



SOCIETY OF ACTUARIES

**Health Spring Meeting
June 2009**

**Session # 32: Hot Breakfast –
Public Medicare Management and Strategic
Decisionmaking in Canada**

[John Abbott](#)
[Shirley Hawkins](#)

Moderator:
[J. D. Have, FSA, FCIA](#)

Health Council of Canada



Conseil canadien de la santé

The Value of Universality

John G. Abbott, CEO
Health Council of Canada
Health 2009 Spring Meeting
Society of Actuaries
June 9, 2009
7:00 a.m. to 8:00 a.m.



How change happens - overview

- Canada characterized by collegiality and accommodation between the state and the medical profession
- Public systems like the UK and Canada have tended to change slowly and are affected by path dependency
- UK – hierarchy/rules
- U.S. – markets/contracts

Source: Chris Ham, HSMC University of Birmingham (based on Carolyn Tuohy's "Accidental Logics")



U.S. Critics say. . .

- “The single-payer model has yielded inefficient service and lower-quality care. For example:
 - In Britain more than 700,000 patients are waiting for hospital treatment
 - In Canada, it takes, on average, seventeen weeks to see a specialist after a referral.”

Health Care in Three Acts by Eric Cohen and Yuval Levin @ commentarymagazine.com

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Did you know that (1)**

- No emergency is neglected in Canada
- No one in Canada goes bankrupt because of medical bills
- Canadians are able to choose their own physicians and to seek multiple opinions
- Canada’s healthcare system actually helps enhance economic productivity: workers diagnosed with illnesses are not rejected by employers with health benefits due to pre-conditions

**Diane Francis, National Post, May 12, 2009

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Did You Know that (2)

- Canadian health system is 70% publicly-funded – transfer payments from the Federal government to 14 jurisdictions; therefore, 14 different health care ‘systems’
- Single-payer system
- Each jurisdiction is responsible for the delivery of health care services to its citizens



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Did You Know that (3)

- Medicare is almost 50 years old
- The Canada Health Act passed in 1984 is designed to:
 - protect, promote and restore the physical and mental well-being of all residents of Canada
 - to facilitate reasonable access to health services without financial or other barriers
- Publicly-funded Canadian healthcare is based on:
 - Portability
 - Public administration
 - Comprehensiveness
 - Accessibility
 - Universality

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The system was/is not perfect

- Public provided input into what changes were needed (Romanow Commission, 2002)
- Two health accords signed by First Ministers in 2003 and 2004 to address major areas of concern
- The need for accountability and transparency
- Creation of the Health Council of Canada

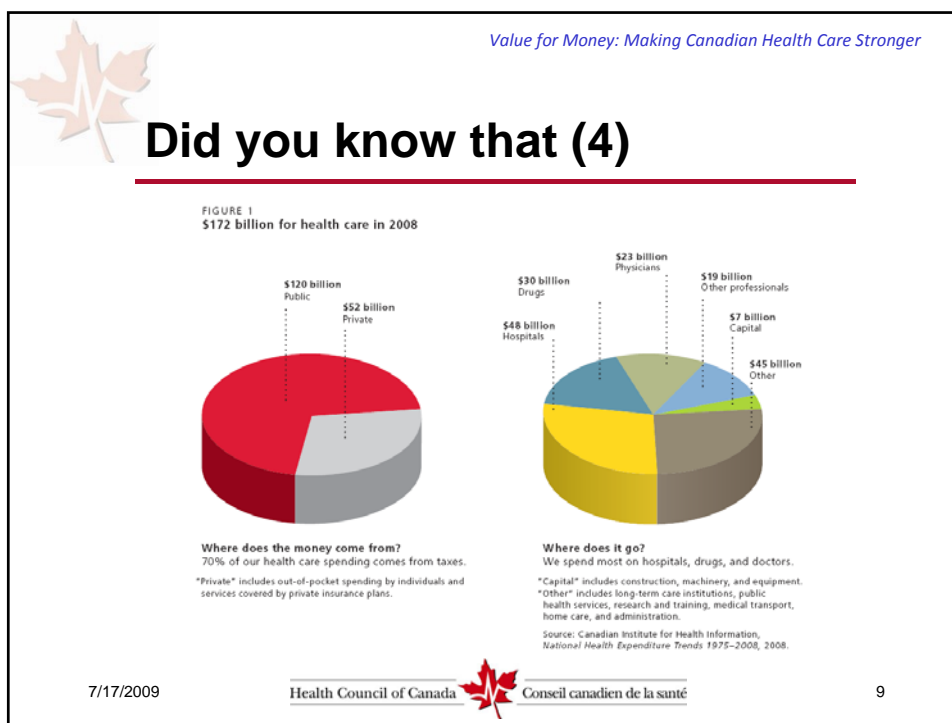
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The Health Council of Canada

- VISION: An informed and healthy Canadian public
- MISSION: To foster accountability and transparency by assessing progress in improving the quality, effectiveness and sustainability of the health care system


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But we don't know...

- **If Canadians are getting any healthier!**
 - We're ordering more tests, prescribing more drugs, performing more surgeries and employing more expensive technologies.
 - How Canadians' health improves, or worsens, or doesn't change as a result of using health care services.

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How do we get there from here?

- Assessing value for money in health care is a complex but critical challenge.
 - We need to consider what we value about health and care, about the way health care gets delivered, and about the relationships between providers and patients.
 - We need a much better understanding of what we get for our health care dollars, and what we want the system to achieve.
 - We need to constantly evaluate the efficiency of our health care organizations and the utilization of our health care providers to ensure we are getting full value for the resources allocated to delivering health care services in Canada.

Value for Money: Making Canadian Health Care Stronger
www.healthcouncilcanada.ca


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How do we get there from here? (cont'd)

- We need to ponder the limits to care, the ethical and practical implications of having finite resources and, in many cases, uncertain knowledge.
- We need more and better evidence to guide our decision-making. More evidence-based health care will reduce variations in practice and outcomes, lead to greater use of standards of care, and enhance value for money. But for health care practice guidelines to be effective, providers have to use them. In day-to-day health care, guidelines can be and are often ignored.

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Value for Money: Making Canadian Health Care Stronger

For example. . .

PREVENTION OR TREATMENT: VALUE CAN VARY
 The idea of preventing health problems makes sense, but not all approaches to prevention are highly cost-effective. Treatment, on the other hand, is not always expensive.

In 2008, the *New England Journal of Medicine* published an article that reviewed hundreds of top-quality studies on the cost-effectiveness of various medical procedures and programs designed to prevent disease and to treat existing conditions.²⁴


For each intervention, the authors determined how much it would cost to add one year of good health to someone's life. They used a measure known as the "quality-adjusted life-year" or QALY, which takes into account both the quantity and quality of life resulting from health care.

They found that the "cost per QALY" of prevention efforts and treatments ranged widely. For example:


Preventive measures	Cost-effectiveness
Haemophilus influenzae type b (Hib) vaccination of toddlers	Saves money
Intensive tobacco-prevention program for Grade 7 and 8 students	\$23,000/QALY
Diabetes screening of all 65-year-olds, versus screening only 65-year-olds with high blood pressure (a risk factor for diabetes)	\$590,000/QALY

Treatments for existing conditions	Cost-effectiveness
Family therapy (cognitive-behavioural) for patients with Alzheimer's disease	Saves money
Combined drug therapy (antiretroviral) for patients with HIV	\$29,000/QALY
Mechanical heart pump implant (left ventricular assist device), versus optimal medical management, in patients with heart failure who are not candidates for a heart transplant	\$900,000/QALY
Surgery in 70-year-old men newly diagnosed with prostate cancer, versus watchful waiting	Uses more money and worsens health

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Better utilization of health resources

FIGURE 6
Should value-for-money questions drive the system?

The diagram illustrates a process flow: **Resources** (Health professionals, Technology, Facilities) lead to **Services** (Doctor visits, Surgeries, medication, Preventive care), which lead to **Health** (Reduction in a disease rate, Pain control, Return to work). **Health** leads to **Outcomes** (Are we using services well to produce health?). **Outcomes** lead to **Goals** (High-quality care, Sustainable system). **Inputs** (Are we using resources well to provide services?) and **Outputs** (Are we using services well to produce health?) are also shown as key questions.

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What is the U.S. situation?

“By a wide margin, the biggest threat to our nation’s balance sheet is the skyrocketing cost of health care.”

President Barrack Obama, March 2009

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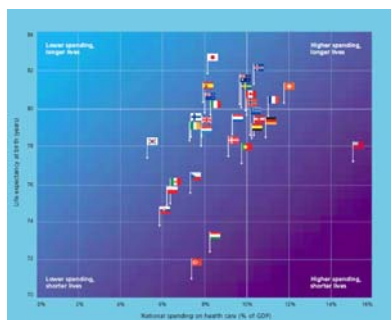
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What We Are Told ...


- 15% of (U.S.)GDP is spent on healthcare (Canada spends 10% to protect 32,000,000)
- Outcomes with major illnesses, such as cancer and heart disease, are better than in the United States (but the incidence of diabetes is more than 50 per 1,000)
- More spending is not creating better health outcomes
- 47 million American people do not have health care coverage




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Obama's Vision of Healthcare Reform



- Prevention and public health
- Insurance coverage for all, beginning with children
- Accelerated adoption of health information technology
- Shared responsibility among individuals and families, school systems, employers, the medical and public health workforce
- All levels of government to address better health


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Expectations & what's needed

- **Will the healthcare system be there for me when I want and need it?**
- Understand/manage expectations
- Improve the health system in ways that simultaneously reduce cost growth and demonstrably increase the value of the dollars spent
- Focus on the social determinants of health, including prevention


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Lessons from Canada

- Imperative to move from a ‘find it, fix it’ to ‘prevent it, find it, manage it’ model
- Goal to provide access to timely, effective care
- Look to system re-design for sustainability and high performance

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Lessons from Europe

- All systems based on principles of universality and solidarity against suffering (no one denied care)
- Vision and political leadership
- Public reporting on progress (transparency)
- Advanced IT strategies
 - Lab reports, prescription
 - Online appointment booking
- Focus on both access and quality of care
- Money follows the patient

Excerpt from: *New Attitudes -- Toward Transformative Change in Health Care*, Dr. Robert Ouellet, CMA May 26, 2009 presentation to the Health Council of Canada

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- Thank you
- Questions and comments
- **www.healthcouncilcanada.ca**

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Canada's Healthcare

Public Management
+
Actuarial Models

John Have, FSA, FCIA
Have Associates

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Health Care Application Committee

ID actuarial role with Medicare

5 Years with limited success

- Some physician resource models
- Assist on royal commission reports
- A few junior actuarial analysts

Regular actuarial models don't apply

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Actuarial Models

Most actuarial models project future costs given specific plan assumptions

Need economic / actuarial model balancing many society needs: ie:

- Education
- Health care vs prevention vs environment
- Ethics and social values

Health Council of Canada

2003 Health Care Accord

Fed gov't + provinces work together

- Strengthen system
- Ensure long term sustainability

Council created in 2004 to report to Canadians on Healthcare progress

John Abbott

CEO of Health Council of Canada

Former:

Deputy Minister of Newfoundland and
Labrador's Department of Health