A Tale of Two Countries – Health Care in Canada and the U.S. in 2012

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Dean, Faculty of Medicine & Dentistry
The University of Alberta
“It was the best of times, it was the worst of times, it was the age of wisdom, it was the age of foolishness, it was the epoch of belief, it was the epoch of incredulity, it was the season of Light, it was the season of Darkness, it was the spring of hope, it was the winter of despair, we had everything before us, we had nothing before us, we were all going direct to heaven, we were all going direct the other way ....”
4th Yr. Medical Student (Dis-)Satisfaction

Perfect State of “Health Care”

Policy

Economics

Systems

HEALTH
Healthy Economy?

Hard Times
(1854)
What is *it*?

- Macro
- Market
- Personal (Micro)

Health *Economics*

- Financing
- Insurance
- Reimbursement

“Expenditures and Budgets”
(Securitization of risk pools; Sustainability of costs)

“Public-Private Markets”
(Covered Lives; Personal Mandates; Eligibility)
Macro-economic Environments

U.S. National Economy

- % Change Real GDP
- Surplus/Deficit as %GDP
- Healthcare as %GDP

Canadian National Economy

- % GDP Change
- Surplus/Deficit
- Health % GDP

3 per. Mov. Avg. (% Change Real GDP)
3 per. Mov. Avg. (Surplus/Deficit as %GDP)
3 per. Mov. Avg. (Healthcare as %GDP)
US Health Economy *Trends* (1950-2010)

- **Health expenditures growth** from 4.6% → 17% of GDP:
  - slower GDP growth from 2.8%/yr pre-1980 → 1.8%/yr
  - peer countries averaging 9-11% of GDP (OECD)

- **Increased annual real per capita health expenditures** (esp. pre-1980; except mid-1990s*): driven by new technology (also drives insurance demand) > specialization > aging

- **Payment**: reimbursement 56% out-of-pocket in 1950 → 86% 3rd party insurance (public** > private) in 2009; driven by:
  - high-risk/-cost interventions,
  - untaxed employer contributions,
  - shift from individual to group insurance

* peak of managed care = +2%/year
** poor, elderly and children

Fuchs, VR. NEJM 366(11), 2012
“Trickle Down” to Regional Jurisdictions

State Health Economy

- Total State Exp. ($B)
- State Health Care Exp. ($B)
- Total MKD & SCHIP($B)
- State MKD & SCHIP($B)
- 3 per. Mov. Avg. (Total State Exp. ($B))
- 3 per. Mov. Avg. (State Health Care Exp. ($B))
- 3 per. Mov. Avg. (Total MKD & SCHIP($B))

Provincial Health Economy

- Federal CHST & CHT ($B)
- Federal Tax Transfers($B)
- P/T Healthcare Spending ($B)
- P/T Total Expend. ($B)
- 3 per. Mov. Avg. (Federal CHST & CHT ($B))
- 3 per. Mov. Avg. (Federal Tax Transfers($B))
- 3 per. Mov. Avg. (P/T Healthcare Spending ($B))
US Health Economy *Trends* (1950-2010)

- **Rising Cost** of hospitals: physicians: drugs = 3:2:1 ‘rule of thumb’; “other” costs = 40% of total
  - Hospital & physician spending greatest 1950-80
  - Drug spending greatest post-1980 (new Rx + better coverage)

- **Hospitals survive despite:**
  - 50% reduced ALOS (AMI from 3 wks → 3 days)
  - Offset by 50% increase in admissions/1,000 pop.
  - Cost-per-case = $6,600 in 1997 → $9,200 in 2009
  - Closing 18% of hospitals (esp. psychiatric)
  - Occupancy fell 10% (to av. 65.5%)

Fuchs, VR. NEJM 366(11), 2012
Personal (Micro) Spending & Saving

**US Personal Finance**
- DebtSvc. Ratio
- Healthcare % of Personal Exp.
- 3 per. Mov. Avg. (DebtSvc. Ratio)
- 3 per. Mov. Avg. (Healthcare % of Personal Exp.)

**Canadian Personal Finance**
- Household Debt
- Health Household Exp.
- 3 per. Mov. Avg. (Household Debt)
- 3 per. Mov. Avg. (Health Household Exp.)
US Health Economy *Trends* (1950-2010)

- **Physician workforce:**
  - “Active” MDs / 1,000 pop. grew from 1.41 → 2.73
    - Fewer hours worked/MD
    - More years in training (by specialists)
    - +30% more MD graduates by 2017 (no GME expansion)
  - “Balance” favoring more:
    - Women MDs
    - Specialists (<50 → >150 specialties)
    - Hospitalists (<1,000 in 1997 → >30,000 in 2011)
    - Team-based care (extenders)
    - Office-based EMRs (costly)

Fuchs, VR. NEJM 366(11), 2012
Two Cyclical ‘Pain’ Indices

Unemployment

Consumer Confidence Index
Health Policy

Bleak House

(1852)
Intense House Fiscal Pressure...

CHA Social Contract

CMS Medicare Trust

2008-11
What is *it*?

**Health Policy**

- National
- Regional
- Local

Legislation

Interpretation

Implementation

“*Jurisdictions and Regulations*”
(Rules; Compliance)

“*Public Acts and Laws*”
(Politics; Torts; Entitlements)
Politics Begets Health Policy

Conservative / Pro-Business

2008
2005
2002
1999
1996
1993
1990
1987
1984
1981
1978

Liberal / Pro-Social Programs

USA
Canada
Two Policy Paths to “Universality”

CHA 1984

ACA 2010
CDN “Health Care” Social Contract
Canadian Policy... It’s a Right

CHA: Social Contract for universality, etc.

Mazankowski Report

Premier’s Advisory Council on Health for Alberta

Ministers Accord & Provincial Reinterpretation

System Performance Challenges (Access)

1984 ➔ 2001-2003 ➔ 2004 ➔
Canada’s Social Contract

1. Canada Health Act (CHA): 5 Tenets

- Canadian Parliament
- Minister of Health
- Health Canada CHA Division
- Inter-provincial Health Insurance Coordinating Comm.

- Federal Tax Transfer (44%)
- Canada Health Transfer (56%)
- +Equalization Payment
- +Territorial Formula

13 Provinces & Territories

- CHA Dispute Avoidance & Resolution
- Compliance
- Min. Of Health & Long-term Care
- P/T Health Care Region Expenses

Strategic priorities, practice standards, billing, PC directives, outcome reporting, etc.

Workforce Readiness | Reimbursement Rules
Professional Regulations | CEO Salary (Quality)
U.S. “Health Care” *Quasi-Market*

- Lobbyists
- Health Policy
- Beneficiaries
- Health Economics
- Health Systems
- Investors

???
US Policy-making... It’s a Process

Act-ronym Soup: MCR PPS, RBRVS, COBRA, EMTALA, HIPAA, BBA, PSQIA, ARRA, PPACA...

You-name-a-Care

Progress?
- SCHIP
- Personal Mandates
- Universality
- Shared Savings
- Triple Aim

Healthcare Lobbying

1993

Hillary’s health care plan forces everyone to buy insurance, even if you can’t afford it...

2006

2010

2012
America’s Benefit Plans

**Multiple Federal Acts (Public Laws)**
- U.S. Congress
- Secretary of H&HS
- Centers for MCR and MKD Services (CMS)
  - MCR Part A
  - MCR Part B
  - Carriers
- Fiscal Intermediaries
- Insurers
- Premiums
- UM
- ‘Local’ Medical Review Policies
- MCR Expenditures
- Private (co-)Ins. Expenditures

**Federal (MCR) Taxes**
- Federal (MCR) Taxes
- Department of H&HS
- Federal “Grant Programs”
  - Federal “Grant Programs” (MKD, SCHIP)
- FQHCs
- IGТ’s
- FMAP’s
- State Taxes
- 50 State “Mandatory Programs” (MKD, SCHIP)
- Statewide Expenditures
### Budget Balancing Acts

#### US State vs Canadian Province Budgets

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>US State Balance % of Expenditures</th>
<th>P/T Surplus/Deficit % of Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>1982</td>
<td>0.15</td>
<td>-0.05</td>
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<td>1985</td>
<td>0.10</td>
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<tr>
<td>2003</td>
<td>-0.20</td>
<td>-0.05</td>
</tr>
<tr>
<td>2006</td>
<td>-0.25</td>
<td>-0.05</td>
</tr>
<tr>
<td>2009</td>
<td>-0.30</td>
<td>-0.05</td>
</tr>
</tbody>
</table>

#### US State vs Canadian Province Health Exp.

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>% Change in PHE for State MKD</th>
<th>% Change in P/T Healthcare Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>1982</td>
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Jurisdictions Make Tough Choices

“Living Within Our Means”
1. Special programs
2. Tuition & fees
3. Salaries & benefits
4. Furloughs
5. Student loans
6. Consolidate units
7. Cut capital budgets
8. Delay expansion projects

California Governor Jerry Brown, December 14, 2011: "Nemo dat [quod] non habet..."
2011: To address federal deficit, P.M. Harper proposes CHT of +6% until 2017, then averaging +3.9% until 2025... $31B ten-year federal share reduction

2005: To control federal spending, Pres. Bush proposes a MKD “savings plan” cost-shifting 3% or $34B to states over 10 years... MKD averages >22% of all state expenditures
Bent on “Bending the Cost Curve”

55% Federal

20.4% Federal

CMS Cost Growth

US Spending Growth

ACA

>7%

5.8%

Victoria, BC

5.1%

3.9%

CHT Transfer Growth

CDN Spending Growth
ACA Insures +2.5M Young Adults

September 2010: Affordable Care Act allows children to remain on parents’ plans until age 26

Martinez, ME, Cohen, RA. National Health Interview Survey 2011
New CHT Formula Impacts the Provinces in 2014-15

Health Systems

Great Expectations
(1860)
What is *it*?

Supply (Providers) — Demand (Services) — Disparities (Gaps) — Health Systems — Access — Quality, Pt. Safety — Cost Sustainability

"Rational Care Models & Controls"
(Accountability; Subsidization; Risk Mgmt.)

"The Triple Aim"
(Value; Comparative Effectiveness)
Reorient The Focus From The Money

Triple Aim to “Cure” Health Care

1. Access
2. Quality
3. Sustainability

“Act locally – mobilize the community and return the money...”
Dr. Don Berwick,
Interim CMS Director (2010-11)
Triple Aim of “Patient Centered Care”
U.S. Health Care System Controls

Medical Necessity

Coverage

Level of Coverage
Benefit Eligibility

Self-Referral
Aging Population

Demand

PC Doctor

Access

Jurisdiction Budget

Denial of Care (Uninsured)
ED Care

PROFIT
CDN Health Care System *Controls*

- **Patient Referral**
- **Aging Population**
- **Medical Necessity**
- **Coverage**
- **Universal Insurance**
- **Demand**
- **PC Doctor**
- **Access**
- **jurisdiction Budget**

**Cost**
- **Delayed Care (Wait Times)**
- **ED Care**
## System-Physician Alignment Essential

<table>
<thead>
<tr>
<th></th>
<th>ARP’s</th>
<th>ACO’s</th>
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<tr>
<td><strong>Triple Aim</strong></td>
<td>Access, quality, sustainability</td>
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</tr>
<tr>
<td><strong>Utilization</strong></td>
<td>Lower</td>
<td>Higher</td>
</tr>
<tr>
<td><strong>Base Payment</strong></td>
<td>Not FFS (volume or complexity-driven)</td>
<td>Not FFS</td>
</tr>
<tr>
<td><strong>Population</strong></td>
<td>Historical pop-based capitation</td>
<td>CMS-approved capitation</td>
</tr>
<tr>
<td><strong>Panels</strong></td>
<td>Largely hospital (specialist) practices</td>
<td>Requires primary care (PC) practices</td>
</tr>
<tr>
<td><strong>Academics</strong></td>
<td>Recognizes faculty effort ($)</td>
<td>Unspecified; AHCs participating</td>
</tr>
</tbody>
</table>
| **Innovation Incentives** | Yes  
Cost-efficiency, team care (MD panel) | Yes  
P4P, VBP, CMS Innovation Award |
| **Shared Savings**   | No                                                                   | Yes (2 risk-reward scenarios)                                        |
| **Regulatory**       | High (less anti-trust/self-referral)                                 | High (more anti-trust/self-referral)                                 |

Miller, DD, et al. 2012
System Competition Encouraged

- 2006 U.K. NHS policy of hospital funding tied to patient choice → created a financial incentive for better clinical performance
- Quality improved → AMI mortality fell in more competitive (red) markets, despite fixed prices

Cooper, Z, et al. LSE Health, 2010
System **Innovation Rewarded**

- CMS Innovation Awards
  - >3,000 applications
  - **May 2012**: 26 projects funded in 27 states = $122.6M
  - **Goal**: reduce spending = $254M over 3-years
  - **Common Themes**: reducing acute care re-hospitalization, care integration, equity, extenders, telemedicine, community-based, workforce, comprehensive, social linkages, medical homes, transitions, post-acute care, special populations
“Romney-care” ... All Smiles in 2006

April, 2006

2008

Massachusetts Hospital Spending per Person as a Percentage of U.S. Average, 1960 - 2008

Annual data from 1980 forward
“Romney-care”...ACA Test Laboratory

**Phase 1 (2006-2008)**
- “An Act Providing Access to Affordable, Quality, Accountable Health Care”
- Uninsured rate = 10% → 5%
  - Public & private enrollment
  - +400,000 insured lives
  - Less adverse selection
- Insurance:
  - Individual mandate or employer contributions
  - Insurance ‘exchanges’

**Phase 2 (2008 - 2011)**
- “Controlling Costs by Reforming Health Systems and Payments”
- Cost-containment:
  - Medicaid-1115 federal waiver
  - Cigarette tax
  - Private employer fees
  - Less automatic re-enrollment
- Delivery system improvements:
  - EMR adoption
  - Medical ‘homes’
“Romney-care” … Reality Bites by 2011

Massachusetts Leads Nation with 96% Health Insurance Coverage

“We have shown the nation how to extend care to everybody, and we’ll be the place to crack the code on costs”

Gov. Deval Patrick
“Romney-care”…. Uncharted Territory in 2013

Phase 3 (2011 → 2015)
- MA Sustainability Challenges
  - Rising costs (15% > U.S. av.):
    - Eliminate FFS by 2015
    - <2% adults, <1% kids uninsured
  - ACO network implementation*:
    - flat ‘global payments’; initially for state employees, MKD patients
    - “shared savings” risk option
  - Public satisfaction ‘scorecards’:
    - Div. of Health Care Cost & Quality*  
  - Continued (worse?) access issues:
    - “critical” PC shortages
    - >4-6 week wait times
    - expand NP & PA “extender” roles

National Unknowns
- U.S. Constitutionality challenges
  - ‘SCOTUS’ decision on ACA (06/2012)
  - Insurers must accept all applicants (2014 MKD enrollment growth per ACA)
- “The Squeeze” of Price Controls:
  - On states
    - insurance commissioners under pressure to freeze rising premiums
  - On hospitals
    - incentives to control costs by reducing provider payments (P4P, VBP, etc.)
    - building relationships with FQHCs
  - On insurers (i.e., BCBS)
    - “alternative quality contract” for HMO fees... PPOs next?
    - re-contracting for lower reimbursement

* Health Care Quality Improvement and Cost Reduction Act of 2012
The War Between the States (2014)

MARKETS NOW
18 STATES HAVE ELECTED TO SET UP A STATE BASED EXCHANGE; 10 UNDECIDED
Modern Health Care Reform

‘Scrooged’? (1843)
Lessons for AHSC’s – *In the U.S.*

- COTH vs non-teaching hospitals *(2008)*
  - Risk-adjusted for average CMI
  - HCAHPS for process-of-care / patient experiences
  - Leapfrog Group quality of care measures, ICU coverage, etc.
  - AHA & USNWR key clinical technologies survey data (MRI, EHR, CPOE, etc.)
  - ACS trauma center levels (Advanced =1)
  - MCR Cost Reports (ICR):
    - intern/resident-to-bed ration (IRB >0.25 for major teaching; IRB <0.10 for non-teaching)
    - Inpatient resource utilization (i.e., costs) per MCR PPS reimbursement method
    - Personnel wage costs adjusted per MedPAC data

Lessons for AHSC’s – In the U.S.

- **Significant** COTH hospital correlates (P<0.0001):
  - Pt. services/technology with teaching intensity
  - Teaching intensity favorably associated with:
    - Surgical care improvement project (SCIP) performance
    - AMI and CHF process of care
  - Teaching intensity unfavorably associated with:
    - AMI and pneumonia readmission rates
    - Patient satisfaction measures

- **Non-significant** COTH v non-teaching differences (P>0.05):
  - AMI thrombolysis <30 minutes = 35% v 43%
  - Pneumonia flu vaccination = 76% v 79%
  - Pneumonia blood culture timing = 89% v 90%
  - CHF 30-day readmission rate = 25% v 25%
  - HCAPHS “Would definitely recommend” = 69% v 68%
  - Cost-per-case = $5,466 v $5,534

Lessons for AHSC’s – In Canada (ON)

- 1st admission to Ontario (ON) hospitals (1998-2008) for:
  - AMI
  - CHF
  - Hip fracture
  - Colon CA

- Hospital exposure (i.e., EOL-expenditure index/EI) for low-cost (<$30K) vs high-cost (>-$35K) categories:
  - Hospital services (ON standard costs for admissions)
  - Physician fees (ON paid for care, tests & procedures)
  - ED services (ON standard costs visits)

With 1-year follow-up for 30-day & 1-year mortality, readmission, and major CE’s

Lessons for AHSC’s- in Canada (Ontario)

Conclusions

1. The low-hanging fruit of health care reform has been harvested – durable reform requires more hard choices & greater sacrifice by *ALL* system elements, with the shared goal of benefitting patients.
2. Physicians are human – they respond to societal cues, and they are also empiricists who respond to appropriate accurately measured data, including peer group performance metrics & financial (dis-)incentives.
Conclusions

3. Medical schools & their AHSC partners must train a new cohort of health professional patient advocates, armed with a solid working knowledge of health policy.