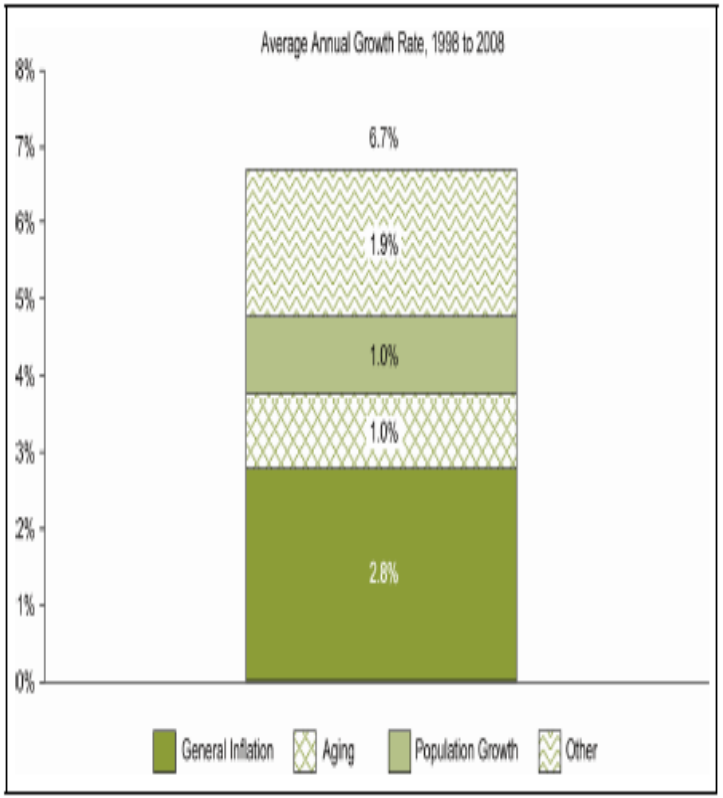
Breakdown for Hospitals & Physicians *(CIHI Health Care Cost Drivers: The Facts)*

Figure 15: Cost Driver Contributions to Physician Expenditure, 1998 to 2008



Note
FFS: fee-for service.
Source
National Physician Database, Canadian Institute for Health Information.

Figure 16: Cost Driver Contributions to Hospital Expenditures, 1998 to 2008



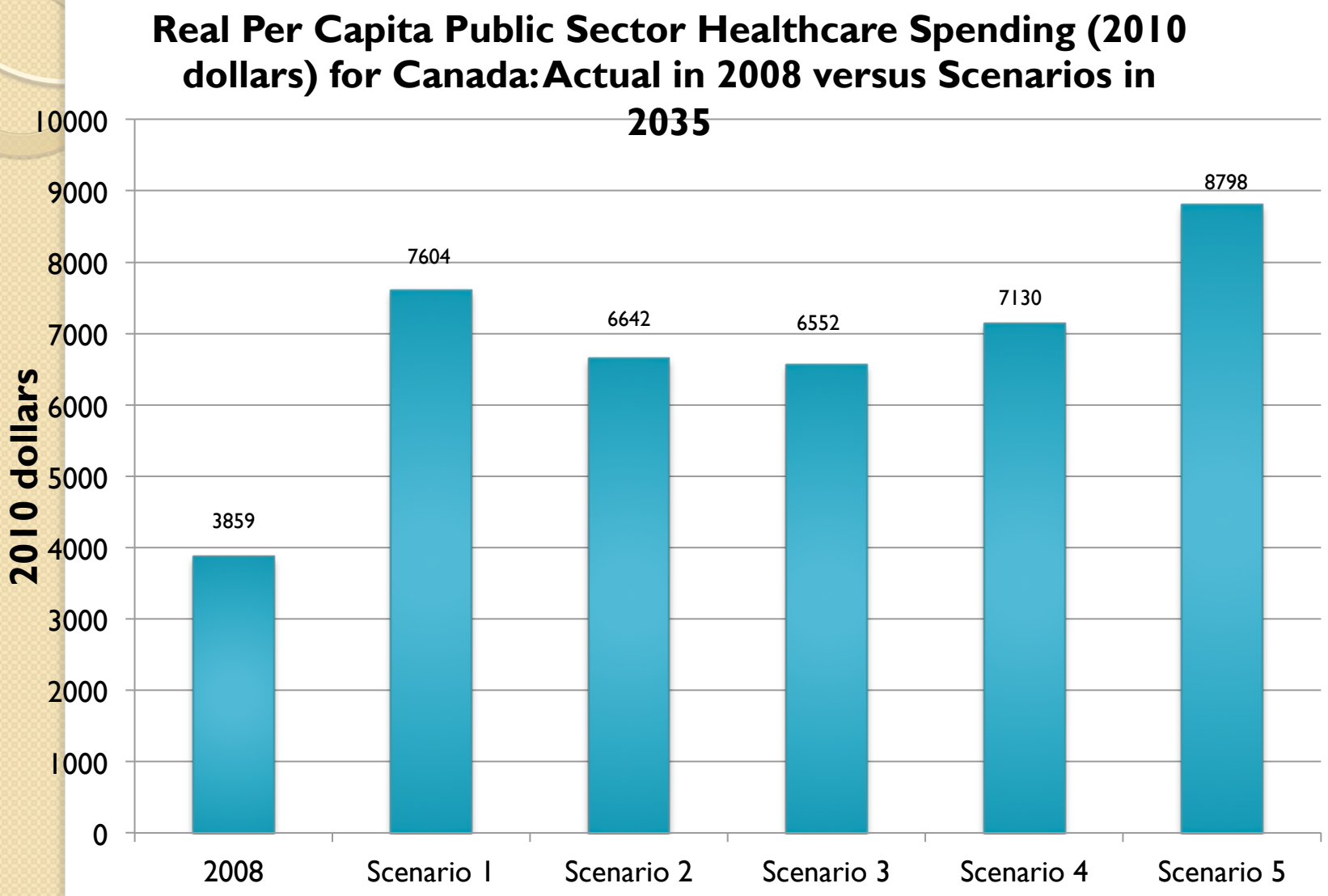
Source
National Health Expenditure Database, Canadian Institute for Health Information.

What Might the Future Look Like?

Five expenditure scenarios for real per capita public healthcare spending constructed.

- Using a regression-based approach:
  - Scenario 1: business as usual,
  - Scenario 2: low economic growth,
  - Scenario 3: rapid aging and low economic growth,
- Using simple growth-extrapolation approach
  - Scenario 4: healthcare spending assumes to grow at the average annual rate of the 1975-2008 period
  - Scenario 5: healthcare spending continues to grow at the high rates of the 1996-2008 period
- Forecast estimates for Canada as a whole, each of the ten provinces and the territories to 2035.

Canada *(Source: Di Matteo & Di Matteo 2012)*



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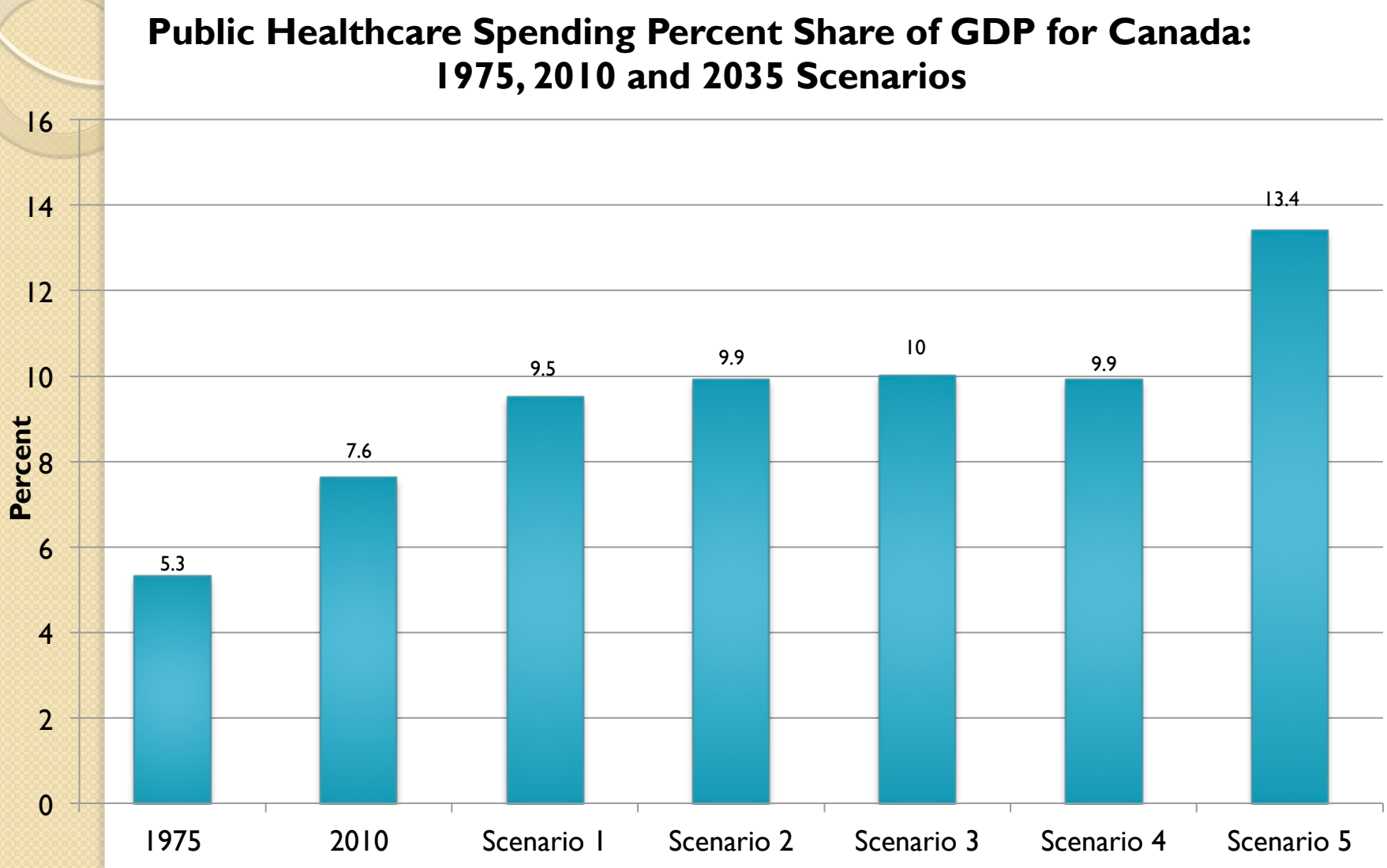

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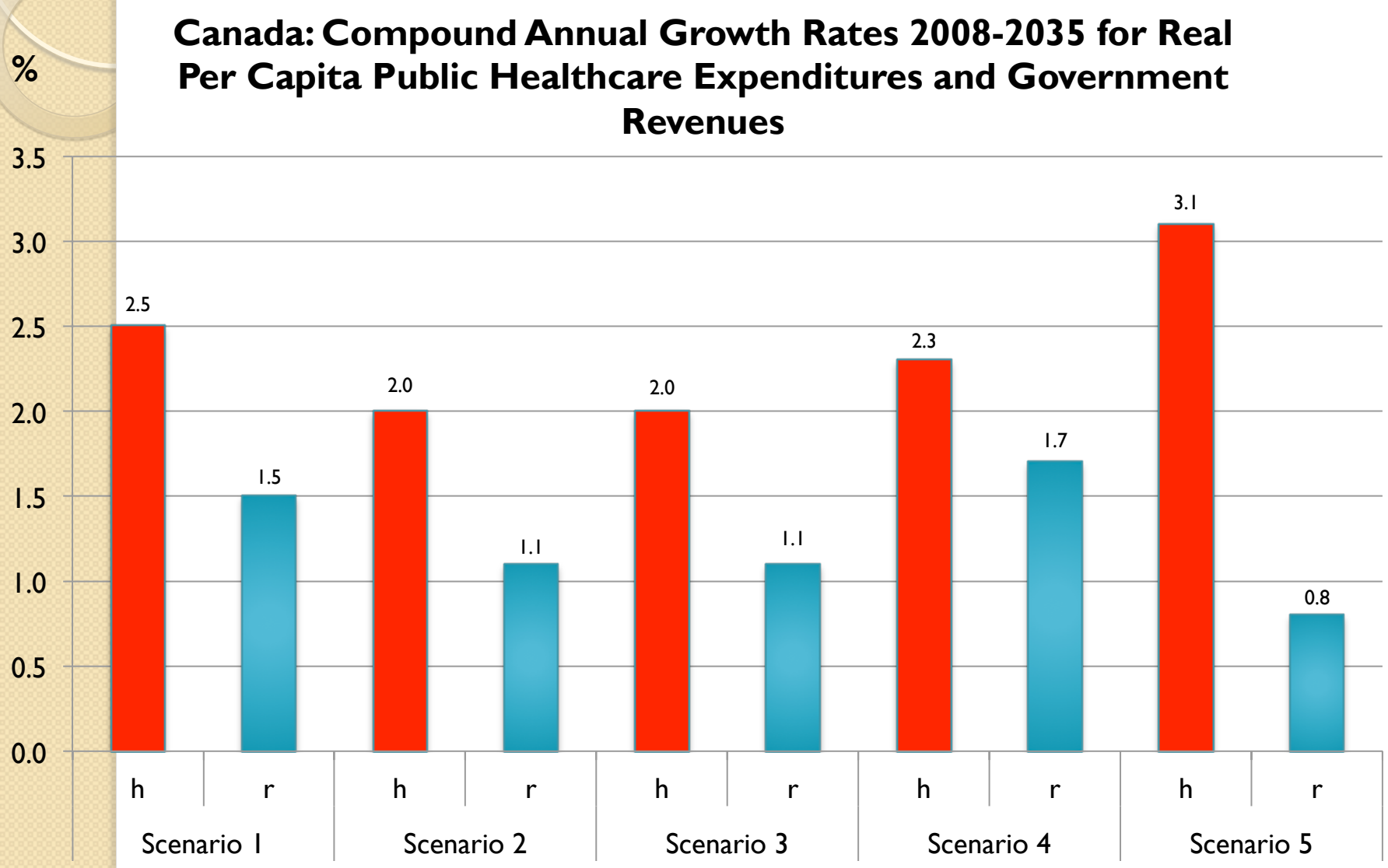
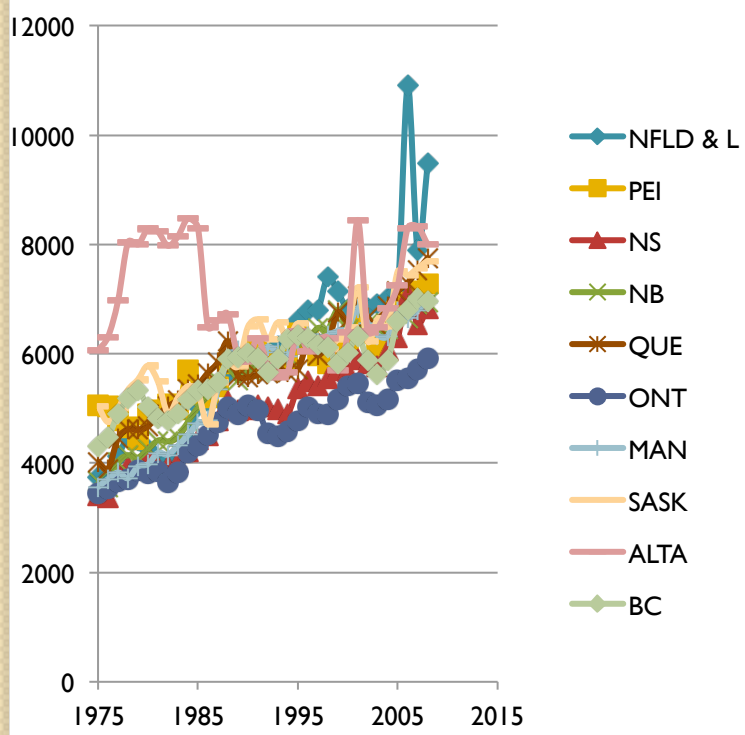


Broad Solutions for Fiscally Sustainable Public Sector Healthcare

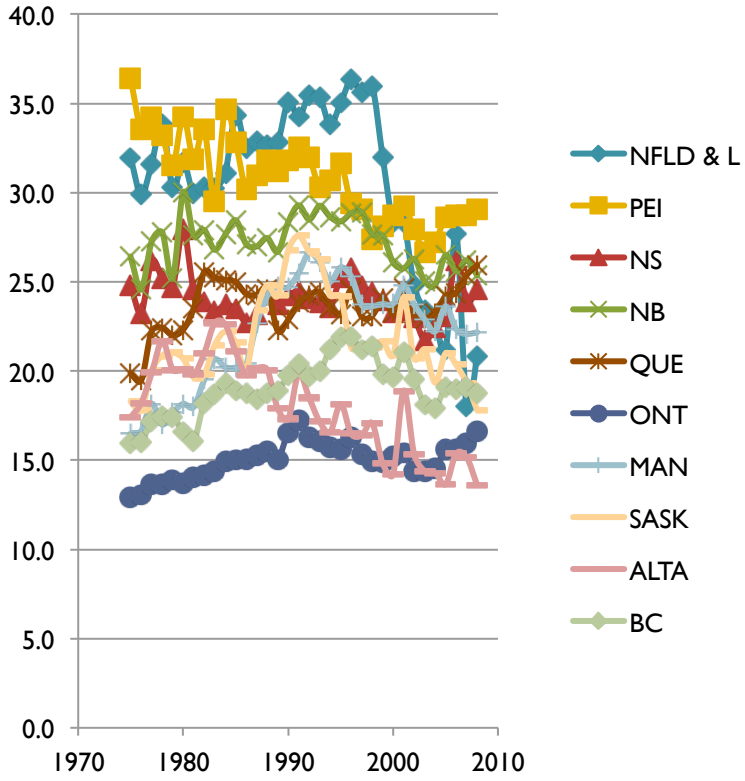
- Increase growth rate of revenues – resource enhancement
- Reduce growth rate of expenditures – bending the cost curve
- Or, a combination of both

Is It Simply A Revenue Problem?

Real Per Capita Provincial Government Revenue(1997$)



Provincial Revenue to GDP (%)



Increasing Resources

- Fiscal dividend era is over.
- How much are people willing to pay?
- How much room for revenue increases?
- Value for money?

Reducing Expenditure Growth: Sword or Scalpel?

- ***Sword*** approach: across the board cuts with health care providers and institutions left to absorb the blow and deal with the shortfalls as best they can.
- ***Scalpel*** approach: targeted reductions with reforms and efficiencies in service delivery and financing (eg. shifting more physicians from FFS to salaries, providing hospitals with payments tied to bundles of services and outcomes rather than global budgets, and shifting care to team based approaches and home care).

Ideal World

- The scalpel approach is what we want. Indeed, the holy grail of fiscal sustainability for public health care is reforms that bend the cost curve down and improve both the quantity and quality of health care via *transformative change*.

Challenges to Transformative Change

- First, there is the *inertia* and established ways of doing things in the current system along with the *entrenched interests* of both current health providers and health care recipients. Change is often uncomfortable, even if it is for the better.
- Second, there are the *transactions and coordination costs* of reform. For example, implementing electronic information systems and establishing team practices take time and money. Despite the inherent optimism of advocates of transformative change, broad based transformative change of the entire health care system may simply bite off more than you can chew.
- Third, to implement change, *persistence and discipline* are needed on the part of governments and those qualities are not always compatible with the politics of governing.

New Dynamic of Transformative Change: No Longer Spend Money to Save Money

- Given the deficit situation there will not be a lot of new money to buy change.
- In the wake of the economic slowdown and deficit situation, successful bending of the health expenditure curve now requires spending less to buy change.
- Some of the savings from the spending reductions can be applied to selective initiatives for transformative change with incentives for implementation – but the transformation will be at the margins and incremental rather than broad based.

Governments Will Need to Make Choices

- Examples:
  - Promote healthy lifestyles or implement tele-health.
  - Adopt new information management technologies or modify physician compensation approaches.
  - Move hospitals to bundled outcome payments or provide team based approaches to primary care or reform drug plans.

Concluding Thought: Select Your Target(s)

- Tackling all these changes at once will be a case of too many targets and not enough instruments. The result will be a failure that we cannot afford.
- Priorities will need to be set with evidence-based decisions – health data.