



Finding Canada's Healthcare Equilibrium: Lessons from Austria

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A Preface



What is the correlation between your
healthcare system and your health?

The debate about healthcare is not about your health but about jobs, privileges, ideologies, politics, power and money.

Equilibrium: demand equals supply.

Demographics
Technology
Providers
Entitlement
Wealth
Social Norms

Demand

Supply



Financing

Healthcare System Funding



1. European (common):

80-90% public; 10-20% private

2. Canadian (unique):

70% public; 30% private (vertical split)

3. American (unique):

50% public (Medicare, Medicaid, S-CHIP, VA); 50% private

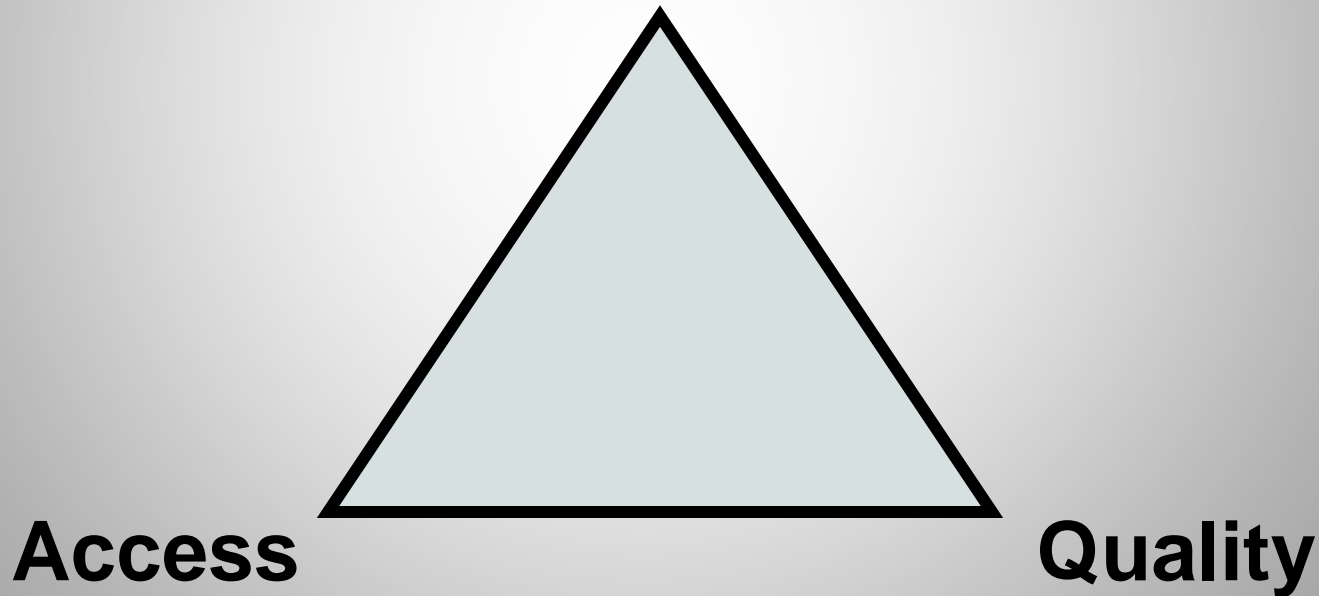
4. Developing countries (common):

10-20% public; 80-90% private

The one truth – public or private

The Iron Triangle

Cost Containment



2009	\$182 B	↑	5.8%	(2 X CPI)
2010	\$192 B	↑	5.5%	(2 X CPI)
2011	\$201 B	↑	4.7%	(2 X CPI)



11.6% of GDP – 8% public

vs. U.S. 18% - 9% public; U.K. 8.4% - 8% public

10.5% of labour force

\$6090 per capita (\$1600 in 1975)

29.1%	hospitals
16.2%	drugs
13.6%	physicians
6.3%	dental
6.3%	public health

1968 median age	21
2008 median age	42

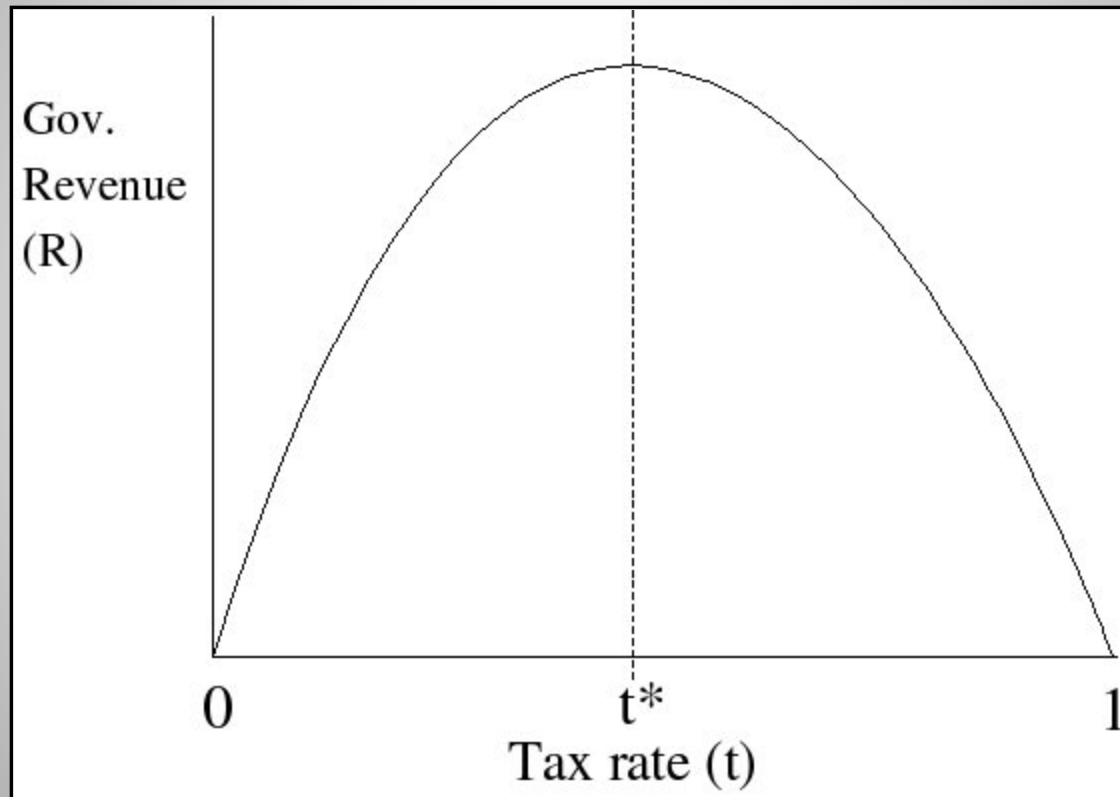
- # 2 Standard of Living
- # 5 total healthcare as % of GDP
- # 8 Human Development Index



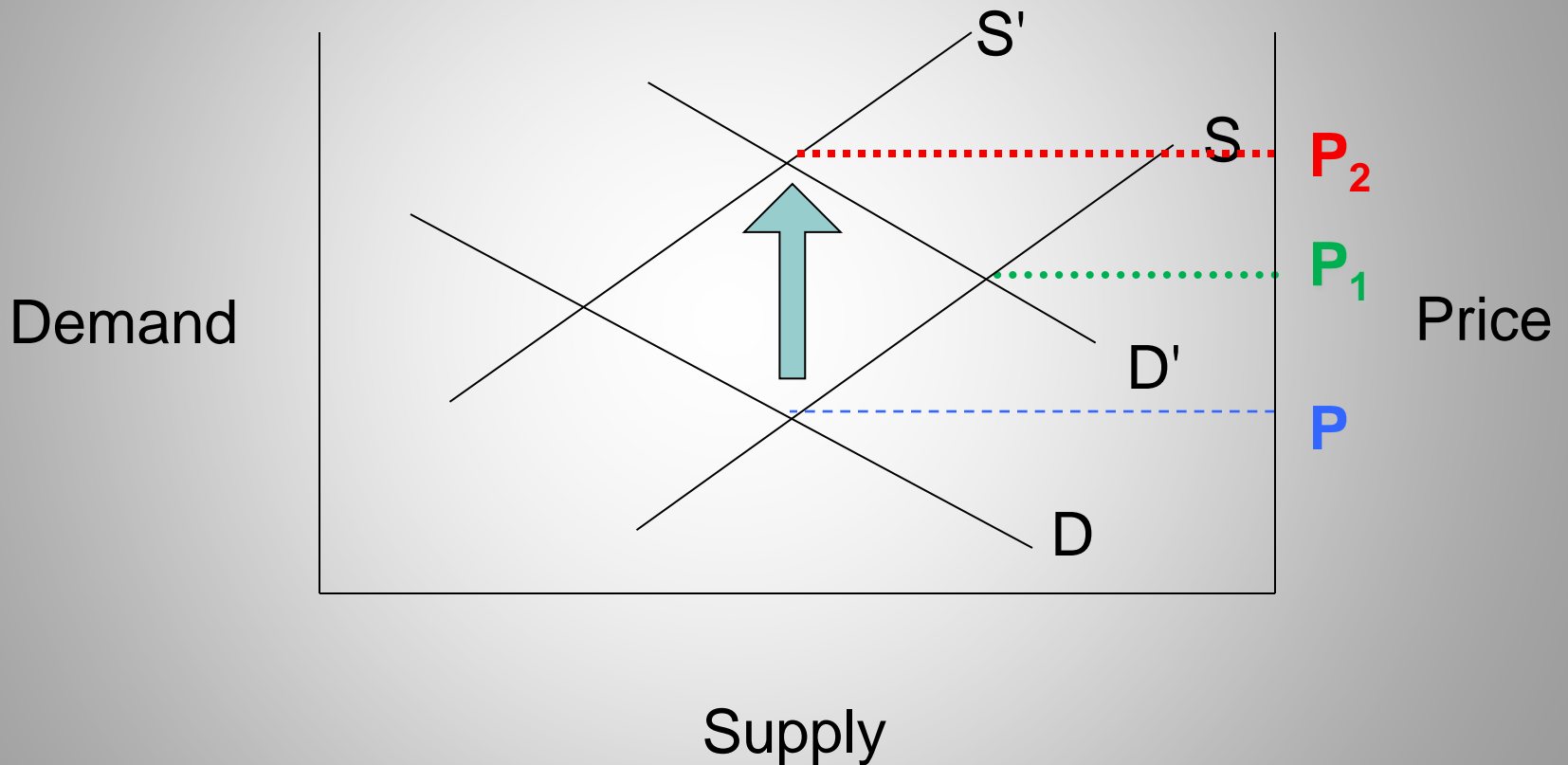
BUT...

- # 11 re healthcare IT innovation (Conference Board of Canada, 2007)
- # 16 re healthy life expectancy (age 72 when chronic disease strikes)
- # 20 re health technology (80% dependent on government financing)
- # 30/30 re Health Care “Effectiveness” or “value-for-money” (WHO 2001; FCPP 2008)
- # 56 re military
- # 88 re soccer (football)
- ~ # 110 re access to new drugs

“Inconvenient” truth #1 - Laffer



“Inconvenient” truth #2 – the double cost whammy



“Inconvenient” truth #3 - Canada’s Aging Population



- Today, Canadians over 65 : 13% of population
 - **2041: 25%**
- Canadians over 65 consume 50% of healthcare expenditures
- 75% of deaths occur in hospitals or long-term care facilities
- The majority of healthcare professionals will retire within next 20 years.

“Inconvenient” truth #4 - Dependency Ratio (aged 0-14 and 65+ as % of working-age population)

	<u>1990</u>	<u>2026</u>
Canada	47% (1:1)	68% (2:1)
OECD	52%	62%
Taxes	48%	85%



So what do we know and
what can we learn from Austria?





Why Austria?

- Well, it's not Estonia (1/30 re effectiveness)
- Identical spend in 2008: 10.1% of GDP
- Austria was 2/30 to Canada's 30/30
- Wait times are Canada's shame
 - Proxy for disequilibrium
 - Add capacity OR reallocate resources

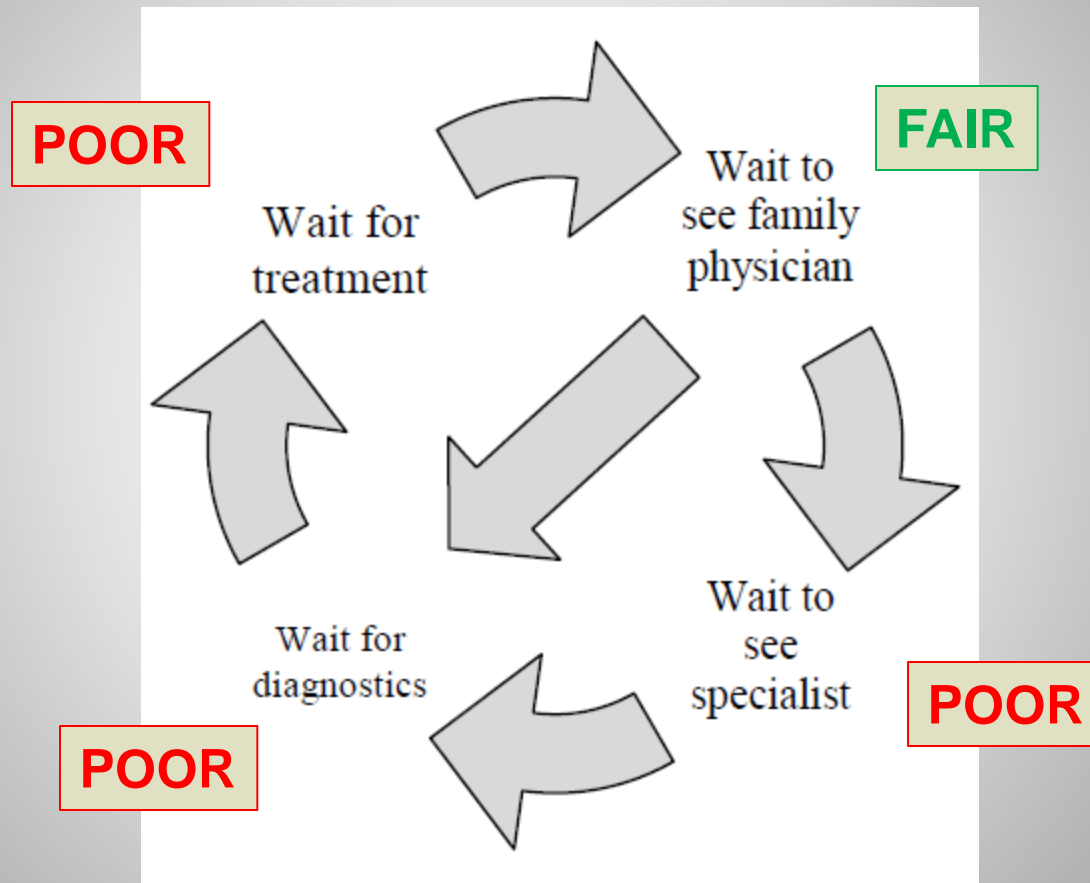


Euro-Canada Health Consumer Index 2008

- Waiting times are the weakest spot in Canada
- **Canada tied LAST** with Ireland and Sweden
(Belgium #1, Germany #2, Switzerland #3, **Austria #4**)



4 Bottlenecks in waiting



Remember the 2008 Ontario Budget?

- Wait times are down!

	<u>2005(days)</u>	<u>2007</u>	<u>% Δ</u>	<u>Target</u>
● Cataract surgeries	313	122	61%↓	80
● Angiography	55	29	47% ↓	15
● Knee arthroplasty	436	240	45% ↓	130
● CT Scans	80	48	40% ↓	15
● Hip arthroplasty	349	220	37% ↓	130
● Cancer surgeries	80	68	15% ↓	20
● MRI scans	117	110	6% ↓	15
● Paediatric surgeries	280	266	5% ↓	-

So What?

- In Michigan, most health systems *guarantee a 72 hour* turnaround for MRI scans!
- *Readmissions* post arthroplasty surgery are way up
 - *2,000 additional* deaths due to DVT/PE!*
- Canadian governments attempt to bring the tails of the bell curve closer to the mean, for the sake of conformity, equity

AND...

- When you finally are tested, Canadians experience the **highest error rate** amongst diagnostic tests:^{*}
 - Australia 11%
 - **Canada 12%**
 - Germany 4%
 - Netherlands 8%
 - New Zealand 9%
 - United Kingdom 10%

^{*}The Commonwealth Fund 2007 International Health Policy Survey







So I asked the Austrians...



- When teaching a group of Austrian and German physicians pursuing their International MBAs what the wait time for a **non-emergent MRI** would be in their respective countries, they responded:
 - 1 day for publicly insured patients
 - no wait for privately insured patients



Then pulled the data...and wrote the article (HCMF, Summer 2012)



- WHO, *The World Health Report 2000*, 2001
- Health Consumer Powerhouse/Frontier Centre for Public Policy, *Euro-Canada Health Consumer Index*, 2008
- *The Rx&D International Report on Access To Medicines*, 2008-2009
- OECD, *Health Data*, 2009
- CIHI, *National Health Expenditure Trends*, 1975-2011
- Fraser Institute, *Value for Money from Health Insurance Systems in Canada and the OECD*, 2012 Edition



2008		 Canada	 Austria
<u>Financing</u>	% GDP on health	10.1%	10.1%
	Annual % increase in spending 1997-2007	3.8%	2.6%
	% public financing	70%	77%
	Value-for-money	30/30	2/30
<div data-bbox="142 1125 289 1239" style="border: 1px solid black; padding: 2px;"> Value For money </div>	Cost-sharing for MD and hospital services	No	Yes



2008		 Canada	 Austria
<u>Life expectancy</u>	Life expectancy	80	80
<div data-bbox="175 711 320 822" style="border: 1px solid black; padding: 2px;"> Value For money </div>	Healthy life expectancy	72	72

2008		 Canada	 Austria
<u>Correlates of health</u>	Smoking prevalence	17%	25%
	Obesity prevalence	22%	14%
<div data-bbox="160 872 305 981" style="border: 1px solid black; padding: 2px;"> Value For money </div>	Drunk 2+ times before 15 years old	36%	39%

2008		 Canada	 Austria
<u>Health human resources</u>	Clinically active MDs/1000 population	2.1	4.6
	Registered nurses/1000 population	10.3	7.5
<div data-bbox="175 996 322 1103" style="border: 1px solid black; padding: 2px;"> Value For money </div>	Average MD income (USD)	\$140,000	\$95,000

2008		 Canada	 Austria
<u>Hospitals</u>	Number of hospitals	695	267
	Number of hospitals/1 million population	21	32
	Average hospital size (# of beds)	155	240
	Number of hospital beds/1 million pop.	3270	8000
	Average length-of-stay (acute)	5.9	7.9
	Average length-of-stay (normal delivery)	1.8	4.3
<div data-bbox="175 1158 320 1268" style="border: 1px solid black; padding: 2px;"> Value For money </div>	% Hospital budgets spent on IT	1.7%	5.9%

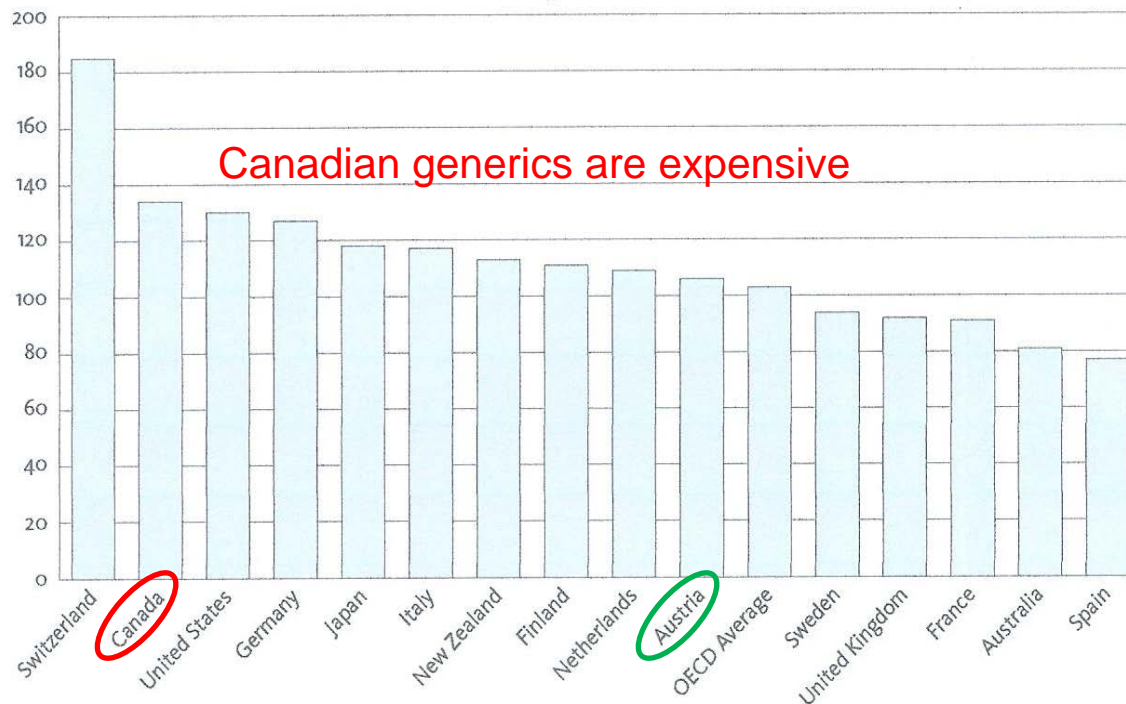
2008		 Canada	 Austria
<u>Access</u>	MRI units/million population	6.7	17.7
	CT scanners/million pop.	12.7	29.8
	Lithotripters (hospital)/million pop.	0.5	3.0
	Lithotripters (ambulatory)/million pop.	0	1
	New drug approval wait time (years)	1.5	1.0
<div data-bbox="193 1156 338 1269" style="border: 1px solid black; padding: 2px;"> Value For money </div>	% New drugs publicly reimbursed	<25%	~90%

2008		 Canada	 Austria
<u>Wait times</u>	% patients wait in ED wait >2 hours	46%	11%
	% patients wait to see family MD >6 days	30%	20%
<div data-bbox="158 901 305 1016" style="border: 1px solid black; padding: 2px;"> Value For money </div>	% patients wait for elective surgery >6 months	14%	<1%

National Pharmacare for Canada?

FIGURE A Detail prices for the same volume of medicines in OECD countries, 2005
(US\$, Market exchange rate, including branded and generics)

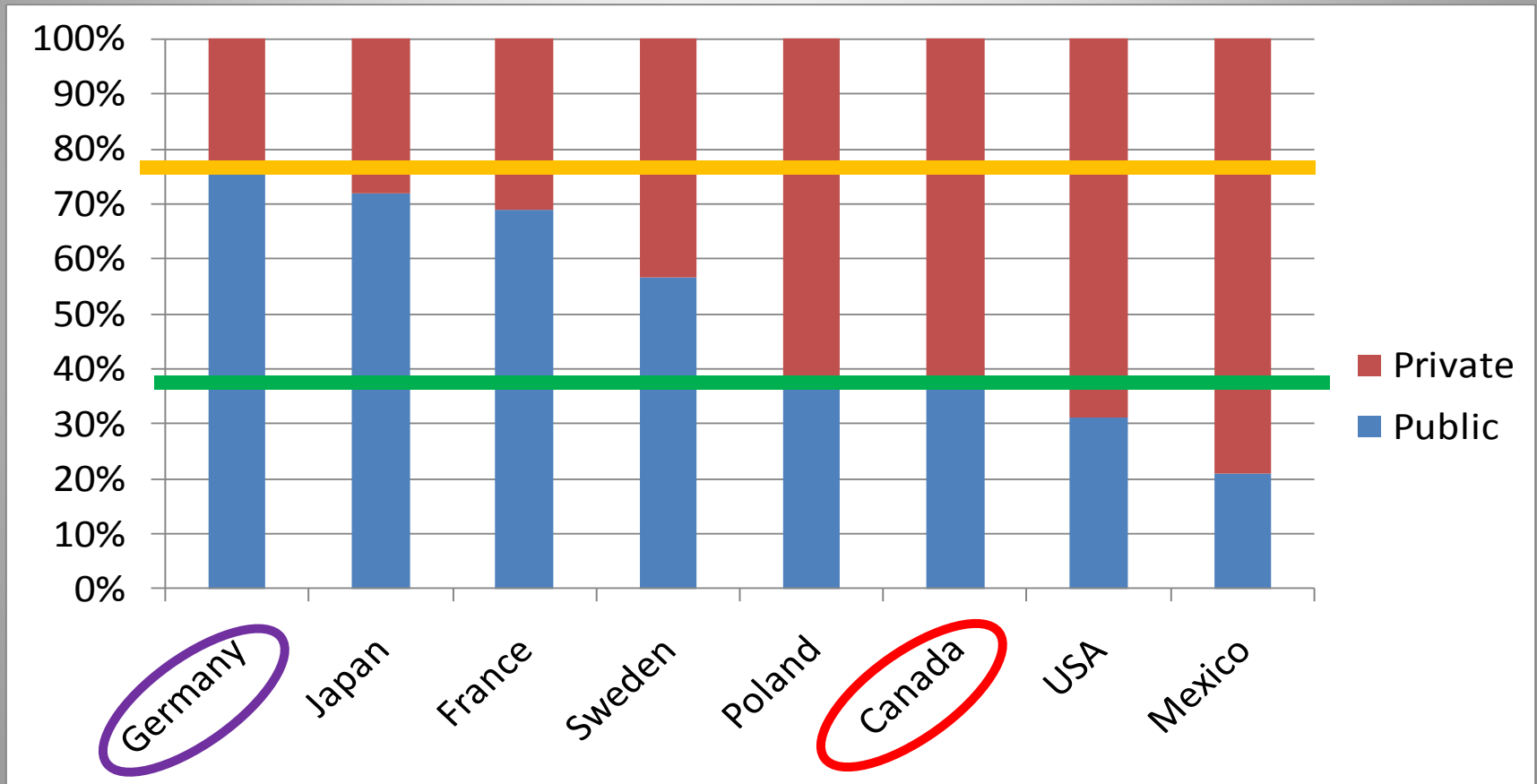
Detail Prices = Ex-manufacturer price + wholesaler markup + pharmacy markup + Prescription fees + tax



SOURCE OECD 2008 - Eurostat OECD PPP Program, 2007

- innovative and generic drugs “combined” therefore disguise costs of each
- no consideration of “differential pricing” by drug innovators because not yet commoditized
- disregards “vintage” of drug

Government spend on all drugs

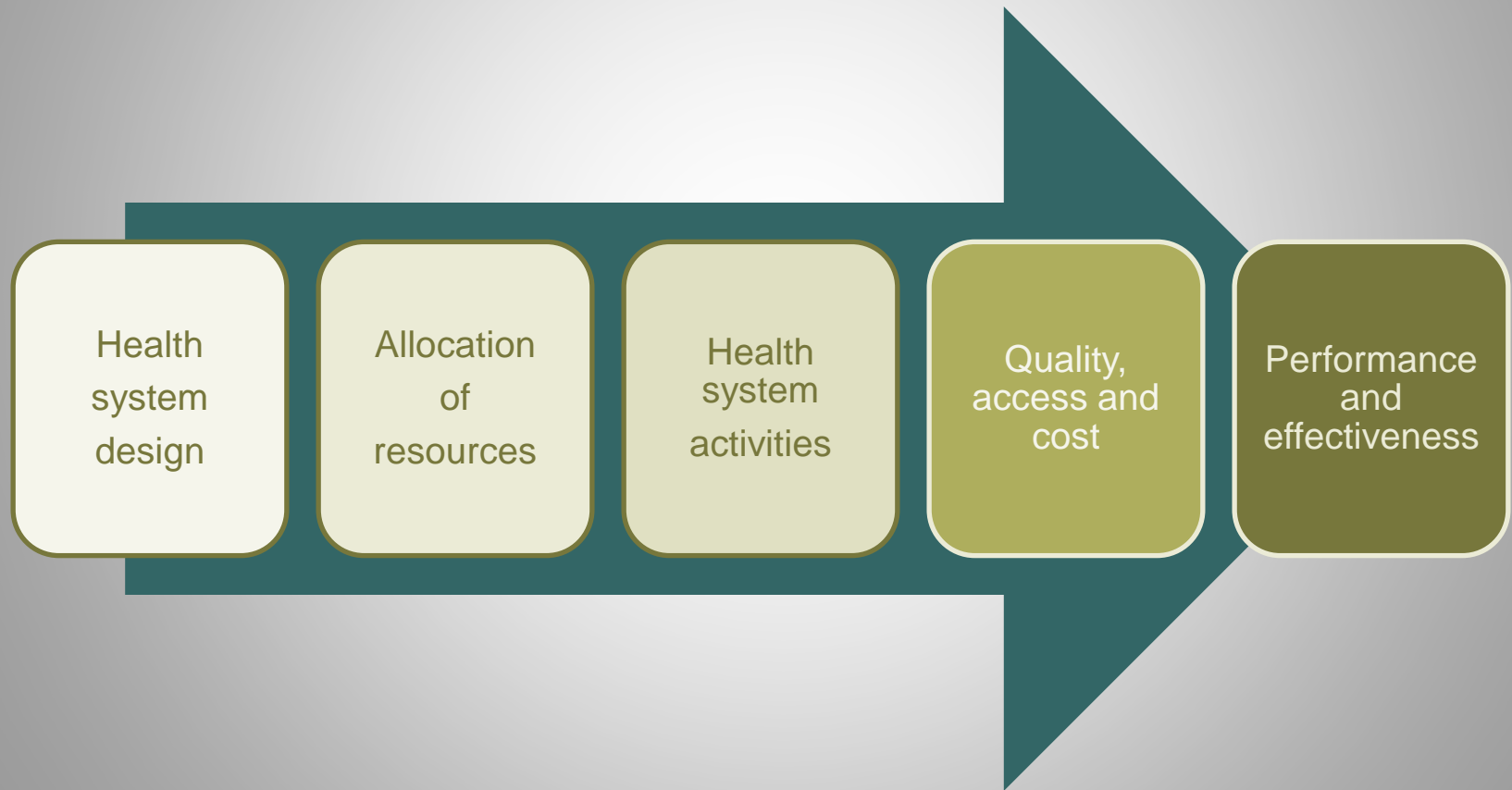




3 Key Learnings

- I. Austria has **better performance** and same health status for **less money**, so more money is not the answer
- II. **Cost containment**, as an over-arching strategy, does not yield better performance or value for money results
- III. System **design** drives results

To be the best
we must learn from the best



But the answer is to always rotate the tires

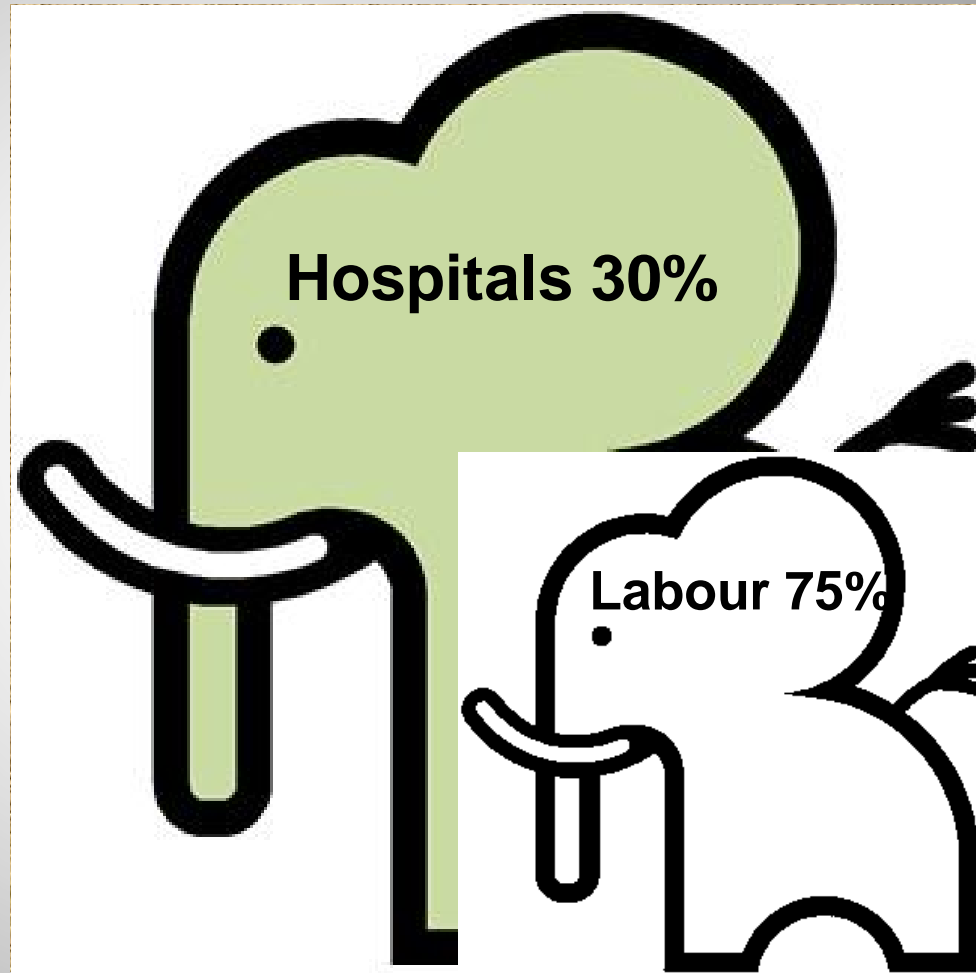




5 Design changes *cont'd*

1. Canada got the “split” wrong – **cost-sharing** (co-payments) for MD and hospital services drive efficiency AND many uninsured services **should be** publicly funded as core (dental, vision, chiropractic, drugs, homecare)
2. We **overpay** MDs, RNs and administrators because there is no comparator or free labour market

Elephant within an elephant in the room





5 Design changes *cont'd*

3. Adopt an **investment not cash flow** mentality e.g. newest drugs are most cost-effective over a life cycle
4. **Disease management** works for those at highest risk of non-communicable diseases and with co-morbidities
5. **Private-pay, parallel** health insurance and delivery system as a pressure valve



Thank-you