

OECD ECONOMIC SURVEY OF CANADA 2004:
INSTITUTIONAL CHANGES TO HEALTH CARE SYSTEM

*This is an excerpt of the OECD Economic Survey of Canada, 2004,
from the section on the health care system in Chapter 4*

Closing the gaps in the safety net

1. In contrast to most OECD countries,¹ prescription drugs outside the hospital setting are not covered by the provisions of the Canada Health Act, so that the publicly funded drug coverage varies considerably from province to province. All provinces have drug programmes covering costs for low-income seniors or recipients of social assistance, and the federal government assumes drug costs for some aboriginals and veterans. Moreover, five provinces provide a protective cap on the cost of drug expenses borne by individuals. Still, a significant percentage of the population have to assume the full cost, either out of pocket or through private insurance coverage. In addition to equity considerations, this situation can lead to inefficiencies, for instance when physicians admit patients to hospital or delay their discharge to spare them the costs of medicines; when cheaper but less effective drugs are prescribed; or when alternative less effective treatment approaches are chosen primarily because they are covered. The loss of coverage in moving off social assistance can also add to the high effective marginal tax rates faced by those on welfare (see Chapter 3). Standardising the coverage at least for all people facing significant pharmaceutical outlays² could provide more effective protection, reduce inefficiencies and lead to better health outcomes. Some measures in that direction were announced in the 2003 Accord on Health Care Renewal, but the level of coverage is a provincial decision, so that it is still unclear whether this agreement will reduce differences between provinces (Boothe and Carson, 2003).

2. In the same vein, home care is considered as an extended service and is thus not insured under Medicare. This has led to a situation where eligibility, scope of coverage and user charges for publicly funded home care vary greatly between provinces, implying inequity amongst Canadians (Conference Board of Canada, 2004b). It also results in some people taking up hospital beds because they cannot afford the support services that would be necessary with an earlier discharge. Moreover, home care still represents a very small part of provincial health budgets, although it is generally considered to be an effective substitute for more costly services and often more in line with patient preferences. The explicit support for home care in the 2003 Accord on Health Care Renewal is a welcome move but is so far limited to a small basket of services. A comprehensive approach to home care development as an integrated part of public health service across the country would reduce current inequalities and facilitate a better allocation of the

overall resources in the system. However, as the United States found, these changes are likely to imply also a rapid expansion of home care services. Careful medical guidelines on the appropriate use of home care would need to be established and payment incentives developed that rewarded efficient discharge planning regimens. Such measures are required from the outset to ensure cost containment.

3. Expanding the basket of services covered by Medicare will require increased public funding, but this could be offset by a rebalancing of the current cost-sharing arrangements. A range of cost-sharing arrangements are possible (see Box 4.6) but, in effect, the public system currently takes an all or nothing approach, whereby services are either reimbursed 100 per cent or not at all. The planned extension of coverage of home care and catastrophic drug care could provide an opportunity to reconsider modest cost-sharing arrangements across a range of health services. This would attenuate the fiscal cost of extending the scope of services covered by Medicare. Such arrangements are common in a number of other OECD countries and, where the initial level of cost-sharing is zero, they can lead to significant reduction in spending on health care (Docteur and Oxley, 2003). However, it is more difficult to ascertain whether they are primarily reducing essential treatment or unnecessary consumption.³ In any case, co-payments should be limited to avoid having undesirable effects on access and health outcomes. Exemptions for vulnerable groups (for example, children, those on low-incomes, and the elderly) and caps on out-of-pocket spending in case of catastrophic illness or injury could help to prevent these negative effects.

Box 4.6. Cost-sharing arrangements in health care

Various insurance concepts can be applied to cost-sharing arrangements in health care. These are based on the principle of containing moral hazard, although if these out-of-pocket payments for publicly funded services are in turn covered by private health insurance, their impact in reducing demand for services may be limited.

The *deductible* is an all-inclusive amount entirely paid by the patient before insurance cover begins. The remainder of the cost of care can be on either a co-payment or a co-insurance basis — where the expenses are shared — or entirely taken in charge by the insurer. This deductible can be applied to each service or to the overall amount spent during the contract period. The deductible makes the system of cover and refunding non-linear in its impact. A higher deductible generally combines with a lower premium as the cost borne by the insurer is lower.

Co-insurance is the percentage of the expenditure beyond the deductible that the patient must pay.

A *co-payment* is the amount paid by the patient for a health service and is independent of the total cost of the service. Behaviour is not affected by the total cost of care but by the number of services used.

Maximum out-of-pocket payments or ceilings in cost-sharing policies ensure that subscribers do not face “excessive” expenses during the year, thereby reducing uncertainty and risk.

Source: Docteur and Oxley (2003).

Changes to the institutional framework to achieve greater efficiency

4. Improving efficiency is an essential part of any strategy for reconciling rising demands for health care with the need for public budget restraint. Providing the right incentives for key actors in the system is a pre-requisite.⁴ In the primary sector, fee-for-service arrangements are used most widely to pay general practitioners and specialists working in ambulatory care, with fee levels negotiated at the provincial level. This approach gives physicians full discretion over the level and mix of services, referrals and other treatment options and is found to be generally associated with shorter waiting lists (Siciliani and Hurst, 2003). However, doctors face incentives to expand the volumes and prices of services they offer, and the risk of supply-induced demand is particularly strong, for example by increasing services provided

“in-house” even if there would be advantage in making more use of secondary suppliers.⁵ Introducing some form of capitation in the payment arrangements would mitigate some of these negative effects. Indeed, it would create an incentive for physicians to have more patients, as a greater number of registered patients would also mean higher incomes.⁶ Increasing numbers of Canada’s doctors are moving away from pure fee-for-service payments to blended payment models including salaried components, capitation or some combination of these options. In the second half of the 1990s, the share of spending on physician services that flowed through alternative payment plans increased in all provinces except Quebec (CIHI, 2003). However, only a small percentage of physicians (less than 10 per cent in most provinces) have alternative payments as their main source of funding. Interestingly, one survey showed that 37 per cent of physicians would prefer to be paid by fee for service, while 27 per cent would prefer to be salaried and 21 per cent to receive a blended option, suggesting that there is room to promote mixed rewards further (Canadian Medical Association, 2003). However, there is a risk that moving towards blended payment might exacerbate the present physician shortage, as it depends on how physicians adjust their treatment style. The present fee-for-service system provides a stronger incentive to maximise the number of consultations made per year, and shifting away from this may make it harder to gain access to a doctor. But capitation can lead to more efficient consultations, making space for the doctor to see more patients. This suggests that contracts for those shifting away from fee for service should be very carefully designed to minimise these risks.

5. Reconsidering the hospital funding mechanisms could increase incentives to improve productivity. In the current system, provinces use a variety of approaches to finance hospitals. In some cases, they rely on a primary funding method to allocate the majority of their funds for operating costs (Table 4.4) and a number of secondary methods to apportion lesser amounts, while funds for capital purposes are provided using a project-based method in all provinces. Population-based, ministerial discretion and global budget approaches are the most common primary funding methods. With these funding methods, decisions are not usually based on detailed cost information, since funding is either decided politically or based on historical trends, neither of which encourages efficiency. By contrast, in the service-based approach, hospitals are reimbursed for the episode of care with which the patient is admitted and with the rate based on the type of service performed and the estimated cost of treatment per diagnosis fixed beforehand. But, so far, the prevalence of this type of funding is only marginal in Canada⁷, despite the recommendation of the Senate report (Kirby, 2002).

6. Shifting the way hospital budgets are allocated toward service-based funding mechanisms is thus likely to be a fruitful avenue. This would change the financing perspective from paying hospitals a specific amount to meet their anticipated needs to paying them according to what they actually do, thereby providing stronger incentives for hospitals to become more efficient as well as pin-pointing where their strengths and weaknesses lie. In addition, it would improve accountability for the use of public funds, as well as the independence of hospitals from local governments. The experience from a number of OECD countries using this approach is that it raises activity, sometimes significantly, and thereby is a key factor for reducing waiting times (Siciliani and Hurst, 2003). A major drawback of service-based funding is that it can lead to over-servicing, especially if hospital-based specialists are paid under a fee-for-service scheme, as is the case in Canada. Nonetheless, this issue could be addressed by having hospital-based specialists paid under a different remuneration scheme, as in Sweden and the United Kingdom. As the final remuneration is linked to the severity of the case and the corresponding resources required, another danger is that hospitals have an incentive to upgrade patients into more costly diagnostic groups or to avoid costly patients by selection. A system of audits and penalties would need to be put in place to prevent this type of abuse. As the implementation of this funding arrangement cannot be done without reliable measures of the costs of all types of treatment, which are not currently available for all provinces, further work on improving financial management data is necessary, as mentioned above.

Table 4.4. Hospital funding in Canada¹

Province	Primary funding approach	Secondary funding approach
British Columbia	Line-by-line and population-based	Policy-based
Alberta	Population-based	Policy-based
Saskatchewan	Population-based	None
Manitoba	Ministerial discretion	None
Ontario	Global budget	Multiple ²
Quebec	Global budget	Multiple ³
New Brunswick	Line-by-line and population based	None
Nova Scotia	Ministerial discretion	None
Prince Edward Island	Ministerial discretion	None
Newfoundland and Labrador	Ministerial discretion	None

1. The *line-by-line* method involves negotiating amounts for specific line items. With the *ministerial discretion* method, funding is based on decisions made by the provincial minister of health in response to specific requests by the hospital concerned. The *population based* method uses demographic information such as age, gender, socio-economic status and mortality rates to forecast the demand for hospital services. The *global budget* method adjusts previous spending to derive a proposed funding level for the upcoming year. Adjustment can be made to the base amount using a multiplier or a lump-sum amount. With the *policy-based* approach, funding is distributed to achieve specific policy objectives. The *facility-based* method uses characteristics of the hospital, such as size, amount of teaching activity, occupancy and distance from nearest tertiary facility to estimate costs. The *service-based* method uses the volume and type of cases treated by a hospital to determine funding.
2. Policy-based, Facility-based, Population-based and Service-based.
3. Population-based and Policy-based.

Source: Kirby (2002) based on Mc Killop *et al.* (2001).

Strengthening the role of RHAs

7. The system could benefit from moving toward more management and governance of health care at the regional level by strengthening the role of Regional Health Authorities (RHAs). In the past two decades all provinces except Ontario have devolved responsibility for the management of parts of the health care system from provincial governments to RHAs. Their responsibilities are generally limited to hospital services, although in some provinces, they also cover laboratory services, long-term care, home care and a variety of other health services. These services are provided by RHAs through contracts with private, not-for-profit and private, for-profit organisations. However, physician services, prescription drugs and cancer care continue to be administrated and funded centrally by provinces. Moreover, a number of barriers prevent RHAs from functioning to their fullest potential. For instance, in some provinces, RHAs' budgets are almost entirely determined by governments, and RHAs have very limited options if they are unable to meet the population's needs with their existing resources other than lobbying the provinces for increased funding.

8. Giving RHAs responsibility for the full range of health services would enable them to have better control over the allocation of resources and result in a better integrated system. Moreover, a more widespread application of internal market principles based on RHAs acting as purchasing agents with the possibility to buy from for-profit and non-profit institutions would foster effective management of health services and provide the incentives for providers to become more efficient and cost-effective. In addition, this approach would introduce much greater transparency into the system and increase accountability of the different agents (Kirby, 2002). However, one condition for the market-style incentives to work is to change the method of remunerating hospitals by moving to a service-based approach, as argued above.

Increasing the coverage of private insurance

9. With rising concerns about excessive waiting lists, the question of allowing private insurance to cover core services has been at the centre of the debate. In the current system, private insurance covers only items not explicitly offered by the public scheme. This means that individuals have to pay out of pocket if they want to have a more rapid access to care than provided by the current system.⁸ This situation is almost unique in the OECD countries and was motivated by the belief that insurance that duplicates public coverage enables high-income people to jump the queue at the expense of the poor (Cutler, 2002). There are also concerns that if the rich can opt out of the public system at will, their demand for a high-quality public sector may decline, potentially leading to an unravelling of support for public insurance (Gouveia, 1997).

10. There could be some potential advantages for the economy as a whole to increase the coverage of private insurance, although these advantages may be limited in a single-insurer model like Canada's where administrative costs are low. Allowing private insurance for services already covered by Medicare could, in theory, attenuate fiscal pressure on public health budgets by bearing costs that would otherwise be borne publicly. But evidence from Australia and Ireland suggests that privately insured persons tend to continue to rely on publicly financed services, resulting in little cost-shifting. More importantly, competition among insurers could encourage them to improve services to the insured and could also create more consumer choice by promoting innovation amongst insurers. It may also improve information for suppliers, as people are able to indicate their personal preferences directly, and increase welfare for those who were previously prohibited from taking out private insurance (see previous *Survey*). Although private insurance premiums are regressive, increasing the coverage of private insurance would not necessarily lead to a worse situation for those on low incomes. Indeed, if an expansion of private insurance coincided with greater supply capacity,⁹ it could also help to shorten waiting times for those without additional private insurance. A multi-payer system can make it difficult to maintain equity of access and financing if private insurers are allowed to "cream-skim". However, government restrictions on risk-based selection could improve the equity of outcomes from private health insurance markets, even though in practice such measures are difficult to implement.

Making more use of new technologies

11. A central element in enhancing the efficiency of health care services is the development of electronic health records, which is currently underway in most provinces. The objective is to provide each individual with a secure and private lifetime record of his or her key health history and care stored within the health system. In theory, if fully implemented¹⁰ and fully interchangeable between provinces, this database could improve the quality and the responsiveness of the health care delivery system. However, in practice, a lack of co-ordination between provinces, leading to the creation of different systems, has increased the technical problems, rendered the process longer and more expensive, and carried the risk that the end result is less useful. The setting of electronic health records was given explicit support in the 2003 Accord on Health Care Renewal, and further efforts by the federal government or provinces to accelerate the process would be welcome.

NOTES

1. All OECD countries have public reimbursement systems except Turkey, the United States and Canada (Docteur and Oxley, 2003).
2. For example, Sweden operates a sliding scale of coverage for pharmaceuticals. Each year the patient pays the entire cost up to the equivalent of the first C\$160 and then there is a rising scale of subsidy so that no person pays more than C\$320 in any 12-month period. New Zealand reduces co-payments to a nominal amount after the first 20 prescription items in any year, as well as operating separate schemes for low-income groups and seniors.
3. In January 2004, Germany, which also used to have consultations without patient charges, introduced a fee of 10 euros for initial consultations. Preliminary results suggest that this change was followed by a 10 per cent fall in visits to doctors in the first quarter of 2004. However, it is unclear what percentage of this fall was for unnecessary consultations (Lauterbach, 2004).
4. Access to specialists *i.e.* whether patients have indirect access through a gatekeeper (as in Canada) or direct access, could also impact the overall system performance (Levaggi and Rochaix, 2004). Predominance of one model over the other will depend *inter alia* on the patient's preferences, physicians' payment arrangements and the presence of information asymmetry.
5. This risk is diminished by the presence of regulations regarding self-referral by physicians in most provinces (except Nova Scotia, Prince Edward Island and Newfoundland). However, whether these regulations provide sufficient protection to consumers can be questioned (Choudhry *et al.*, 2004).
6. Theoretical arguments also suggest that mixed rewards outperform a pure fee-for-service system in an environment of information asymmetry, by reducing the welfare losses that arise when, under administrative price arrangements, fees are set at the "wrong" level, *i.e.* away from the level where marginal costs and benefits of services are equal (Newhouse, 1996).
7. Service-based funding was introduced in 2001 in Ontario with a plan for it to be progressively extended. So far, only a small proportion of hospitals have the financial management systems in place to make service-based allocations possible.
8. The current court case Chaoulli *versus* Quebec provides an interesting illustration of this. The plaintiff had to wait close to a year before having hip surgery. His legal action is based on his desire to pay a private provider for surgery to shorten the wait and to purchase private insurance in the future. The Supreme Court will determine whether an individual may purchase care that is available in the public system but not provided in a timely fashion.
9. An imponderable issue affecting capacity is the extent to which private insurers might be willing to cover treatment by US health care providers, thereby sidestepping the shortage of Canadian medical personnel.
10. The Romanow report (2002) recommended that all provinces and territories move to electronic forms with full inter-operability by 2010.

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