

Accessing Rehabilitation: Current Trends, Practice and Issues

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What's the problem?

- ✓ People with chronic diseases, with effective support and treatment, can live and function without severe health problems.
- ✓ But there can be painful, and expensive, episodes of care. Ideally, these can be prevented/minimized.
- ✓ Evidence is clear that people with certain chronic diseases, including HIV/AIDS, can benefit from receiving rehabilitation services.
- ✓ These services not always available, not always covered.

How should we finance health care?

- ✓ OECD identified the following models:
 - Public financing
 - (tax revenue)
 - Social health insurance
 - (compulsory membership)
 - Private health insurance
 - Out of pocket payments

One key variable: Distributive justice

- ✓ When, and for what, should costs be pooled?
- ✓ If costs are pooled, should payments be
 - Uniform?
 - (flat rates)
 - Based on ability to pay?
 - (solidarity)
 - Based on expected costs?
 - (actuarial fairness)

Underlying question

- ✓ What sort of good is health care?
- ✓ Let's consider logic of insurance

Insurance logic suggests:

1. You cannot insure against a certainty
2. Premiums should be based on expectations of payouts/loss (actuarial fairness)
3. People should not be completely insulated against risk or they will abuse coverage (moral hazard)

Moral Hazard and insurance

- ✓ Does having insurance change behaviour?
 - Have flood insurance, will build in flood plain?



Implications for health insurance?

- ✓ If insurance logic holds, then..

You can't insure against a certainty

- ✓ Pregnant women should not be able to purchase insurance for birth and delivery (indeed, those with pre-existing conditions should not be able to buy insurance for those conditions)

Premiums should be based on expectations of payouts/loss

- ✓ Those with pre-existing conditions who have a higher probability of needing care (although not a certainty) should pay higher premiums, or be denied coverage

People should not be completely insulated against risk

- ✓ Or they will abuse coverage
 - (Those with good insurance will use too many services.)

But is it true?

Let us try some examples

What's the Best Way to Finance Medically Necessary Care?

- ✓ A single payer? Or market competition?

Four hypothetical questions

- ✓ Taxi
- ✓ Free trip
- ✓ Appendix
- ✓ Free surgery

Neo-classical economics says

- ✓ Price links supply with demand
- ✓ If supply fixed and demand high:
 - Price should???
- ✓ If price free:
 - Demand should???

The Non-health examples

- ✓ The taxi?
- ✓ The free trip?
- ▶ These are market goods
- ▶ Supply and demand seems to work

The health examples

- ✓ The ruptured appendix?
- ✓ The free surgery?
- ▶ These are merit goods
- ▶ Supply and demand does not seem to apply

What's the problem?

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- ✓ But there can be painful, and expensive, episodes of care. Ideally, these can be prevented/minimized.
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- ✓ These services not always available, not always covered.

So...why are rehabilitation services so difficult to access?

Macro-Level Issues Include

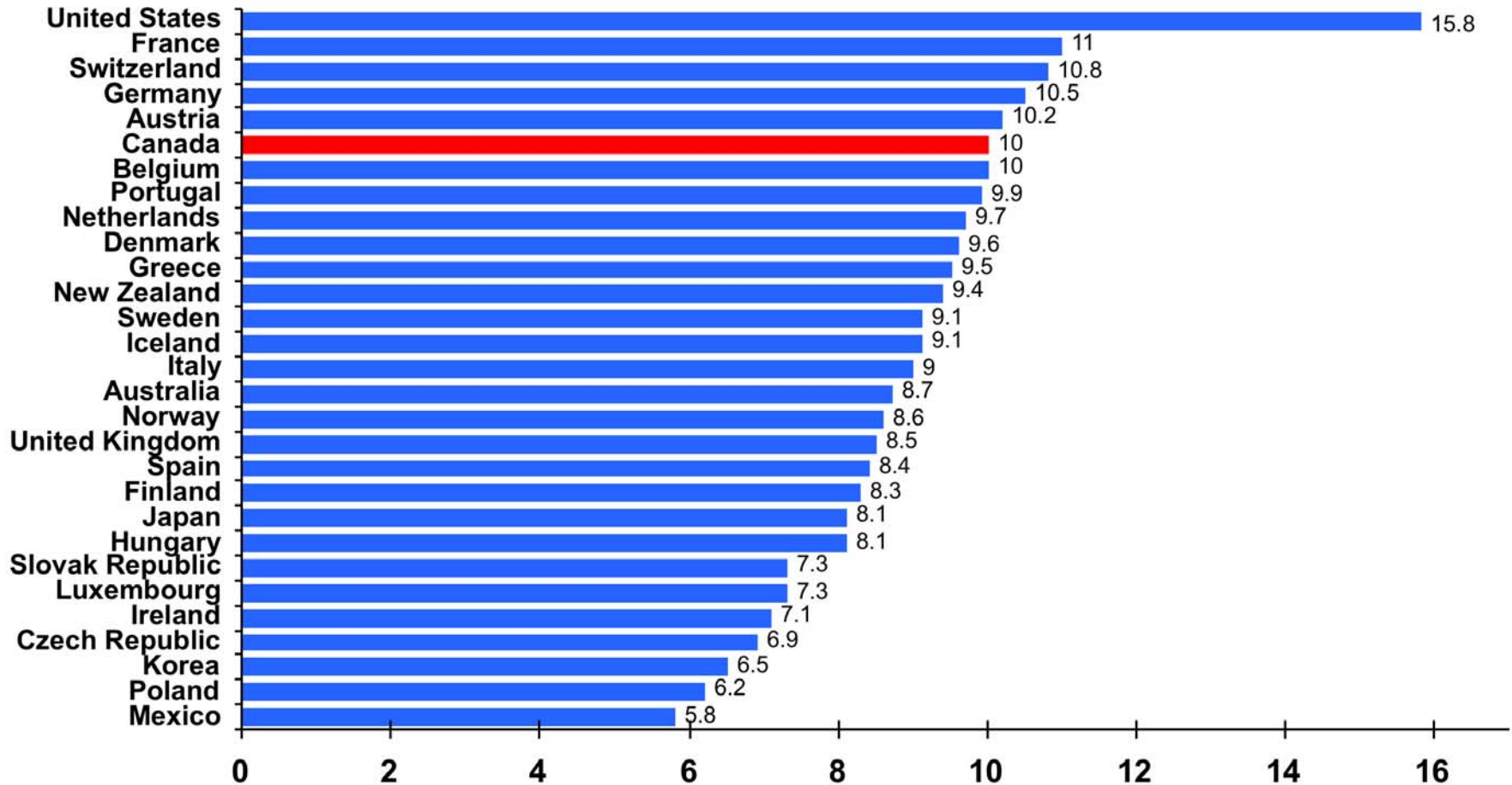
- ✓ Fears about health costs being unsustainable.
The public/private mix
- ✓ The Canadian health system and how it is defined.
The Canada Health Act – what it does/does not require

Health care is expensive

- ✓ And getting more so...
- ✓ Comparisons can be misleading
- ✓ Usual basis of comparison for Canada, US, etc.
- ✓ Look at the OECD countries
 - Relatively developed economies
 - 22 to 30 members
 - Canada is about where one would expect, given our GDP



Comparative Data: 2006 Health Expenditures as % of GDP

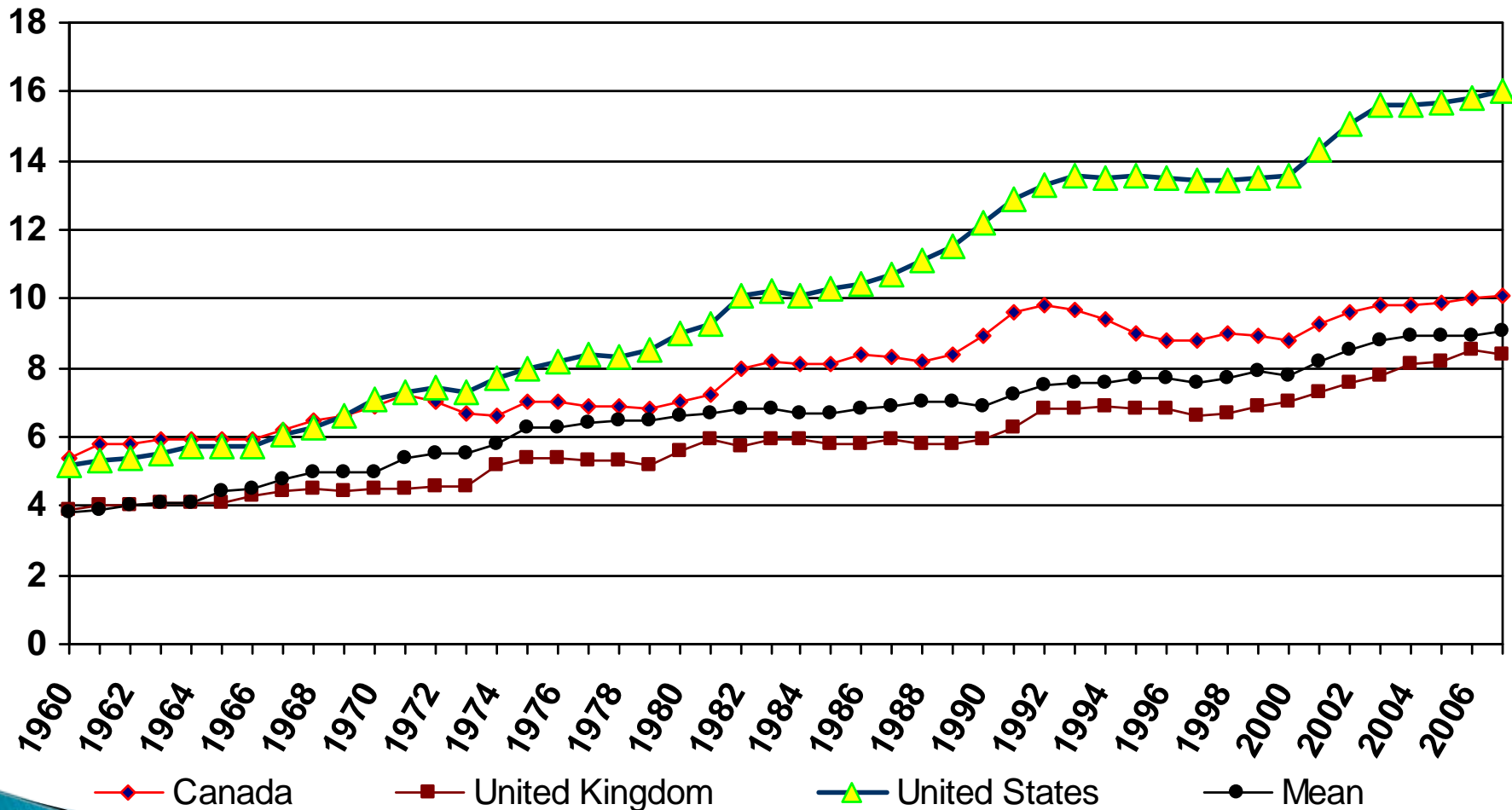


Source: OECD Health Data 2009

Often forgotten

- ▶ Ratios have numerators and denominators
- ▶ So, what does it mean when we look at health expenditures as a % of GDP?

As the economy improves, the ratio of spending to GDP falls



What are the cost drivers in a publicly funded system?

- ✓ To oversimplify:
- ✓ $\text{Cost} = \sum_{n=1}^n (\text{cost}_n) * (\text{utilization}_n)$
- ✓ Or, in English:

- ✓ Costs are a function of:
 - How much you pay for each item
 - How many of each item you buy
 - Mix of items you buy

More causes of variation

- ✓ What do you need to buy?
 - Related to age, burden of disease, ...
- ✓ Who delivers care
 - And how much are they paid?
- ✓ How is care organized and delivered?

- ✓ We can control some (but not all) of these factors

Fearless prediction

- ▶ When we get the data from the current years
- ▶ Recognizing that the economy has not done very well
- ▶ Health spending as a % of GDP will increase in all OECD countries!
 - This will pressure governments to attempt to contain costs even further
 - Key focus likely to be “value for money”

Need to distinguish between

- ▶ Financing

- How care is paid for (and by whom)

- ▶ Delivery

- How care is delivered (and by whom)

- And the related question of Allocation (the incentives inherent in how people are being paid)

Health Systems in General: Public and Private

- ✓ Public can be:
 - Nation
 - Sub-national (State/Province)
 - Region within a state/province
 - Local
- ✓ “Quasi public” (e.g., WSIB, regional health authorities)

Public and Private

✓ Private can be:

- Corporate for profit
 - E.g., pharmacies, pharmaceutical companies, medical laboratories
- Small business/entrepreneurs
 - E.g., physicians, many PT practices
- Not-for-profit (volunteers or paid workers)
 - E.g, hospitals, community agencies
- Individuals and families
 - E.g., parents, family caregivers

Canada Does Not Have “Socialized Medicine”

- ✓ It has a system of public financing of certain categories of health services
- ✓ These services are delivered by private (albeit often not-for-profit) providers
- ✓ This system of publicly-financed hospital and medical insurance is referred to as “Medicare”



Canada Health Act (1984)

- ✓ Requires coverage based on:
 - Where care delivered (in hospital)
 - Or by whom (physicians)
- ✓ Governments can insure beyond this
- ✓ But they are not required to

“Hospital Services”

“Means any of the following services provided to in-patients or out-patients at a hospital, if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability, namely:

(Continued)

“Hospital Services” (Continued)

- A) accommodation and meals at the standard or public ward level and preferred accommodation if medically required
- B) nursing service,
- C) laboratory, radiological and other diagnostic procedures, together with the necessary interpretations

(Continued)

“Hospital Services” (Continued)

- D) drugs, biologicals and related preparations when administered in the hospital
- E) use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies
- F) medical and surgical equipment and supplies

(Continued)

“Hospital Services” (Continued)

- G) use of radiotherapy facilities
- H) use of physiotherapy facilities
- I) services provided by persons who receive remuneration therefore from the hospital but does not include services that are excluded by the regulations

Canada Health Act, 1984



Canada Health Act (1984)

- ✓ Is a 'floor', and not the 'ceiling' in terms of what must be insured by provinces
- ✓ Outpatient rehabilitation services are not explicitly included within the Act (neither are outpatient pharmaceuticals, dental care, eye care, home care...)
- ✓ Provinces, and individuals hospitals, can chose to include rehab, but this is not a requirement

The First Law of Cost Containment

- ✓ The easiest way to contain costs is to shift them to someone else

What Happens When We Move Out of Hospitals?

- ✓ These services move beyond Medicare
- ✓ No longer a requirement to include them within public financing
 - Even though many are undeniably “medically necessary” (e.g., much rehabilitation)

What happens as the community-based services erode?

- ✓ Often, people wind up in hospital emergency rooms
- ✓ Why?
 - Only place they can be assured of getting free care

What happens as the community-based services erode?

- ✓ Result?
 - Public pressure to increase hospital funding, even if other services would be more cost-effective
- ✓ Open question –
 - Will regional bodies break down funding silos and allow more efficient resource allocation? What will that do to hospitals?

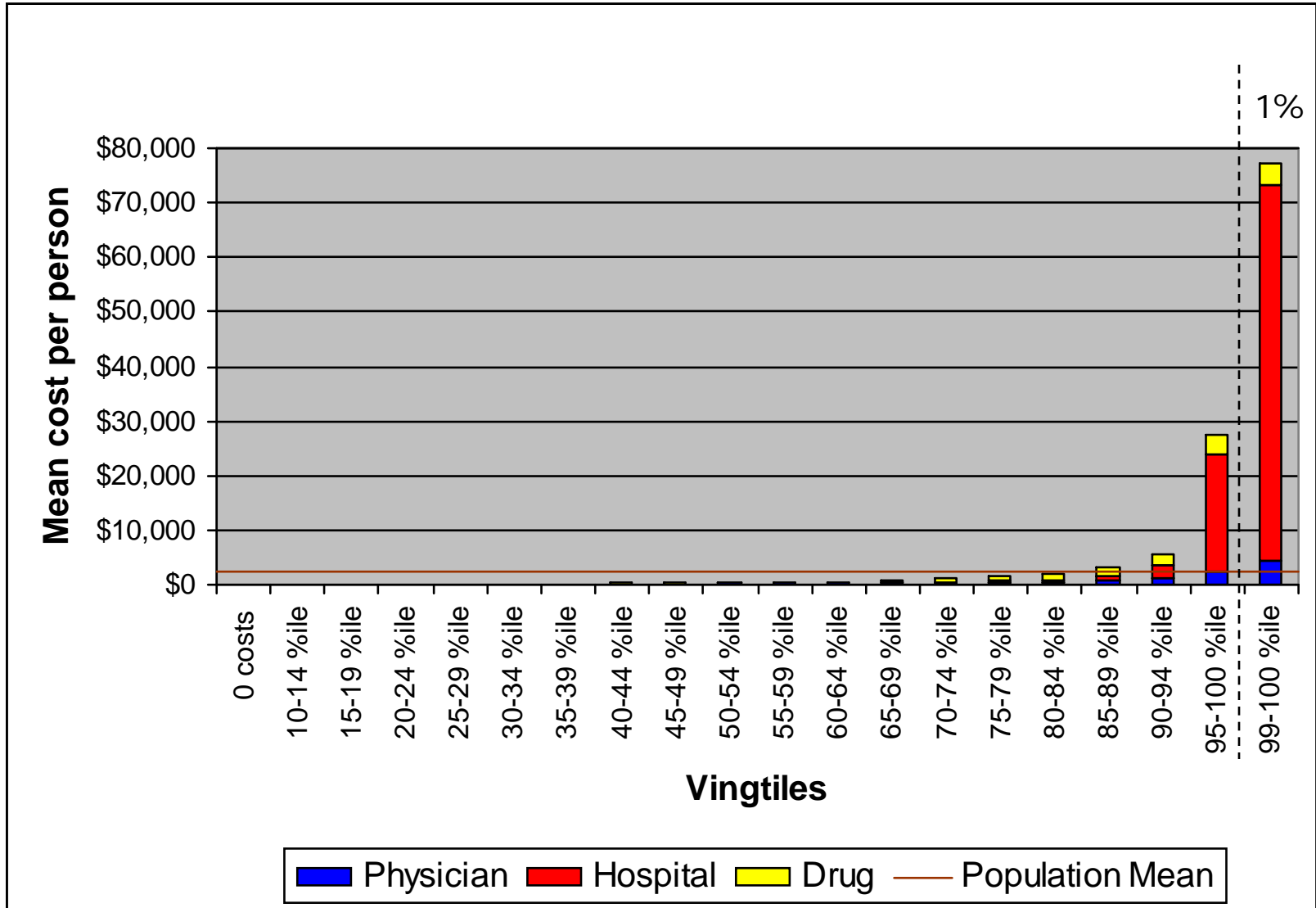
Deber, Roos, Forget et. al. studied Manitoba

- ▶ Kenneth C. K. Lam is doing in-depth analysis for his PhD
- ▶ This work done by Raisa B. Deber, Kenneth C. K. Lam, Leslie L. Roos, Evelyn L. Forget, Gregory S. Finlayson, and Randy Walld
 - Through Manitoba Centre for Health Policy, Faculty of Medicine, University of Manitoba

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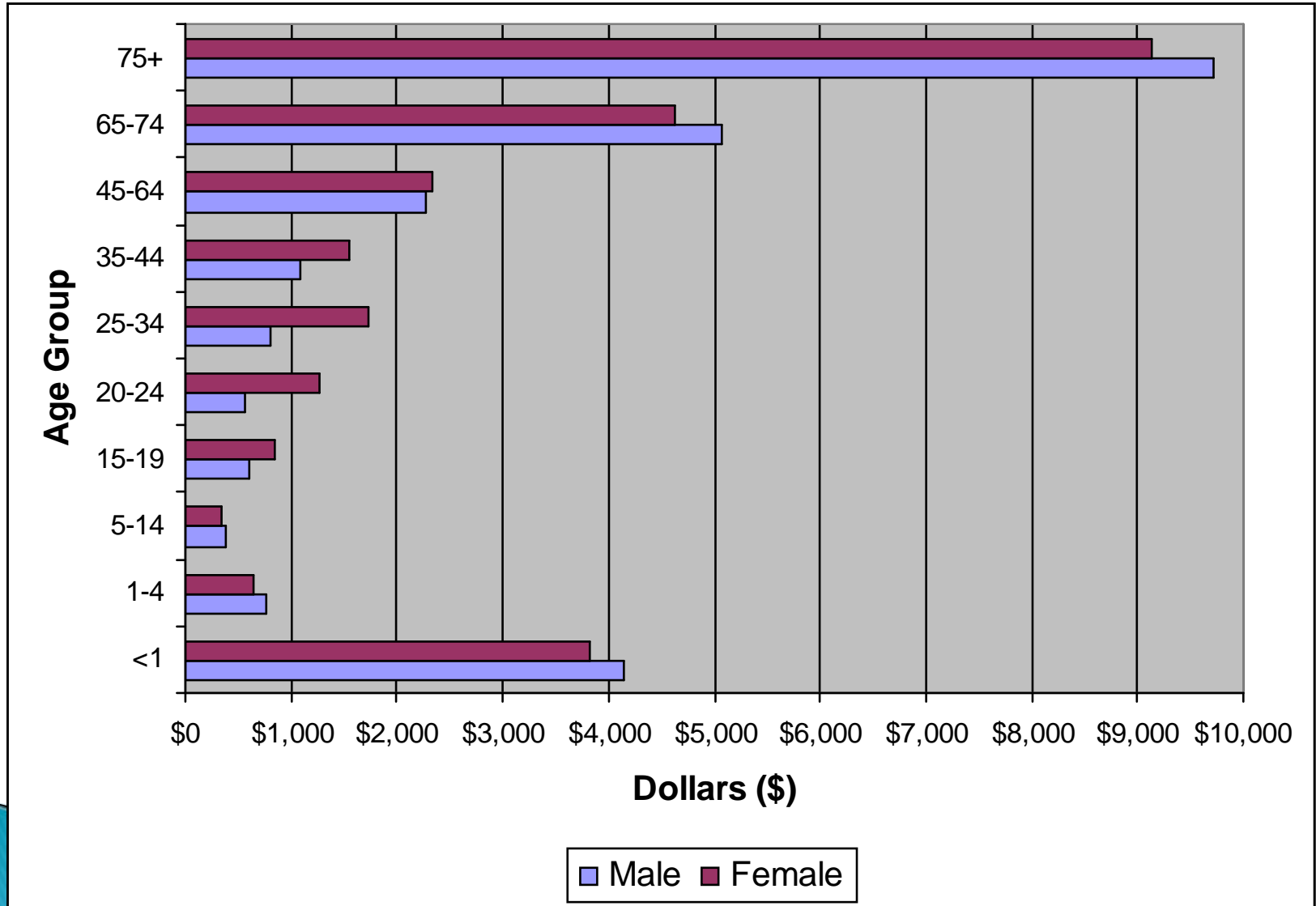
Mean Total Expenditures for the Full Population by Vingtiles in Manitoba, Fiscal 2005–2006



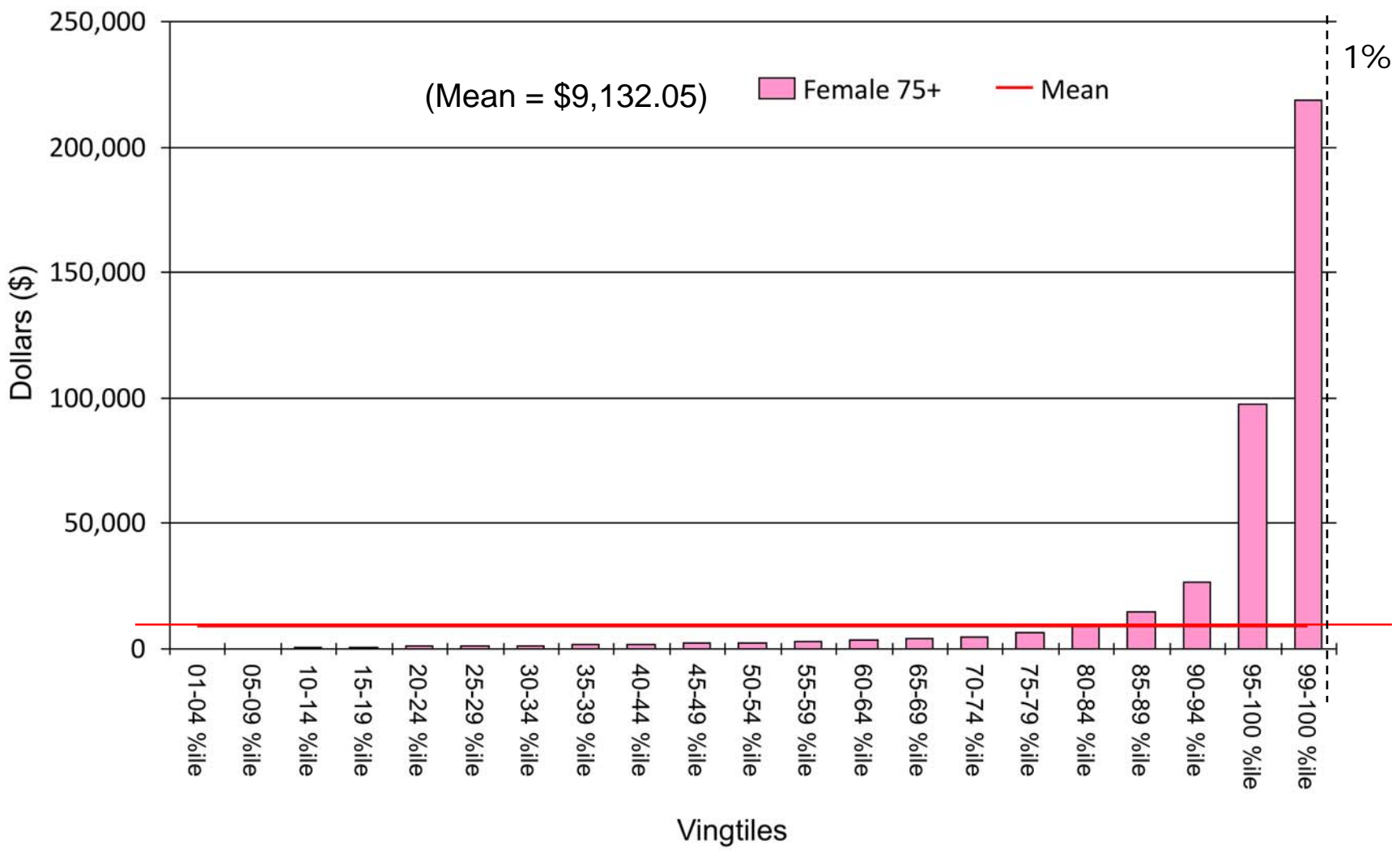
What should funders do?

- ✓ Considerable variation in costs
- ✓ Is it sufficient to control for age and sex?

Mean Total Expenditures for all Age-Sex Grouping, 2005-06



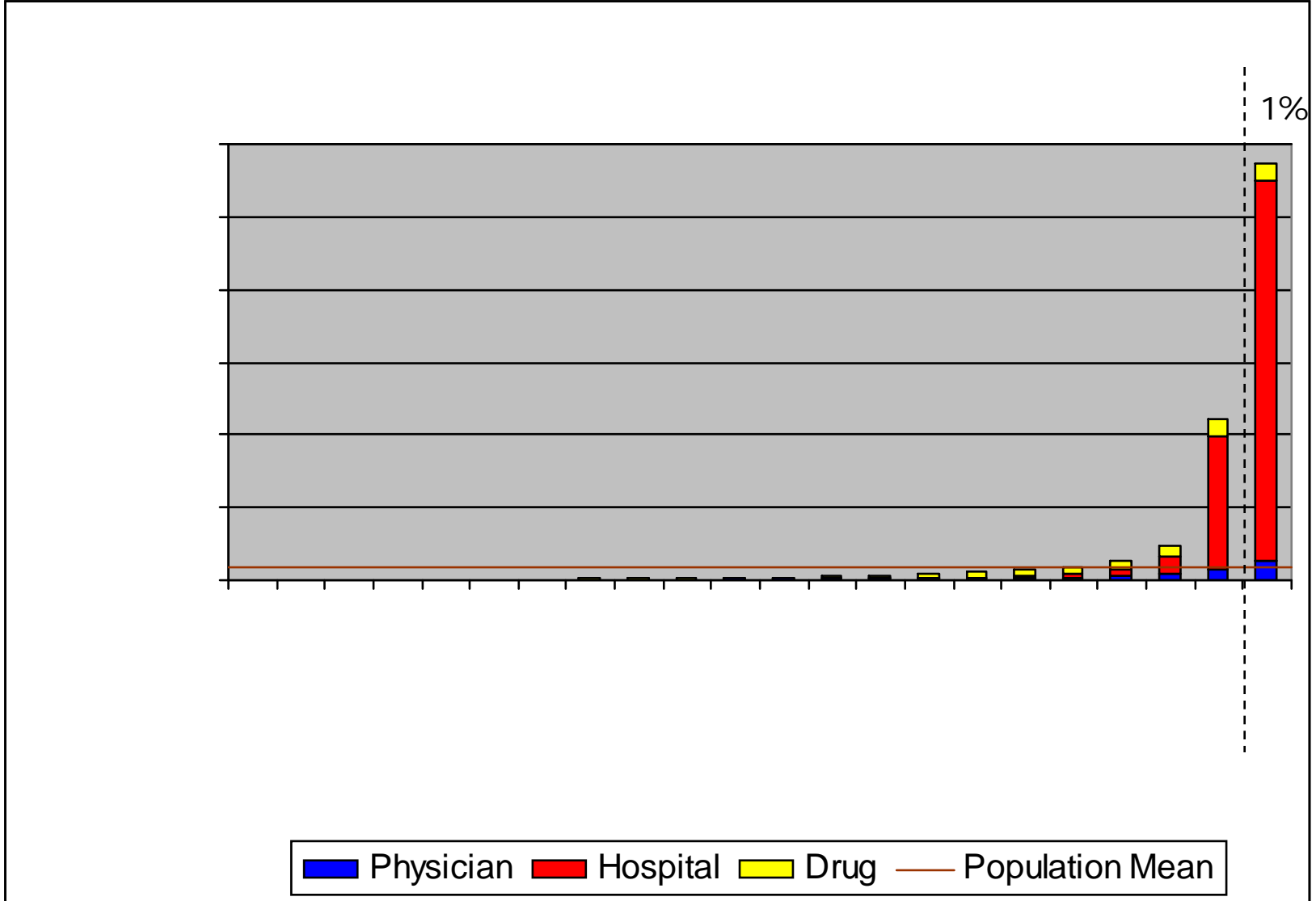
Mean spending by vingtile for females Age 75+, Fiscal 2006



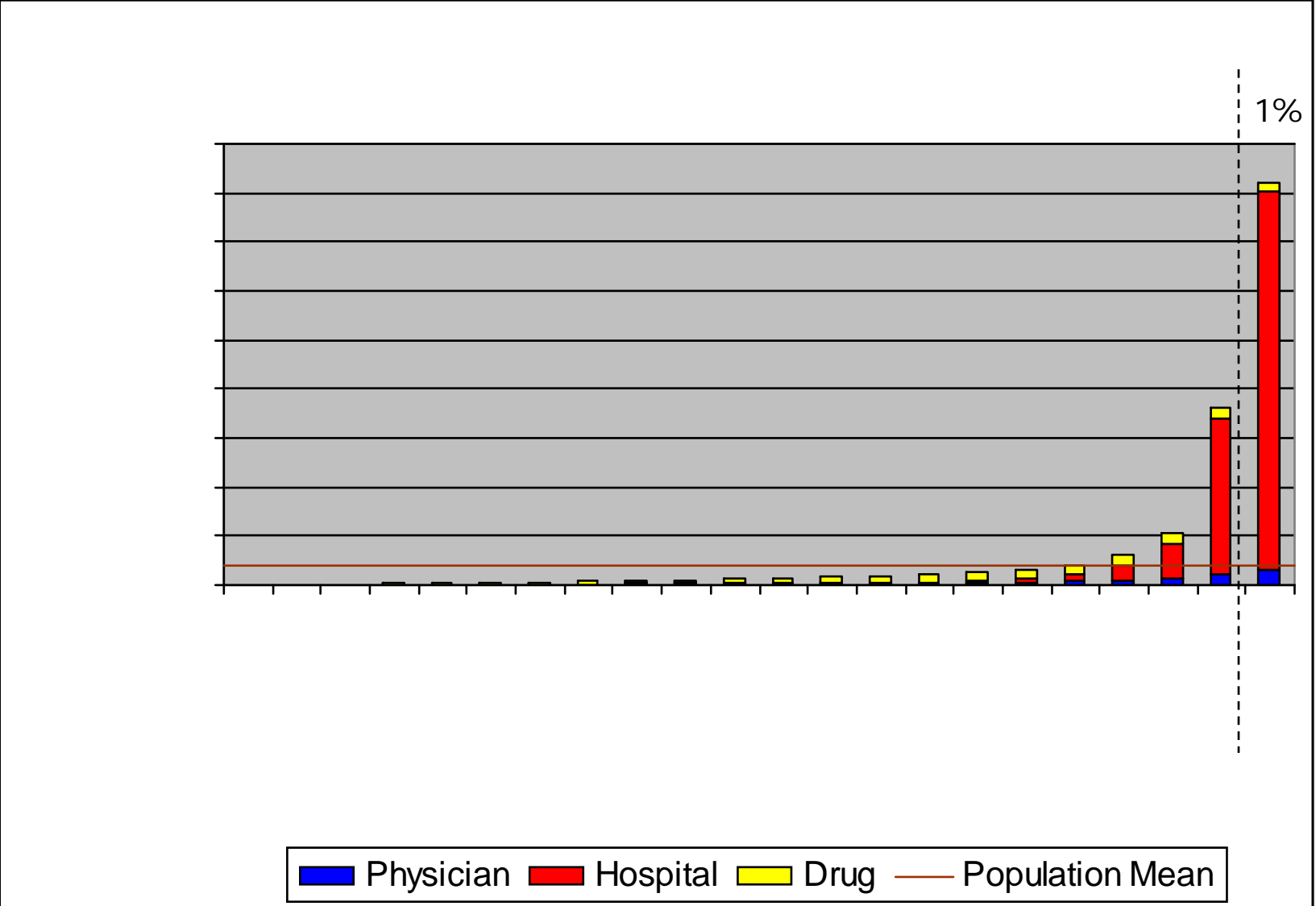
How about chronic diseases?

- ✓ We analyzed distributions for specific diseases (using algorithms developed and validated by the Manitoba Centre for Health Policy)
 - Asthma
 - Diabetes

Mean Total Expenditures for the Asthmatic Population by Vingtiles in Manitoba, Fiscal 2005-06



Mean Total Expenditures for the Diabetic Population by Vingtiles in Manitoba, Fiscal 2005-06



A problem for policy makers?

- ✓ Health spending is heavily skewed
- ✓ Moral hazard does not appear to apply
- ✓ It is hard to find savings from those whose spending is already very low
- ✓ Incentive for payers to (pick your term)
 - cherry pick?
 - cream skim ?
 - risk select



What is the Canadian System?

- ✓ Trick question: There is no Canadian system
- ✓ Constitutionally, health care is a provincial responsibility
- ✓ Considerable variation both between and within provinces
- ✓ One size does not fit all

How about Ontario?

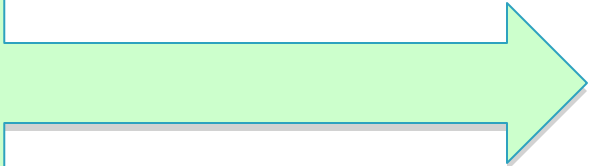
- ✓ Relatively more generous than some other provinces in going beyond CHA minimums
- ✓ Some coverage for home care clients
- ✓ Some coverage for defined populations
 - Seniors (e.g., for drugs)
 - People with particular diagnoses
 - People on social assistance
- ✓ May be perverse incentives (e.g., not to work to avoid losing benefits)

Multiple Funding Options for Rehab services in Ontario

Public	Quasi-Public	Private
Global budget/hospitals	Motor Vehicle Accident Insurance	Employers direct Funding
Community Care Access Centres (CCAC)	Workplace Safety and Insurance Board	Extended Health Insurance
OHIP		Out-of-Pocket payments
Veterans Affairs Canada		

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- 1) Unlike physician and hospital services (where everyone is eligible), multiple funding streams may also mean different eligibility criteria.
 - 2) Multiple streams also means that funders can shift the burden of cost elsewhere.
- 

Who do hospitals give rehab to?

- ✓ With budget constraints, many have closed their outpatient clinics
- ✓ Service tends to go first to:
 - Those receiving priority services (e.g., ensuring that those with hip/knee replacements do not need to be readmitted)
 - Those who need rehab to facilitate discharge from the hospital (“acute” patients)
 - Then, perhaps, people living in that hospital’s catchment area (although in most cases, hospitals want them referred to community clinics and/or home care)

Result? Longer wait times for PT for those with chronic conditions

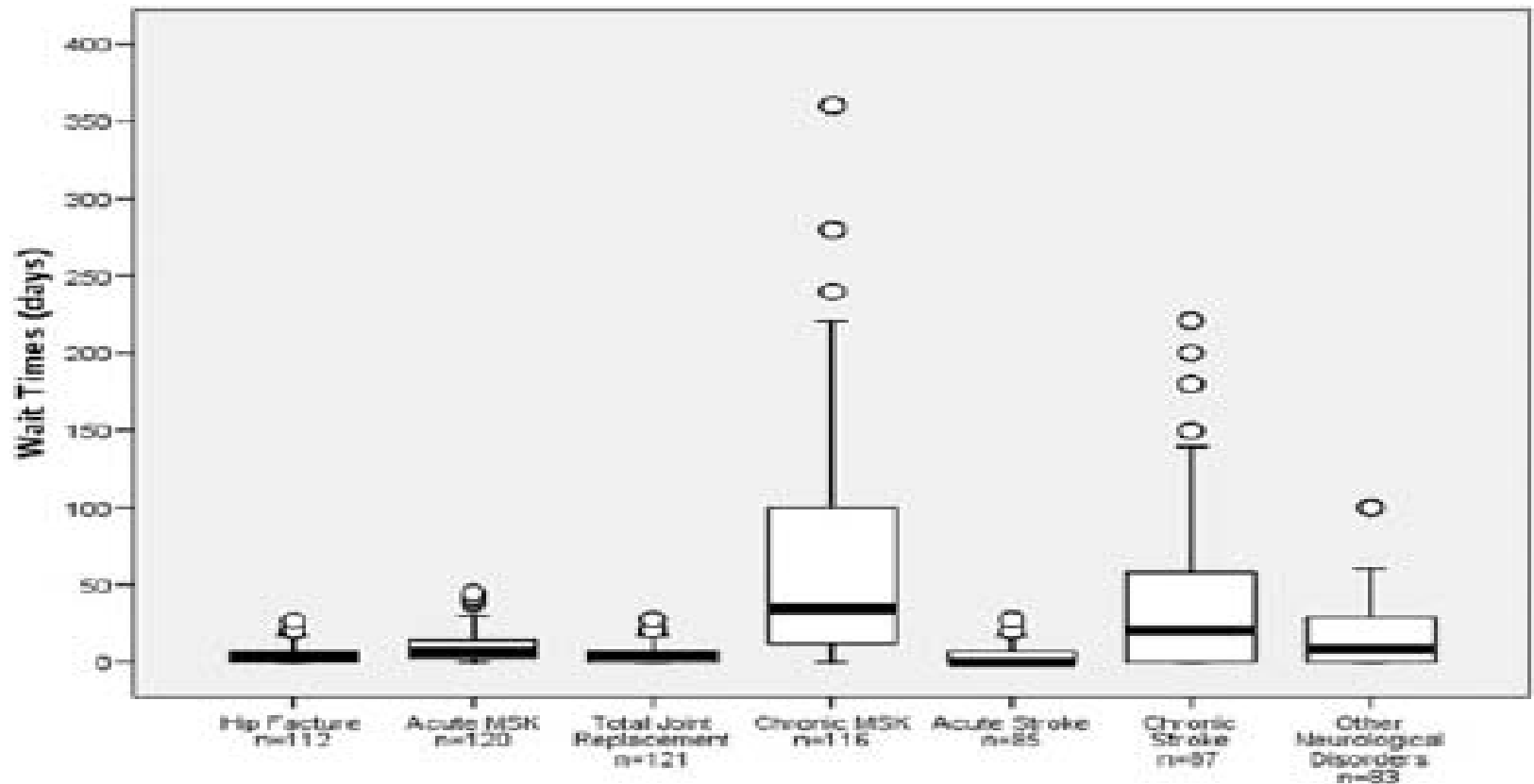


Figure 6 Reported wait time (days) for physical therapy by condition (MSK = musculoskeletal)

Similarly, longer wait times for OT for people with chronic conditions

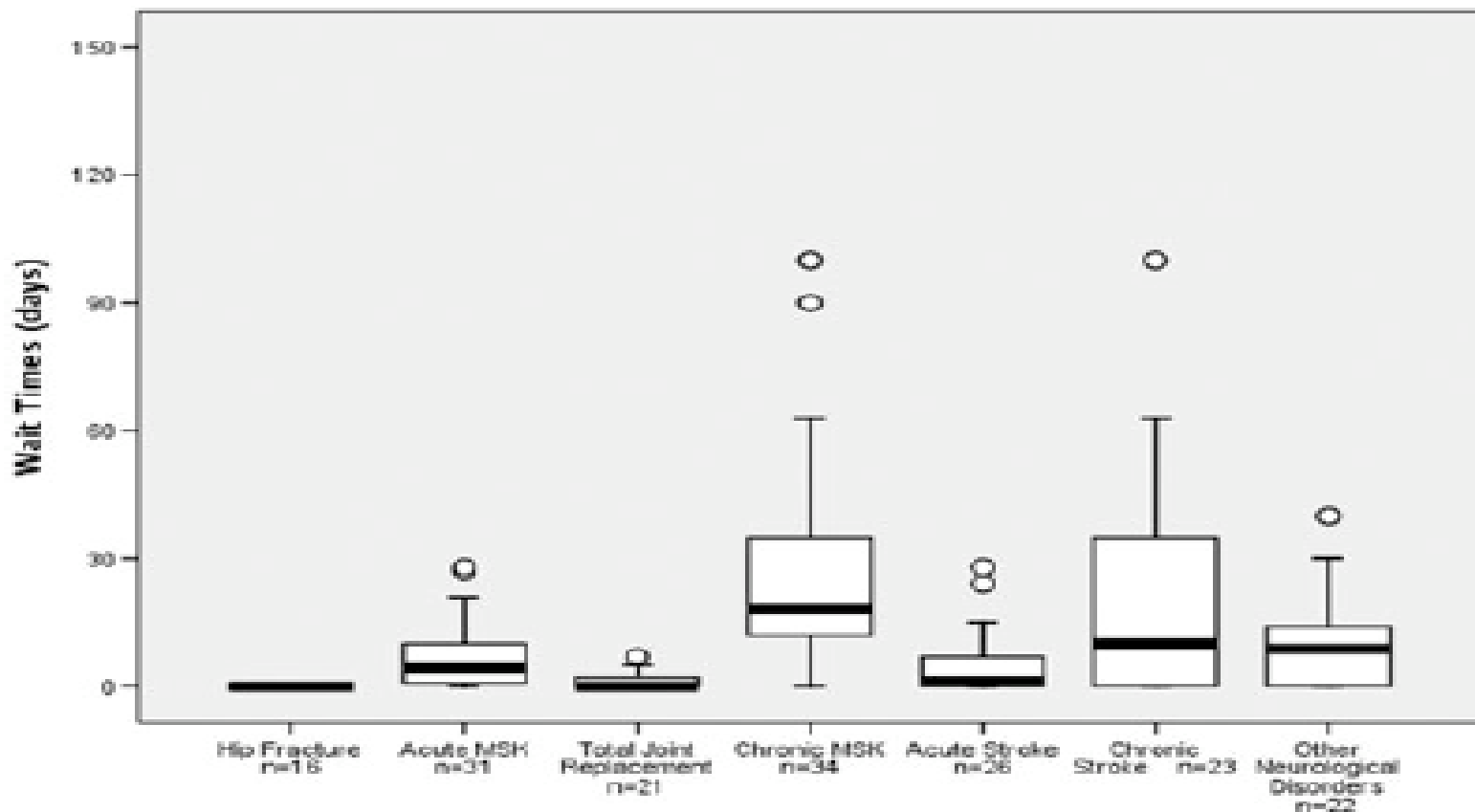


Figure 5 Reported wait times (days) for occupational therapy by condition (MSK = musculoskeletal)

What does this mean for access?

- ✓ Outpatient rehab is not required to be an insured service – but it can be.
- ✓ Provinces, regions, and/or providers (e.g., hospitals, clinics) can decide to include and pay for rehab, but it depends on what other services (and people using those services) are competing for those resources.
- ✓ Data shows that people with chronic diseases seem to be waiting longer for care (in large part because hospitals may not think they fall within their definition of who they are serving)

What happens if you need rehab, but do not get it?

- ✓ In 2005, Ontario partially delisted community based physical therapy services (OHIP).
- ✓ To be eligible a person needed to be
 - 1) under 20yrs, or over 65 yrs
 - 2) qualify for ODSP
 - 3) resident of a long term care facility
- ✓ We conducted a study to examine the outcomes.
 - One of our important findings=those who remained eligible were more statistically likely to report good health (Odds Ratio: 10.72)

Implications?

- ✓ Access to necessary rehab does matter...and can have an effect on function (i.e. ability to work)
- ✓ Those who cannot (or will not) pay may have worse health outcomes than might otherwise be the case

What's Broken?

- ✓ Public financing and not-for-profit delivery seem to work relatively well for physician and hospital services
 - But the current system limits the extent to which outpatient rehabilitation services are included as a publicly funded service.
 - The current situation is that access to rehab is based on tight eligibility criteria, ability or willingness to pay.
 - Challenge: How to increase access to rehab, without increasing overall health care costs?
 - How to recognize when we are being penny wise and pound foolish?
 - How to ensure that we look at appropriateness, and not just access!

One Policy Problem: Who Should Pay?

- ✓ What is the responsibility of society?
- ✓ What is the responsibility of voluntary organizations (including faith-based groups)?
- ✓ What is the responsibility of individuals and their families?
- ✓ Not a questions of evidence, but of values

My Policy Assumption: There is No Quick Fix

- ✓ Policy choices are often about trade-offs
- ✓ As Wildavsky noted:
 - One rarely solves complex policy issues
 - One usually replaces one set of problems with another set
 - The mark of success is whether you prefer the new problems to the old ones

Thank you for the invitation

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For more information, check:
www.teamgrant.ca (and links therein)