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.
Demand

Supply

Financing

Demographics
Technology
Providers
Entitlement
Wealth
Social Norms

Access
Cost
Quality
Demand
Supply
Financing
Demographics
Technology
Providers
Entitlement
Wealth
Social Norms

Budgets
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

Access  Quality
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)

<table>
<thead>
<tr>
<th></th>
<th>1990</th>
<th>2026</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canada</td>
<td>47%  (1:1)</td>
<td>68%  (2:1)</td>
</tr>
<tr>
<td>OECD</td>
<td>52%</td>
<td>62%</td>
</tr>
<tr>
<td>Taxes</td>
<td>48%</td>
<td>85%</td>
</tr>
</tbody>
</table>
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
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

- Wait for treatment
- Wait for diagnostics
- Wait to see specialist
- Wait to see family physician

Status:
- Poor
- Fair
- Poor
- Poor
Remember the 2008 Ontario Budget?

- Wait times are down!

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

- *The Rx&D International Report on Access To Medicines, 2008-2009*
- OECD, *Health Data*, 2009
- Fraser Institute, *Value for Money from Health Insurance Systems in Canada and the OECD, 2012 Edition*
<table>
<thead>
<tr>
<th>2008</th>
<th>Canada</th>
<th>Austria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% GDP on health</td>
<td>10.1%</td>
<td>10.1%</td>
</tr>
<tr>
<td>Annual % increase in spending 1997-2007</td>
<td>3.8%</td>
<td>2.6%</td>
</tr>
<tr>
<td>% public financing</td>
<td>70%</td>
<td>77%</td>
</tr>
<tr>
<td>Value-for-money</td>
<td>30/30</td>
<td>2/30</td>
</tr>
<tr>
<td>Cost-sharing for MD and hospital services</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>2008</td>
<td>Life expectancy</td>
<td>Health life expectancy</td>
</tr>
<tr>
<td>--------------------------</td>
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<td>------------------------</td>
</tr>
<tr>
<td><strong>Canada</strong></td>
<td><strong>Austria</strong></td>
<td><strong>Canada</strong></td>
</tr>
<tr>
<td>Life expectancy</td>
<td>Life expectancy</td>
<td>80</td>
</tr>
<tr>
<td>Healthy life expectancy</td>
<td>72</td>
<td>72</td>
</tr>
<tr>
<td>2008</td>
<td>Correlates of health</td>
<td>Smoking prevalence</td>
</tr>
<tr>
<td>------</td>
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<tr>
<td></td>
<td>Obesity prevalence</td>
<td>22%</td>
</tr>
<tr>
<td></td>
<td>Drunk 2+ times before 15 years old</td>
<td>36%</td>
</tr>
<tr>
<td>2008</td>
<td>Canada</td>
<td>Austria</td>
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<tr>
<td><strong>Health human resources</strong></td>
<td></td>
<td></td>
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<tr>
<td>Clinically active MDs/1000 population</td>
<td>2.1</td>
<td>4.6</td>
</tr>
<tr>
<td>Registered nurses/1000 population</td>
<td>10.3</td>
<td>7.5</td>
</tr>
<tr>
<td>Average MD income (USD)</td>
<td>$140,000</td>
<td>$95,000</td>
</tr>
<tr>
<td></td>
<td>2008</td>
<td>Canada</td>
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<tr>
<td>----------------</td>
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</tr>
<tr>
<td><strong>Hospitals</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of hospitals</td>
<td>695</td>
<td>267</td>
</tr>
<tr>
<td>Number of hospitals/1 million population</td>
<td>21</td>
<td>32</td>
</tr>
<tr>
<td>Average hospital size (# of beds)</td>
<td>155</td>
<td>240</td>
</tr>
<tr>
<td>Number of hospital beds/1 million pop.</td>
<td>3270</td>
<td>8000</td>
</tr>
<tr>
<td>Average length-of-stay (acute)</td>
<td>5.9</td>
<td>7.9</td>
</tr>
<tr>
<td>Average length-of-stay (normal delivery)</td>
<td>1.8</td>
<td>4.3</td>
</tr>
<tr>
<td>% Hospital budgets spent on IT</td>
<td>1.7%</td>
<td>5.9%</td>
</tr>
<tr>
<td>2008</td>
<td>Access</td>
<td>MRI units/million population</td>
</tr>
<tr>
<td>------</td>
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</tr>
<tr>
<td></td>
<td>CT scanners/million pop.</td>
<td>12.7</td>
</tr>
<tr>
<td></td>
<td>Lithotripters (hospital)/million pop.</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>Lithotripters (ambulatory)/million pop.</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>New drug approval wait time (years)</td>
<td>1.5</td>
</tr>
<tr>
<td></td>
<td>% New drugs publicly reimbursed</td>
<td>&lt;25%</td>
</tr>
<tr>
<td>2008</td>
<td>Canada</td>
<td>Austria</td>
</tr>
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<td>------</td>
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</tr>
<tr>
<td><strong>Wait times</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% patients wait in ED wait &gt;2 hours</td>
<td>46%</td>
<td>11%</td>
</tr>
<tr>
<td>% patients wait to see family MD &gt;6 days</td>
<td>30%</td>
<td>20%</td>
</tr>
<tr>
<td>% patients wait for elective surgery &gt;6 months</td>
<td>14%</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>
National Pharmacare for Canada?

- 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

**Canadian generics are expensive**

**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
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

- Health system design
- Allocation of resources
- Health system activities
- Quality, access and cost
- Performance and effectiveness
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

Hospitals 30%

Labour 75%
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