The Management of Care and Costs in Canada and the US. Closer than we know?

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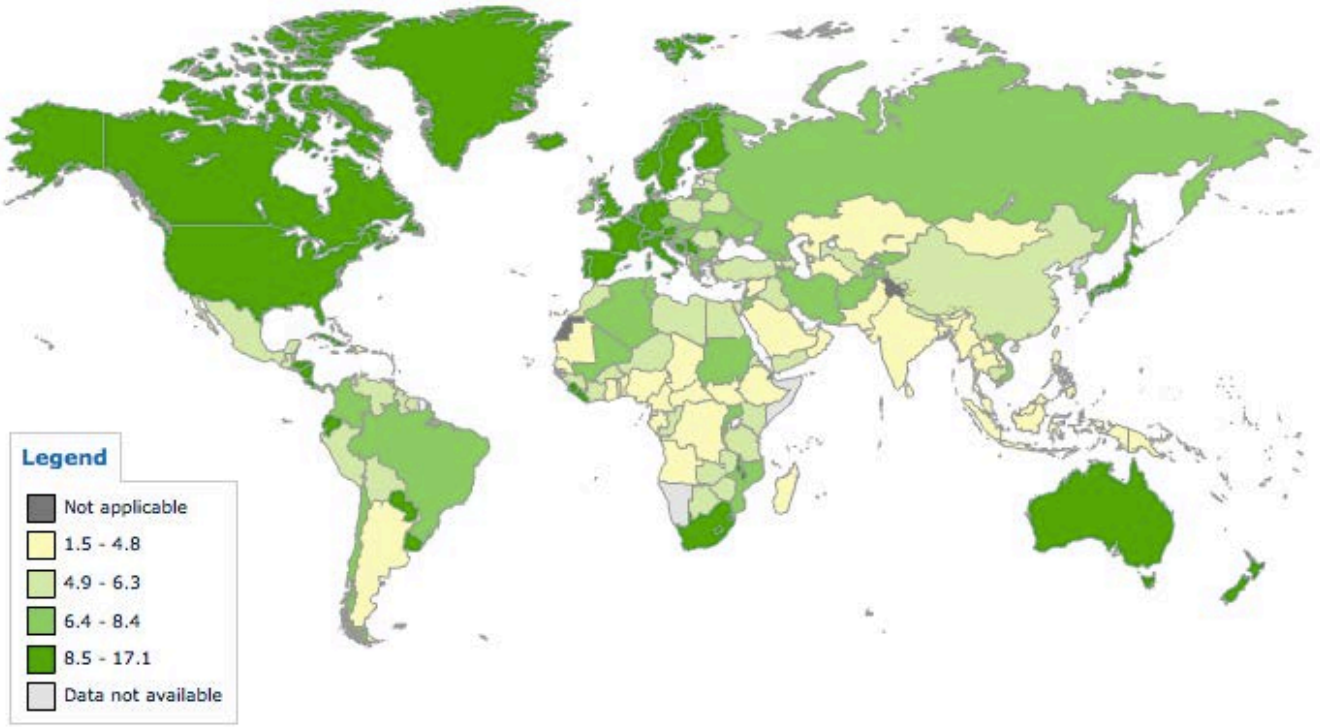
How different are our health systems?



Health Expenditure as a percent of GDP
Source: WHO

How are coverage decisions made?

A sample case of two large payors for new devices

	BCBS	**Ontario**
Cost-Effectiveness	Explicit consideration; Coverage with evidence development	Explicit consideration but little use; Coverage with evidence development
Access to capital to purchase	Private, public, and philanthropy	Little access outside of government financing or philanthropy
Ability to operate	Dependent on coverage	Dependent on allocation of capital and operating funding and coverage

The biggest difference in determining coverage is physicians' time

Exhibit 3

Mean Dollar Value Of Hours Spent Per Physician Per Year For All Types Of Interactions With Payers

Personnel	United States (SE)	Canada (SE)	Canada costs with US salaries[a]	Canada costs with US salaries and US specialty mix[b]
Physicians	$17,775 (932)	$6,191 (1,074)[c]	$8,422[c]	$9,616[c]
Nurses	$23,478 (1,332)	$2675 (366)[c]	$2,349[c]	$2,302[c]
Clerical staff	$37,010 (1,650)	$10,766 (715)[c]	$9,178[c]	$9,603[c]
Senior administrators	$4,712 (458)	$779 (415)[c]	$1,386[c]	$684[c]
Total	$82,975 (3,453)	$20,410 (1,404)[c]	$21,335[c]	22,205[c]

US Physician Practices vs. Canadians
Source: Morra et al, *Health Affairs,* 2011

How are physicians and executives paid?

Much greater innovation in the US

	US	Ontario
Physician payment	Wide variety of models ranging from fee-for-service to risk-based payments to ACOs	Largely fee-for-service or modified capitation tied to productivity
Physician organization	High degree of physician organization (IPAs, ACOs)	Mostly solo or primary care group practice
Executive compensation	Relatively high: $2,913,000 for Greenwich Hospital (Yale)	Relatively Low: $715,000 for Sunnybrook Hospital (University of Toronto)

Higher physician compensation in US vs. Canada

Exhibit 4

Physician Capacity, Earnings, And Spending In Six Countries, 2008

Country	Density per 10,000	Density relative to US	Pretax earnings net of expenses (US$ 2008)	Earnings relative to US	Payments to MDs per 1,000 ($)	Payments to MDs relative to US	Primary care MD earnings relative to orthopedic surgeons (%)
Primary care physicians							
Australia	14	1.4	92,844	0.50	129,982	0.70	49
Canada	10	1.0	125,104	0.67	125,104	0.67	60
France	17	1.7	95,585	0.51	162,494	0.87	62
Germany	10	1.0	131,809	0.71	131,809	0.71	65
United Kingdom	7	0.7	159,532	0.86	111,672	0.60	49
United States	10	1.0	186,582	1.00	186,582	1.00	42
Orthopedic surgeons							
Australia	0.45	0.68	187,609	0.42	8,442	0.29	—[a]
Canada	0.32	0.48	208,634	0.47	6,676	0.23	—[a]
France	0.34	0.52	154,380	0.35	5,249	0.18	—[a]
Germany	0.44	0.67	202,771	0.46	8,922	0.31	—[a]
United Kingdom	0.28	0.42	324,138	0.73	9,076	0.31	—[a]
United States	0.66	1.00	442,450	1.00	29,202	1.00	—[a]

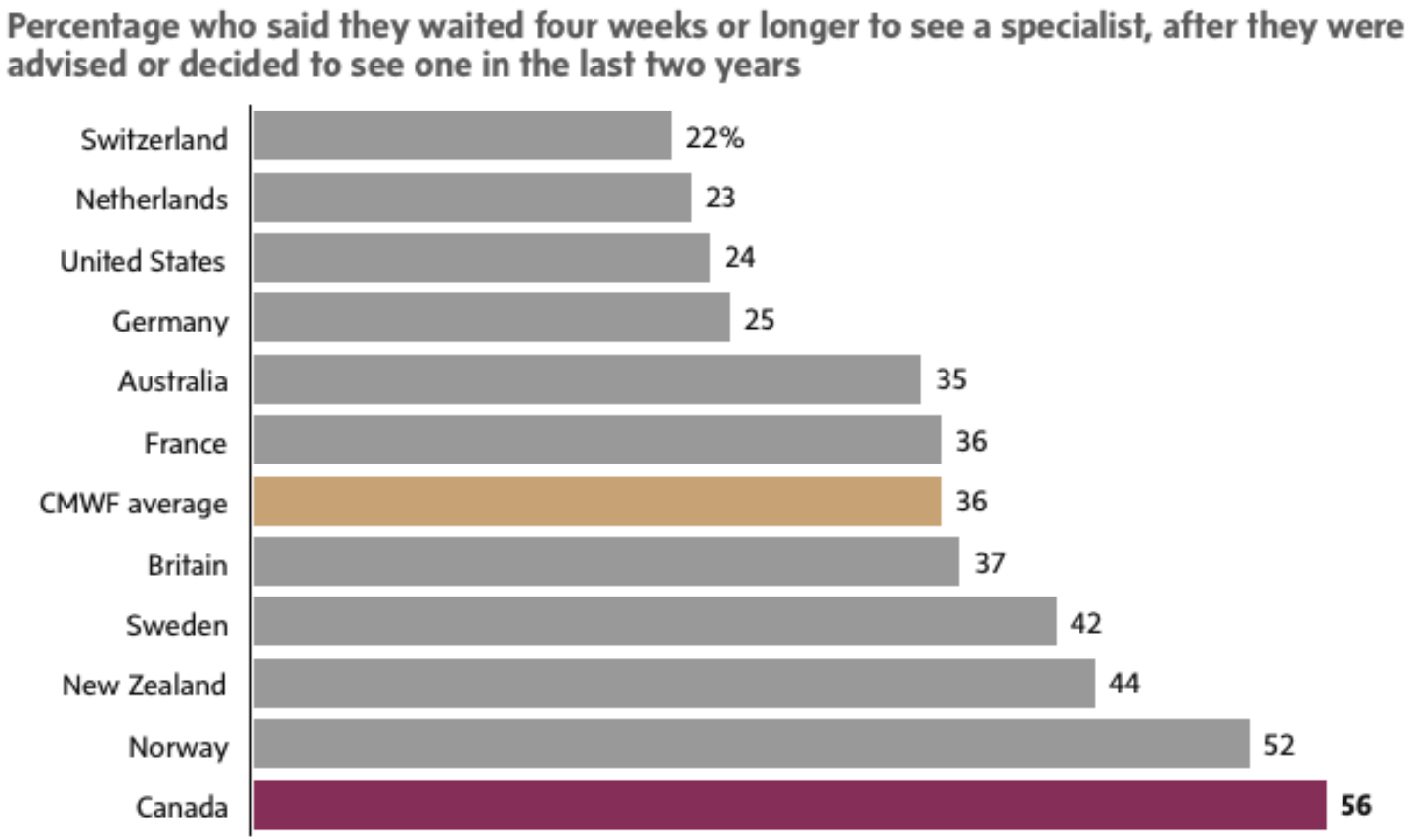
Higher fees paid to US Physicians

Source: Laugesen and Glied, *Health Affairs,* 2011

How is access to care decided?

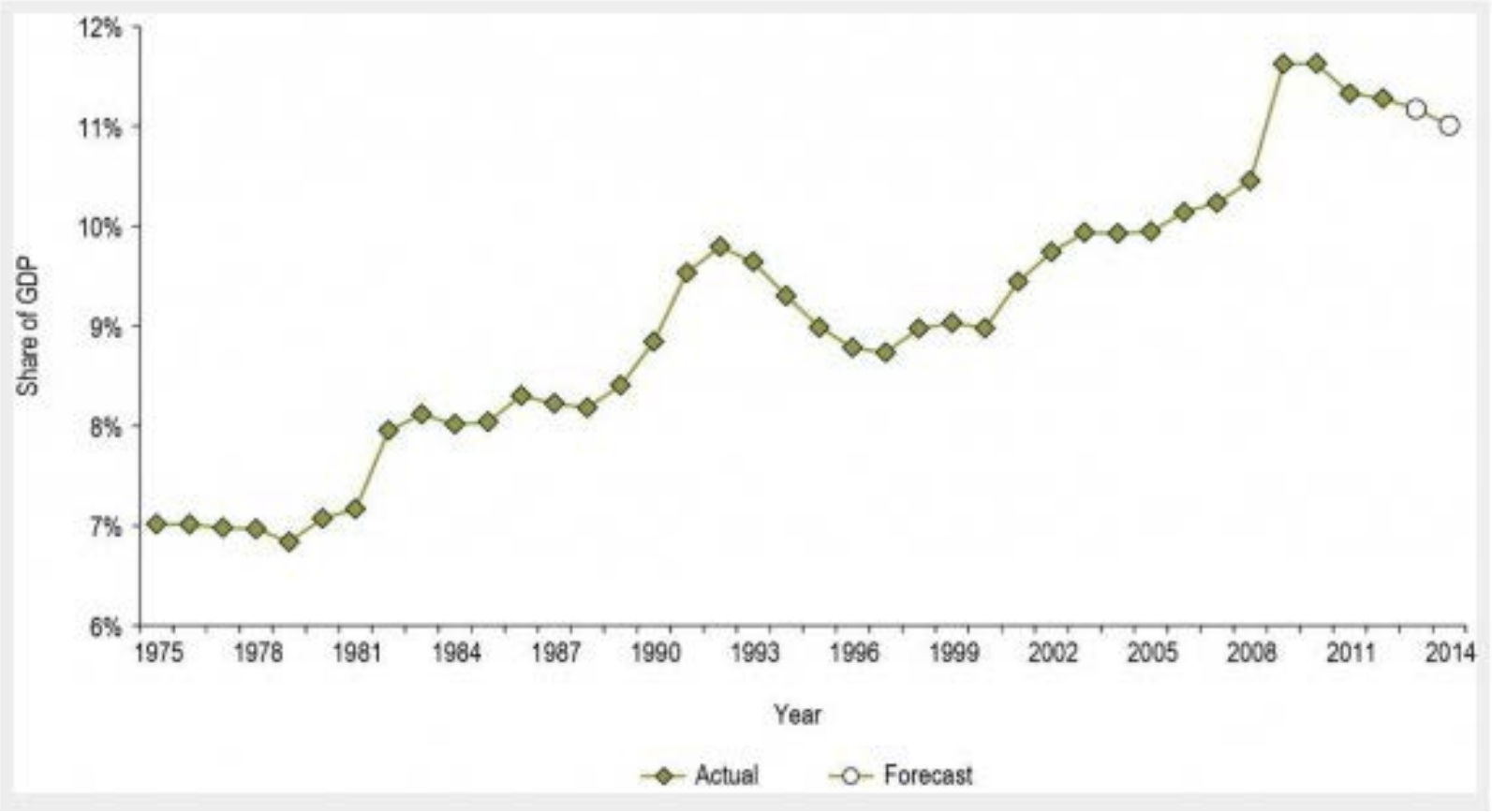
	US	**Caanada**
Processes based on insurance plan	Extensive use of processes to ensure in-network, cost-effective care	Almost none once coverage established
Exceptional access	Appeal through payor processes or courts	Appeal through payor processes or courts
Explicit prioritization	Within practice only	Within practice and across practices for increasing numbers of indications
Availability of care	Availability much higher, little outside of rural/marginalized areas	Availability of physicians, hospital beds and other resources are critical determinants of access

Access to care in Canada lags on virtually all access indicators except equity and surgery



Commonwealth fund data reported in the Globe and Mail, February 16, 2017

Without significant delivery innovation cost growth has slowed in Canada



CIHI as reported in Healthydebate.ca

Some tentative conclusions

Outside of questions around “who is covered” many determinants of “what is covered” are similar

- Central control over capital is key to explaining differences
- Single payor (and decider) on access intensifies effect of coverage decision-making

Limits on compensation and supply of care are major determinants of differences in costs, not coverage decisions

Much greater innovation in how care is organized and compensated in the US, greater supply side control in Canada

- Little comparative evaluations of innovations in policy like integration and impact in different jurisdictions
- But these innovations are unlikely to drive significant changes in overall spending in either jurisdiction
- Simple policy options (supply-side controls) beat sophisticated delivery system innovation