



## **Health Economics: An International Comparison of Health Systems**

July 26, 2006

### International Comparisons the grass is always greener on the other side of the fence

Mark Kennedy -The Ottawa Citizen

**Public despair about health care is a North American phenomenon, with new polls showing about two-thirds of Canadians and Americans think their health-care systems are in a "state of crisis".**

**As part of the research, Environics polled 3,221 Canadian adults while a comparable poll surveyed 1,008 adult Americans. Both surveys asked a simple question: Is your country's health-care system "in a state of crisis" or is it "basically in good shape?"**

**In Canada, 67 per cent said the system is in crisis, while 32 per cent said it is in good shape. One per cent offered no opinion on the question.**

**In the U.S., 63 per cent said their system is in crisis, 28 per cent said it was in good shape, and nine per cent offered no opinion.**

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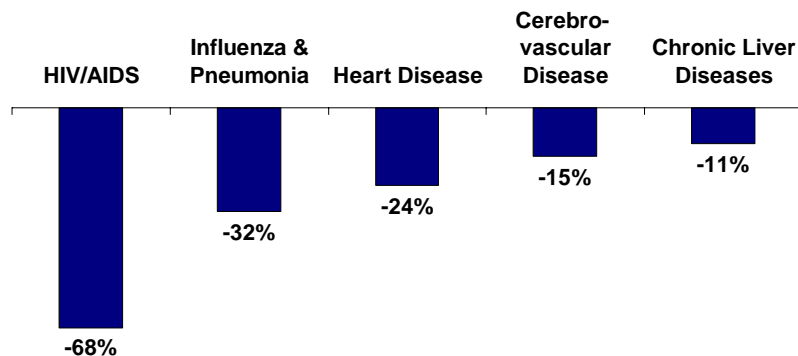
## Health Economics in the Current Policy Environment

- Health spending is increasing at a rate far greater than other government spending
- Drug policy is driven by access restrictions to contain costs
- Restricting Rx drug access does not limit health spending growth
- Institutional care is driving health spending growth
- Demographic change drives health spending growth and increased drug utilization
- As the population ages the prevalence and economic burden of chronic conditions increase

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## Medical Innovation Saving Lives: Drop in Death Rates (1993-2003)



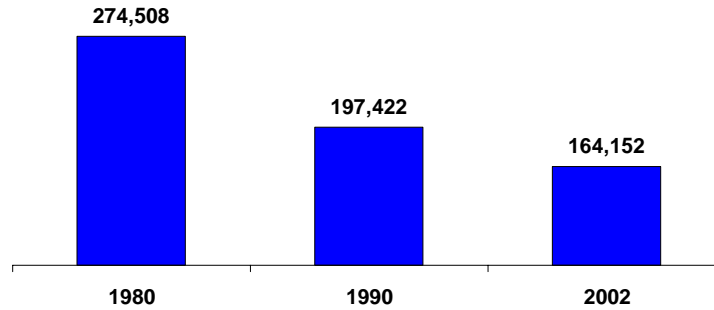
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Source: CDC, National Vital Statistics Reports, Vol.53, No. 15, Deaths: Preliminary Data for 2003, February 28, 2005



## Medical Innovation Saving Money: Days of Hospital Care: U.S.

From 1980 to 2002 hospital utilization in the U.s. dropped 40 %

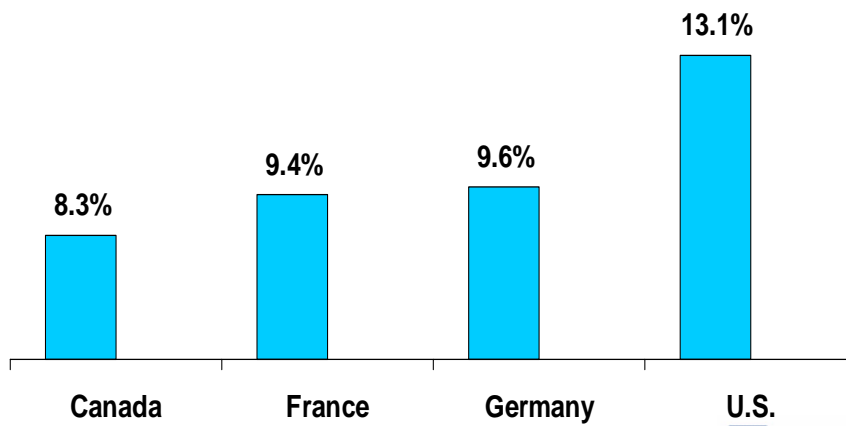


Source: CDC, National Hospital Discharge Survey:2002 Annual Summary with Detailed Diagnosis and Procedure Data, march 2005.



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## Personal Health Costs as a Percent of GDP 2003



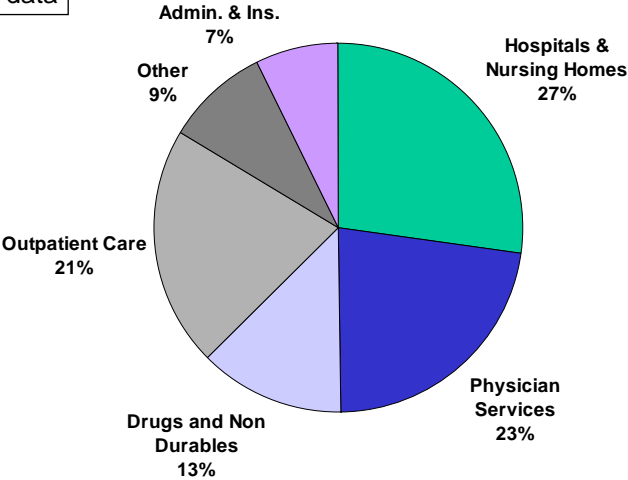
OECD Health Data 2005



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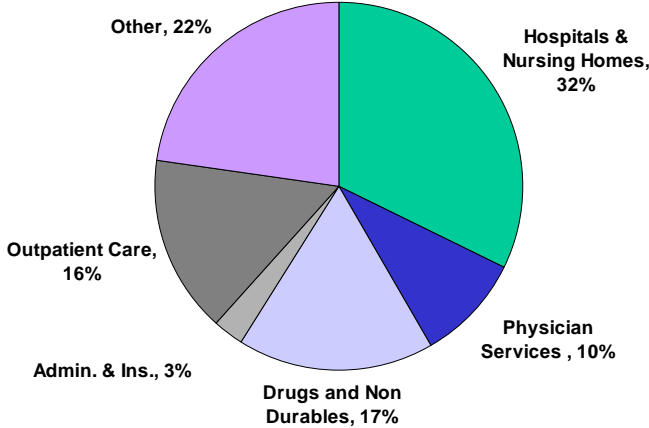
# U.S. Spending on Health

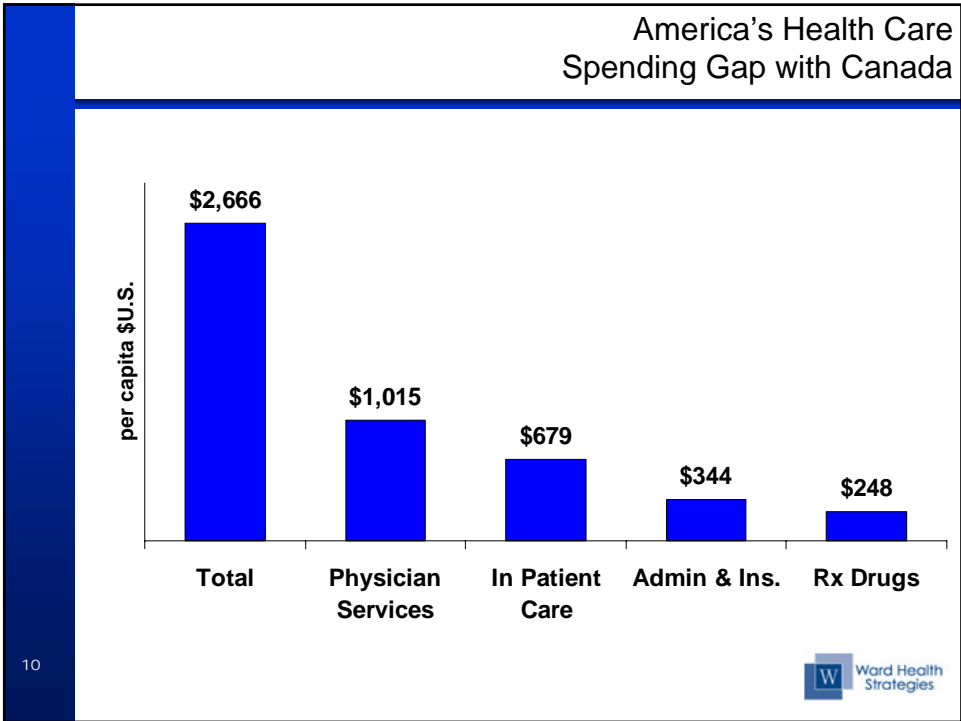
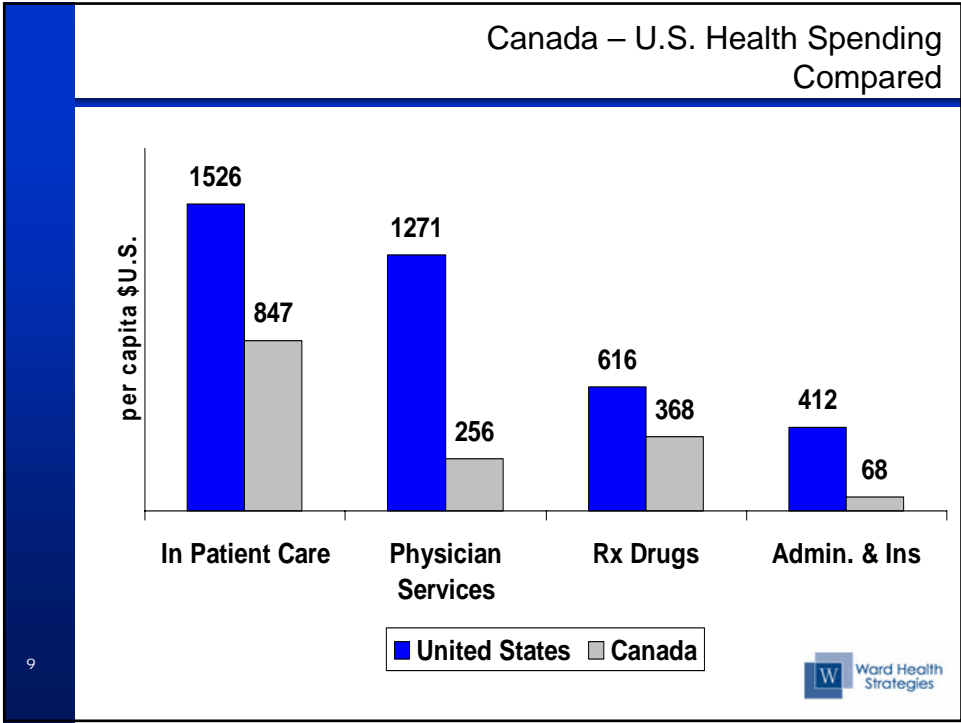
2003 data



# Canadian Spending on Health

2003 data





Less than Half of the Top 50 Drugs Covered by State Medicaid programs are Covered in Canada

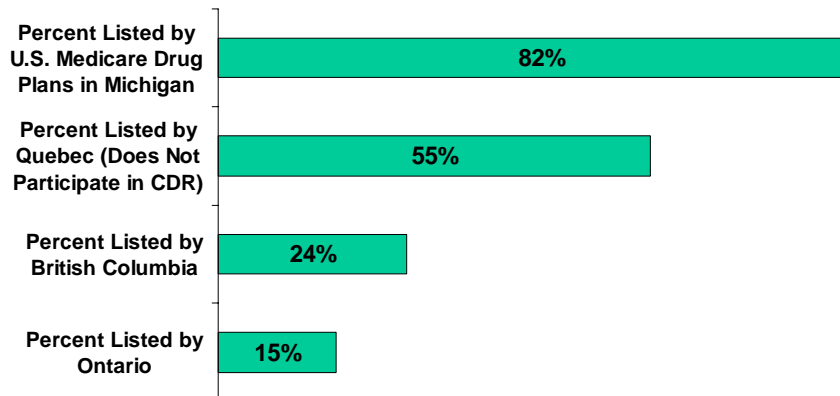
U.S Medicaid	Ontario	British Columbia
U.S. total	21	22
Michigan Medicaid	21	26
Minnesota Medicaid	25	32
Pennsylvania Medicaid	22	29
New Hampshire Medicaid	20	28

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Drug Access Compared : U.S. Medicare Part D vs. Quebec British Columbia and Ontario

Listing Status of 33 Drugs Reviewed as of Dec 31 2005

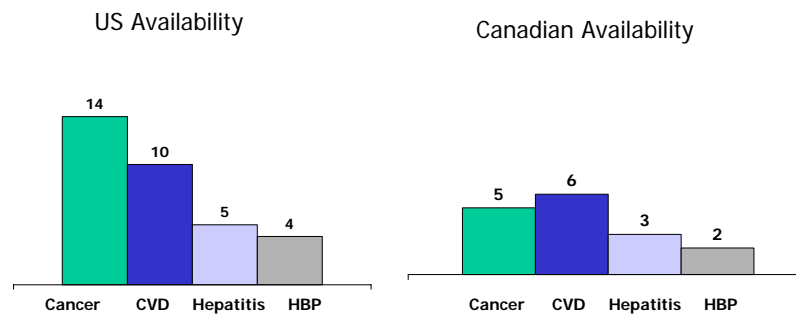


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Ward Health Strategies



## Availability of Drugs Approved by the FDA from 2000 to 2003



Note: Of the 124 new drugs launched in the US between 2000 and 2003, 49 were also made available in Canada, all 7 drugs approved by Health Canada prior to 2000 are available, and 15 of the 20 drugs approved in 2004/05 are available. The remaining 43 drugs were either not approved or not submitted for approval. Does not include all other drugs approved by Health Canada between 2000 and 2003. (Canadian launch data not available for Pantoloc)

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## Canadian Health System Characteristics

1. Portability— means you get the same coverage no matter where you live. (But no “national” program)
2. Universality- everyone is covered. (For physician and hospital care only)
3. Single payer. (Means you wait in line for rationed services and you can't pay for what the government refuses to give you)

Currently publicly funded programs in the U.S do a better job of adhering to these principles but fall short on “universality”.

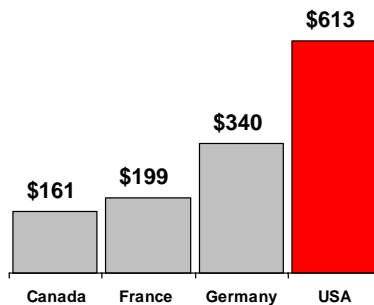
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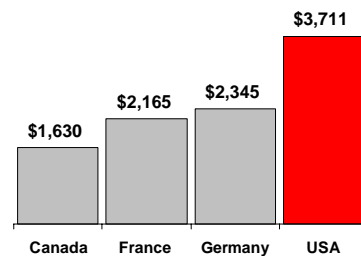
- Only Canada, Cuba and North Korea have no private-pay MDs and hospitals
- Canadian Medicare was created to eliminate financial barriers to medically necessary care
- Institutionalized cost containment has reintroduced a financial barrier to care
- No one is copying Canada’s “system”

### Why Health Care Costs More in the U.S. than Elsewhere: High Liability Costs

Per Capita Spending on Liability (Tort)



Per Capita Spending on Personal Health Care

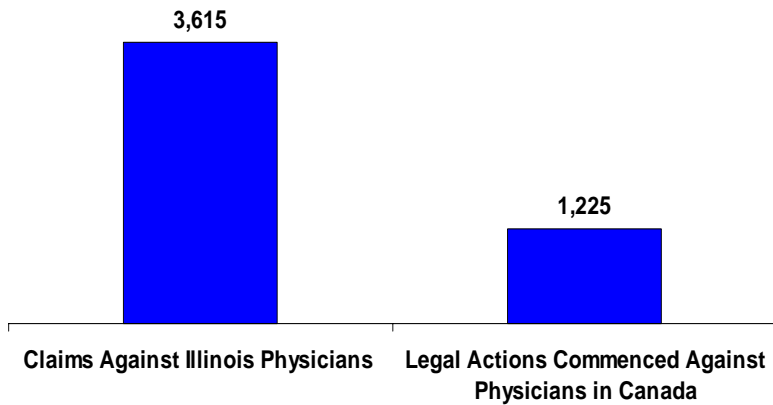


1998 Data



## Impacts of a Litigious Environment

Legal Claims Against Physicians in Illinois and Physicians in Canada

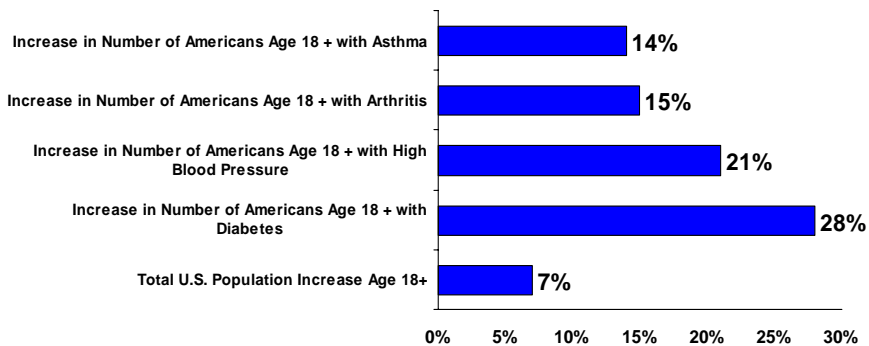


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## An Aging Population Increases the Economic Burden of Illness and Disease

Increase in Diagnoses of Selected Chronic Conditions U.S. 2000 to 2004



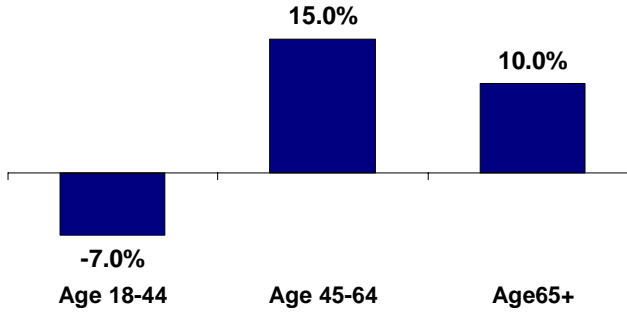
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## The Cost of New Technologies and Medicines Are Not Driving health Spending Growth

*Most of us prefer getting old rather than the alternative !!*

**Shift in Selected Age Groups as a Proportion of the Total Population : 2002 to 2012**

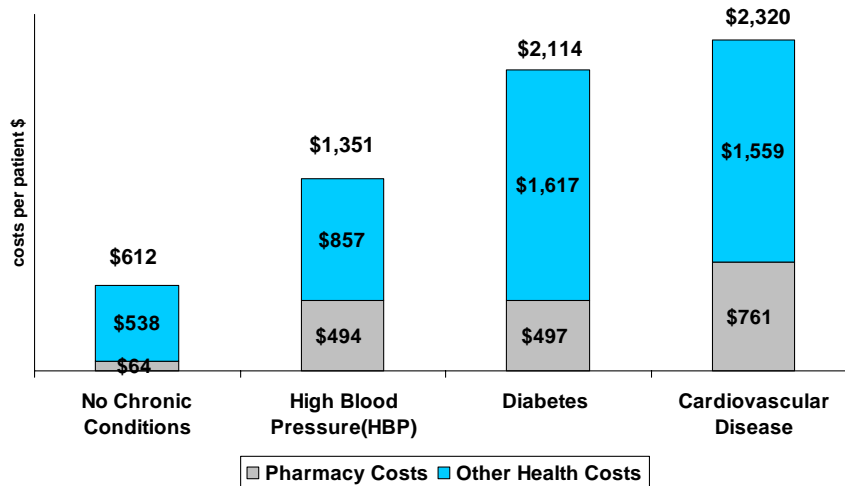


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Source: U.S. Census Bureau



## Impact of Chronic Conditions on Health Spending



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Robert I. Garis, Kevin C. Farmer, *Examining Costs of Chronic Conditions in a Medicaid Population, Managed Care*, August 2002

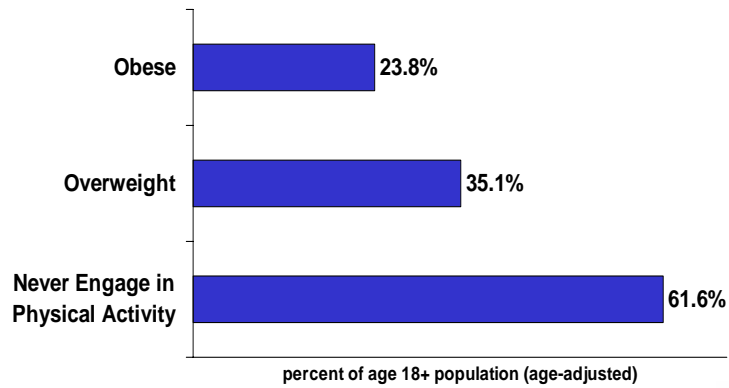


## Health Spending and Lifestyle Choices

Most health spending is avoidable or preventable

More than 1 out of every 4 health care dollars spent on Americans over age 40 is attributable to being overweight, obese or physically inactive

Overweight Obese and Inactive Adult Population 2004

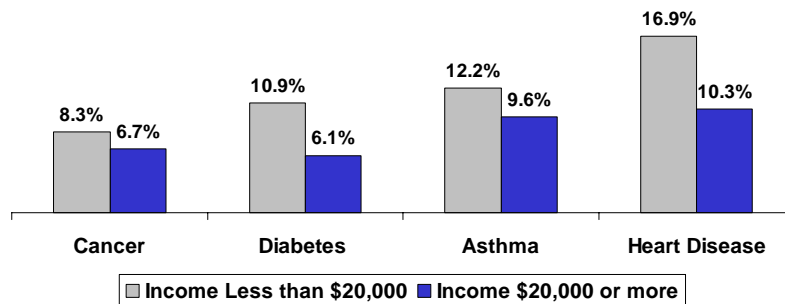


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## Disparities are also determinants of health

Prevalence of Chronic Conditions by Income Level 2004



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## What Drives Patient Centered Care?

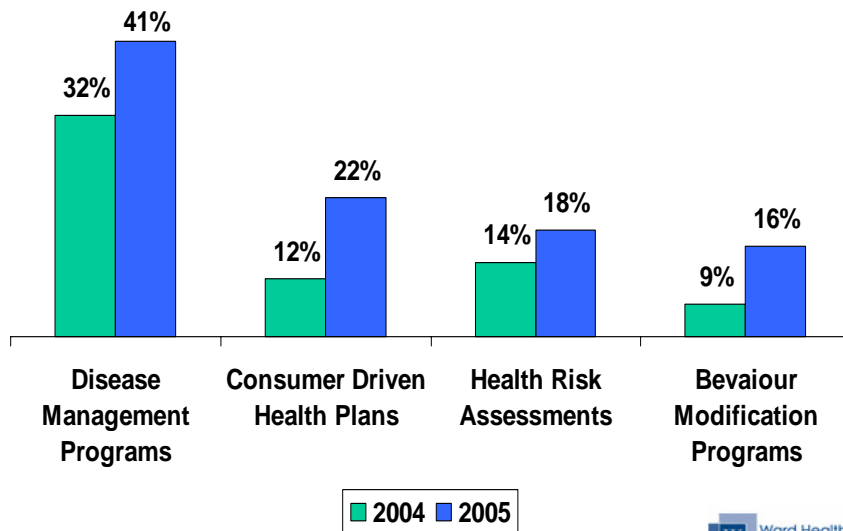
As the system has grown more complex and fragmented, and as providers feel more pressure to see more patients in less time, care has become centered not on the needs of patients, but around the needs of the system itself.

The burden of chronic disease requires a different approach that sees the patient as a partner in achieving better outcomes.

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## Growth of Care Management Strategies in Employer Health Plans

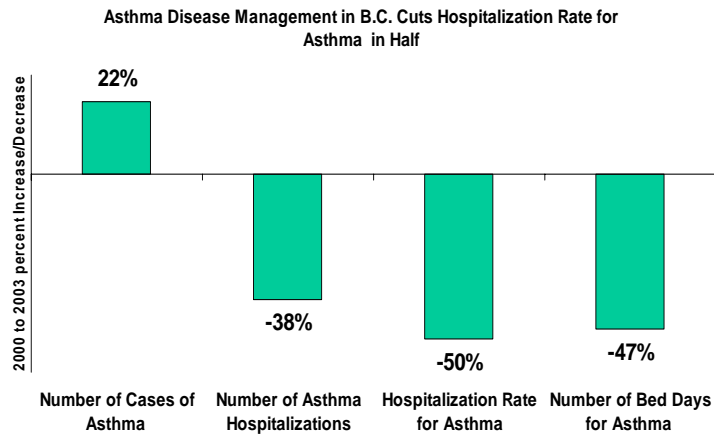


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## Getting results from patient centered care

Drug costs may soar but overall spending drops-often dramatically



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## Principles of Patient Centered Care

### IAPO Declaration

1. **Respect** – Patients and care-givers have a right to patient-centered healthcare that respects their unique needs, preferences and values, as well as their autonomy and independence.
2. **Choice and empowerment** – Patients have a right and responsibility to participate as a partner in making healthcare decisions that affect their lives. This requires a responsive health service that provides suitable choices in treatment and management options that fit in with patients' needs

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## Principles of Patient Centered Care

3. ***Patient involvement in health policy*** – Patients and patients' organization deserve to share the responsibility of healthcare policy making through meaningful and supported engagement in all levels and at all points of decision-making, to ensure that they are designed with the patient at the centre.
4. ***Access and support*** – Patients must have access to the healthcare services warranted by their condition. This includes access to safe, quality and appropriate services, treatments, preventive care and health promotion activities
5. ***Information*** – Accurate, relevant and comprehensive information is essential to enable patients and careers to make informed decisions about healthcare treatments and living with their conditions.

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## Why Patient Centered Care Matters

- Because engaging patients in decisions about their own care is the most effective way to improve health outcomes
- Because patient centered care is shaping health care renewal and primary care reform around the world
- Because engaging patients in health policy decision making improves the quality of care
- Because better outcomes improves cost-effectiveness

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## Managing Health Care Costs

- Increased prevalence of chronic conditions among aging “boomers” drives health spending growth
- Price controls, prior authorizations, access restrictions do not limit exposure to potentially devastating health costs (Coverage does!)
- The excesses of liability litigation in the US. is a major primary reason for differences between health costs in the U.S. and Canada/Europe.
- Providing patient centered care is the most effective way to improve outcomes and manage and health costs.

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## Using “Evidence”

Evidence-based Decision-Making  
OR  
Decision-based Evidence-Making ?

Comparative effectiveness analysis  
should not start with the premise of saving  
money

What might be good on average for an  
entire population may be useless or even  
harm an individual patient

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## No Evidence = Evidence

- “When we looked at the evidence around the drugs for Fabry’s disease we came to the conclusion that there was no evidence that they were cost-effective.
- It may be that society, though, given that this is a rare disease, no other treatments, might then decide that despite that, they would reimburse the drug”

Andreas Lapaucis

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## Treatment Access Decision-Making

*Do outcomes or costs drive access decisions?*

Reimbursement committees...that’s actually how we regulate the cost of drugs and the use of drugs because we don’t have flexibility of price right now.”

Andreas Lapaucis, Chair CEDAC

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## Cost-Effectiveness

“ a lethal dose of morphine upon retirement would be the drug treatment with the most favorable benefit-cost ratio for older patients”

“tobacco turns out to have better benefit cost ratio than insulin”...  
*Powerful Medicines* Jerry Avorn MD

“Death is a great way to cut down on expenses”  
Woody Allen

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## Advocating for Access

- **Health policy is not just about cost drivers, managing budgets and best practices**
- **Health policy is about *people, health, and productivity***
- **Access to innovative products should be just one small part of an integrated, interdependent health care system**

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