

Press Review

Desjardins Financial Security

Long-Term Care in Canada HEALTHCARE SYSTEM

This press review was prepared for internal use only and is intended for our advisors exclusively.
It is strictly prohibited to reproduce or communicate it to third parties.

Documentation Centre
Desjardins Financial Security
November 2009



Money working for people

® Registered trademark owned by Desjardins Financial Security

Life, health, retirement

Health-care spending keeps rising, and it will get only worse

JEFFREY SIMPSON

jsimpson@globeandmail.com

Quick now, which area of spending in Canada jumps about \$10-billion every year?

It isn't postsecondary education, so critical to Canada's future prosperity. And, no, it isn't defence, the Afghanistan mission notwithstanding. That's not a permanent expenditure.

A brief moment's thinking can produce only one answer: health care. In 2009, we'll spend about \$183-billion on health care. Last year, we spent \$173-billion; the year before that, \$163-billion.

Like a gift that keeps on giving, budgets for health care just keep on taking. From 1996 to 2007, health-care spending in Canada rose at a rate of 4.7 per cent yearly – after inflation. In 2008, it rose 5.4 per cent faster than inflation, and this year 3.3 per cent.

The indispensable Canadian Institute for Health Information keeps us abreast of what is happening in health care every year. No one doubts the CIHI numbers, but they interpret them in predictable ways.

Unreconstructed defenders of the Canadian system say, “So what?” Americans spend a lot more of their national income on health care and look what a mess they are in. Anyway, what's another 3 or 4 or 5 per cent above inflation? We can afford it. We're rich.

Indeed, we are rich, relative to most other countries. We spend \$5,452 per capita on health care (compared with \$5,211 last year and \$4,889 in 2007), and that spending approximates what the French, Germans and Dutch spend. Wealthy populations spend a lot on their health. So what?

The unreconstructed defenders maintain that lots of waste and inefficiency can be eliminated. Actually, administration isn't the problem, because the share of total health-care spending on administration is lower than in 1975.

Back then, Canada spent about 7 per cent of its national income on health care. In 2009, it will be about 11.9 per cent.

But let's be fair. This year has been an economic downer. When the economy slumps and health-care costs keep rising, health care's share of the national income will jump. Which it did, from 10.8 per cent in 2008. Even without the recession, however, health care's share of national income would still have been above 11 per cent, up from 7 per cent in the mid-1970s.

Hospitals' share of total spending keeps going down; drug costs keep going up. Aha, say certain analysts of the remorseless rise in health-care spending. Give Canada a national pharmacare program to curtail the increases in costs.

Quebec has one of those. Quebeckers above a certain income pay premiums for drugs, but the state pays roughly 80 per cent of the costs. Since its introduction in 1997, government costs have more than tripled; since 2002, when changes were made to the plan, public costs have almost doubled. So if the Quebec experience is any guide, public drug coverage might bring social benefits, but it doesn't curtail costs.

You might think that provincial governments would be focusing on reducing the increase, at least. Instead, most of them are averting their eyes. They are doing so, in part, because since 2004-05, Ottawa has been shovelling money at them for health care – an additional \$4-billion a year, indexed at 6 per cent.

That money doesn't make things better, since 6 per cent is roughly the rate of health-care inflation, but at least the federal infusion helps to prevent things from getting worse. The federal-provincial accord of 2004-05 was signed when Ottawa enjoyed surpluses. When the pact expires in 2014-15, the federal government will be in deficit. Either it will keep up that level of transfer payments, in which case other programs will be restrained, or the transfers will decline.

There's the dilemma every government in Canada faces, yet none wishes to draw public attention to it because of the political risks. Spend more each year on health care beyond inflation and something has to give.

For now, the answer to what must give is government borrowing because of the recession. But with health care eating more and more of every province's budget – 45 per cent in Ontario – other programs will suffer or debt will rise, or both.

And look what's coming: aging. For people aged 1 to 64, health-care costs are \$3,089 per person. For those 70 to 74, the cost is \$7,732; for those 75 to 79, \$10,469; for those over 80, \$17,469.

The share of older folks in the population will soon start rising rapidly. It's not hard to figure out the impact on health-care budgets.

Median hospital wait time falls slightly to 113 days year over year

Canwest News Service

Canadians have had to wait about 113 days for surgery this year, a slight improvement over last year, a national health-care survey has found. The Fraser Institute's annual report on hospital wait times found that the median wait time for Canadians seeking surgical or other therapeutic treatment has been 16.1 weeks in 2009, down from 2008's 17.3 weeks. "While that wait time is shorter than it was last year, it is still a far cry from what Canadians should expect from their expensive health-care program," said report author Nadeem Esmail. For total time spent waiting between doctor's referral and treatment, Ontario performed best with a wait of 12.5 weeks, followed by Manitoba (14.3 weeks) and Quebec (16.6 weeks). Canada's eastern provinces fared poorly -- Newfoundland recorded the longest wait at 27.3 weeks, then P.E.I. (26.7 weeks) and New Brunswick (25.8).

Getting more for less in health care

NADEEM ESMAIL
National Post

Thanks to poor fiscal management, the government of Ontario finds itself in a difficult fiscal situation. It must find a way to eliminate the significant deficits that are expected until at least 2015/16. Given that tax increases are certain to damage the road to economic recovery, Ontarians should instead begin contemplating reductions in government spending. And there's no better place to start than health care.

According to the 2009 budget, health expenditures are expected to consume 43% of government program expenditures this year. In recent times, health spending has been rising faster than government expenditures or GDP, meaning that share is likely to continue growing over time. The reality is that health care spending will have to be cut to avoid future tax increases.

Any government looking to reduce health-care expenditures should expect backlash from a public that is likely to expect increased rationing of health care services. But this need not be the case. A look at the realities of medicare suggests there is actually a great deal of room to cut expenditures while actually decreasing rationing. The key is to enact sensible health care reform.

Consider that Canada maintains the developed world's second-most expensive universal access health insurance system on an age-adjusted basis. Within Canada, provincial health expenditures in Ontario are only slightly below the national average. In spite of these high expenditures, Ontarians endure relatively poor access to medical professionals and medical technologies, are cared for using far too many old and outdated pieces of medical equipment, and must wait for health care in some of the longest queues for treatment in the developed world.

How other nations are able to purchase more health care for less money should provide a lesson for Ontario. Getting more for less in health care will, however, require adopting two key health policies that are common in other nations with universal-access health care: competition in the delivery of publicly funded care and cost-sharing.

Cost-sharing, requiring patients to share in the cost of their care, is essential to providing a less expensive and more accessible universal health-care system. The reasoning is straightforward: People spend their own money more wisely than they spend someone else's. According to research and international evidence, when patients are responsible for some of the cost of their care, they use fewer resources (making more available for other patients and saving money overall), and end up no worse off in terms of health outcomes.

Just how much might such a policy save? A 2004 Fraser Institute study of cost-sharing in Alberta found that a 25% coinsurance payment (with reasonable annual limits for patients, old-age and low-income exemptions, and exemptions for hospital care for children and the elderly) would reduce total medicare spending (including the additional out-of-pocket payments made by Albertans under the scheme) by some 12%, while the reduction in spending for the public budget was approximately 20%.

The same approach in Ontario could be expected to reduce the \$42.6-billion the province plans to spend on health in 2009/10 by approximately \$8.5-billion.

Another way to reduce spending and improve the state of health care in Ontario is to change the way hospitals are funded and allow more competition in the delivery of publicly funded services. To that end, Ontario should scrap its current global budget funding model for hospitals, where the hospitals receive a set amount of money each year and thus see every patient as a drain on their budget. Instead the province should move to activity-

based funding in which hospitals would be paid per patient. This would save Ontarians significant resources, while at the same time providing Ontarians with a greater quantity and quality of services from hospitals that would be operating more efficiently.

The Swedish experience with moving to activity-based funding provides some insight: Gerdtham, Rehnberg and Tambour studied the move to activity-based funding by Swedish county councils (provinces) in 1993 and 1994 in the journal *Applied Economics* and estimated that the cost savings of such a reform were approximately 13%. For Ontario, that 13% cost savings on hospital care adds up to roughly \$2.5-billion in 2009/10.

In total, a rough calculation shows that by introducing just these two sensible health policies, Ontario could have reduced public health spending by an estimated \$11-billion in 2009/10. That reduction in spending would have cut the \$18.5-billion forecast deficit by some 60%. At the same time, the allocation of medical resources in the system would be improved, actually leading to better access to health care services for Ontarians.

The provincial government's poor fiscal management is likely to mean a reduction in public spending in the future. But these reductions in spending need not reduce the quality of public services. Indeed, the level of misallocated and wasted resources in health care is high enough to allow the province to substantially reduce spending through sensible health-care reform while actually improving access to health care. - Nadeem Esmail is the director of health system performance studies and manager of the Alberta Policy Research Centre at the Fraser Institute.

STUDY » SENIORS AND PROVINCIAL DRUG PLANS

Out-of-pocket costs vary widely by province

BY ANDRÉ PICARD
PUBLIC HEALTH REPORTER

Technically, every Canadian aged 65 or older is covered by a provincial drug plan, but the out-of-pocket costs paid by seniors for prescription drugs vary wildly between provinces, new research shows.

For example, a 65-year-old single woman on a government pension who suffers from diabetes and high blood pressure and is being treated with four prescription drugs pays only \$8 for the medication in Ontario but \$503 in Manitoba.

Similarly, a 73-year-old married man with an above-average income taking five drugs to treat heart failure pays \$60 for the prescription medicine in New Brunswick and \$1,332 in Manitoba.

"Given differences in reimbursement according to age, income level, marital status and province of residence, drug reimbursement in Canada is manifestly unequal," said Louise Pilote with the divisions of general internal medicine and clinical epidemiology at McGill University Health Centre in Montreal.

"I don't think the provinces themselves realize how great the differences are," she said.

In a study published in today's edition of the Canadian Medical Association Journal, Dr. Pilote and her co-authors recommend a more cohesive pharmaceutical strategy to reduce these inequities, an approach they say is important given ever-increasing spending on prescription drugs.

"If we want to call ourselves a universal health system, we have to address these issues," she said.

In 2007, Canadians spent \$26.9-billion on drugs, of

which more than \$4-billion was out-of-pocket, according to the Canadian Institute for Health Information.

Prescription drugs taken outside the hospital are not covered by medicare. About 75 per cent of Canadians have private insurance coverage for drugs.

There are also a host of government programs that reimburse drug costs, principally for seniors, recipients of social assistance and those with chronic illnesses that entail high drug costs such as HIV-AIDS and diabetes.

According to the new study, the number of people eligible for reimbursement for prescription drugs varies greatly between provinces, from a low of 9 per cent in Manitoba to a high of 43 per cent in Quebec.

The amount those with plans pay out-of-pocket also differs substantially between jurisdictions, the research shows.

New Brunswick and Prince Edward Island offer the most comprehensive drug plans for seniors, with patients either fully covered or paying up to 35 per cent of prescription drug costs, regardless of income. Ontario and Nova Scotia offer fairly comprehensive plans, but reimbursement is proportional to income. Quebec seniors generally pay more of their total annual prescription costs than those in other provinces, though there is relief for low-income seniors and those who require a lot of drug treatment. Seniors in Saskatchewan, Manitoba and Newfoundland are covered only if they have a low income.

Dr. Pilote noted that low-income non-seniors in most provinces must pay the full cost of their prescription medications unless they have insurance through work.

By contrast, social assistance recipients have their drug costs covered in all provinces, though they may pay up to 35 per cent of annual costs depending on where they live.

For example, a 40-year-old man on welfare who is suffering from high blood pressure and taking three medications whose cost totals \$1,389 a year will pay nothing in Alberta, \$8 in Quebec, \$20 in Nova Scotia and \$200 in Quebec.

To conduct the study, researchers used 32 scenarios, based on the age, income level, marital status and prescription burden of drug plan members in various provinces.

Health spending hits \$172-billion, outpacing inflation Up 3.4%, Agency Says

BY BRADLEY BOUZANE

Canwest News Service

OTTAWA - Health care in Canada will cost \$172-billion this year, or nearly \$5,200 for every person in the country, according to figures released yesterday by the Canadian Institute for Health Information.

The independent statistical agency says that total health spending is forecast to increase by 3.4% in 2008, up from nearly \$162-billion last year. In 2006, the tab for health care ran to about \$151-billion. In all, health spending in Canada is expected to soak up 10.7% of the country's gross domestic product this year, the highest proportion ever recorded by CIHI.

"Health-care spending is expected to grow faster than Canada's economy, outpacing inflation and population growth," said Glenda Yeates, the group's president.

After adjusting for population increases and inflation, health spending jumped by 2.8% in 2007 from the year before and 3.7% the year before. That follows a 2.8% rise from 2004 to 2005.

The report also said the ratio of public-sector to private-sector spending on health care is expected to remain relatively stable, at exactly 70/30. It has been at this level for more than 10 years.

Among 25 countries with similar accounting systems, Canada was in the top fifth in terms of per-person spending on health, spending US\$3,678 per person, which was similar to seven other OECD countries (including France, Germany, the Netherlands and Austria) but considerably less than per person spending in the United States (US\$6,714). The ratio of public-sector spending (70%) in Canada is slightly lower than the OECD average (72%).

Although hospitals still account for the biggest single share of health spending, at \$48.1-billion, their 28% stake of the total budget is actually in decline. In 1975, the first year of the organization's statistics, hospitals accounted for 44.7% of the country's total health care costs.

Spending on drugs, however, is on the rise. Both prescribed medications and over-the-counter remedies continue to lay claim to the second-largest share of health spending. They're forecast to cost just under \$30-billion in 2008, or 17.4% of the total tally. That's about double their share in 1975.

Spending on physician services gobbles up the third-biggest slice of the spending pie, with a total tab of about \$23-billion in 2008.

In terms of the costliest patients, infants and seniors take the lead.

Health care for kids under the age of one year costs, on average, \$7,900, while people 65 and older racked up an average bill of almost \$10,000 in 2006, the last year for which age-specific data were available.

Not surprisingly, patients between the ages of 85 and 89 cost the most in health services -- more than \$21,200 on average in 2006.