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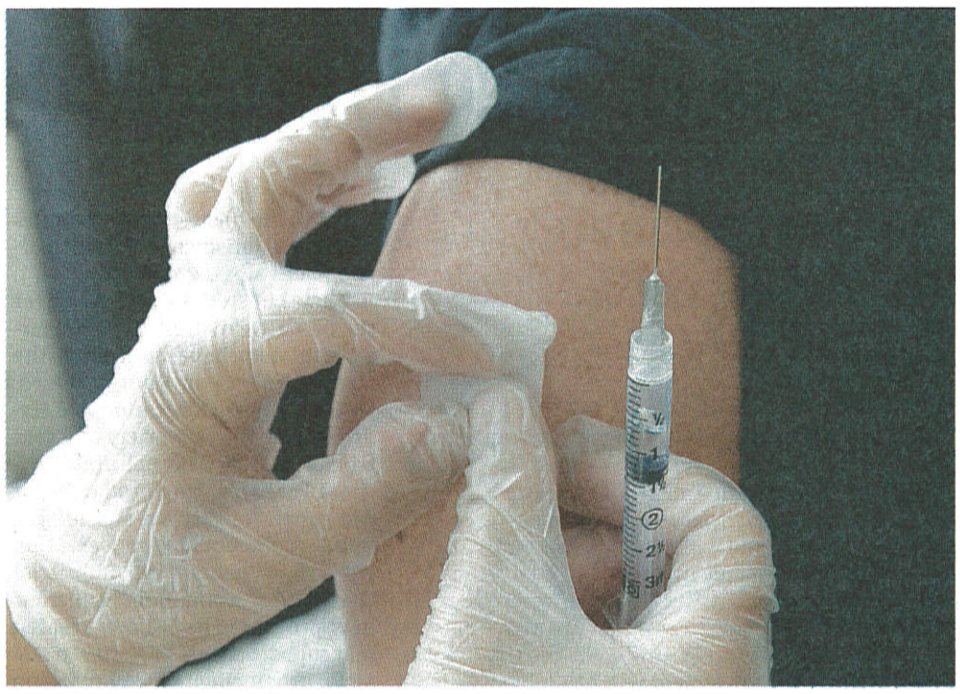

KEVORK DJANSEZIAN / GETTY IMAGES

Germany's public healthcare system has a lot to teach Canada about effective funding.

Funding fix

REBECCA WALBERG

The Commonwealth Fund and the OECD are among the organizations that regularly compare health care in developed countries, and they consistently show Canada to be in the middle of the pack. Canada does well in some areas, such as post-heart attack survival rates, and poorly in others, like wait times for orthopedic surgery, and comparative studies reveal much room for improvement. In the business world, organizations often look to high-performing market leaders and mimic their best practices. But can the Canadian system benefit by adopting the habits of high performers?

A recent Fraser Institute paper argues that German health care — where universal access is provided through independent insurers — is an example that Canada should nation to consider a switch from global to activity-based funding, Mr. Esmail says, and the experience of other systems shows that with appropriate oversight and auditing, linking payment to services delivered results in shorter waits without compromising outcomes or escalating costs.

"Many provinces are beginning a shift to activity-based funding," says Kathleen Morris, director of Health System Analysis and Emerging Issues at the Canadian Institute for Health Information (CIHI). "What they've found is that embedding best practices in the funding model means that quality measures are built in. This ensures that hospitals are providing appropriate care."

One of the hurdles to adopting ABF more widely is a lack of data about many dimensions of health care in Canada, including demographics and the specific costs of many aspects of delivering services, and the

"Healthcare systems evolve within the context of a specific culture, economy, politics and history and what worked in one place or time won't necessarily work in a different country, or now," she argues. "We can't glue together the best parts of a number of different systems and expect to get something functional. We can certainly learn from other countries' experiences and maybe adapt with those lessons in mind, but it's more complicated than trying to swap out something we've been doing for decades for something from a totally different system."

Timothy Jost, a professor at Washington and Lee University who specializes in comparative healthcare law and policy, points out that the German system is more than one hundred years in the making and today involves more than 100 independent insurers. "These funds negotiate with hospitals, doctors and dentists

YOUR HEALTH

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Canada needs a national strategy for rare diseases

Getting access to, and funding for, treatments for rare diseases has been a long-standing challenge in Canada. Unlike more common diseases, where economies of scale allow for easier access to research and funding support, rare-disease groups have been facing an uphill battle that spans years.

Rare diseases are classified as those that affect fewer than one in 2,000 people. Overall, according to the Canadian Organization for Rare Disorders (CORD), there are close to 7,000 rare diseases.

Canada stands apart as a country that does not yet have a policy in place to help bring treatments for rare diseases. The United States has had its Orphan Drug Policy since 1983. Japan (1993), Australia (1997), and Europe (2000) have been equally forthcoming in developing frameworks to support rare disease research, drug development and access to treatment.

According to CORD, of the 307 orphan drugs currently approved in the United States and Europe only 60% make their way into Canada; and most get approved up to six years later than in the United States and Europe. As a result, people with rare disorders are missing out on treatment that could save or significantly improve their lives, says Durhane Wong-Rieger, CORD president and chief executive officer in Toronto.

This is an issue that was brought to light in the 1990s, she adds. "Up until the mid-1980s nobody was making drugs for rare diseases because it was too difficult to find patients, and too expensive. The United States recognized that the need to give special assistance to researchers and drug companies was important enough to establish a policy."

Since 2006, rare-disease organizations have joined forces to help devise a Canadian Orphan Drug Regulatory Framework policy. Wong-Rieger anticipates that Health Canada will approve the policy will pass this fall, barring further delays.

Even when a drug is approved, patients are in no position to pay for them, she says. "These drugs could cost anywhere from $20,000 to $100,000 a year or more. You would either have to have a good private insurance plan or a public health system to pay for it. That's a problem for us in Canada."

> "WE ARE HOLDING THESE PATIENTS HOSTAGE WHILE NEGOTIATIONS CARRY ON

While the framework will play its part in helping to fast-track approvals, funding will remain an issue. "Even if 80% of drugs coming to Canada get approved, provinces may say no to funding them."

One significant stumbling block has been the measurement criteria applied for funding approval, she explains. "The calculations are quite complex. Because rare diseases are very expensive compared to more common drugs, they can't meet the current cost-effectiveness threshold used to determine approval."

The answer, she believes, is a "special pathway" for approvals, in which drugs will be evaluated based on benefits to patients versus a simple cost-per-patient basis.

Wong-Rieger counters the traditional methodology with the fact that rare-disease treatments are extremely targeted and only prescribed to patients who respond to them. This is not the case for more common treatments. "There is a great deal of money wasted today where the system is prescribing drugs for people where there is no benefit. Rare-diseases treatments are only prescribed where there is a benefit."

Considering in detail who might benefit and monitoring responses will, in fact, save considerable costs in terms of hospital care. "Some of the care requirements in hospitals for these patients is extremely expensive," she says.

Measuring value on a benefits basis is already a practice in other areas of health care. For example, cardiac surgery has reduced deaths from heart disease by 50%. "No one says that the surgery is too expensive because the benefit is clear," Wong-Rieger says. "Treatments for rare diseases should be considered in the same light."

Diseases such as cystic fibrosis and muscular dystrophy have been among the more highly publicized afflictions involved in an uphill battle for early treatment coverage, she adds.

"The sad part of all this is that we are holding these patients hostage while negotiations carry on. Treatments are not meant to be weapons in this battle."

emulate, since the depoliticized system is driven by the interests of patients, not bureaucracy, and offers good outcomes while spending less per capita than the current Canadian system.

Other reforms also have potential to bring the healthcare system into alignment with the interests of patients. For example, most Canadian hospitals are currently given a global budget, from which they fund all their activities for the fiscal year. It's a system that creates the wrong incentives for managers, argues Nadeem Esmail, author of the Fraser Institute study.

"Under global budgets, it's actually in the hospital's interests to slow the delivery of services down, because every patient is a drain on the budget," he says. "Activity-based funding [ABF] flips that on its head, it only provides funding to hospitals for the services they provide to patients. So now there is an incentive to provide better access, because the more patients you treat and the more you're patient-focused, the more revenue you'll have."

Canada is the last developed analytic capacity to develop an accurate funding formula based on those factors.

"The best funding model is one that has checks and balances in the system, because each has strengths and weaknesses," says Ms. Morris. "A potential weakness of ABF is overprovision of services, and adherence to a best-practice framework is the most effective check on this."

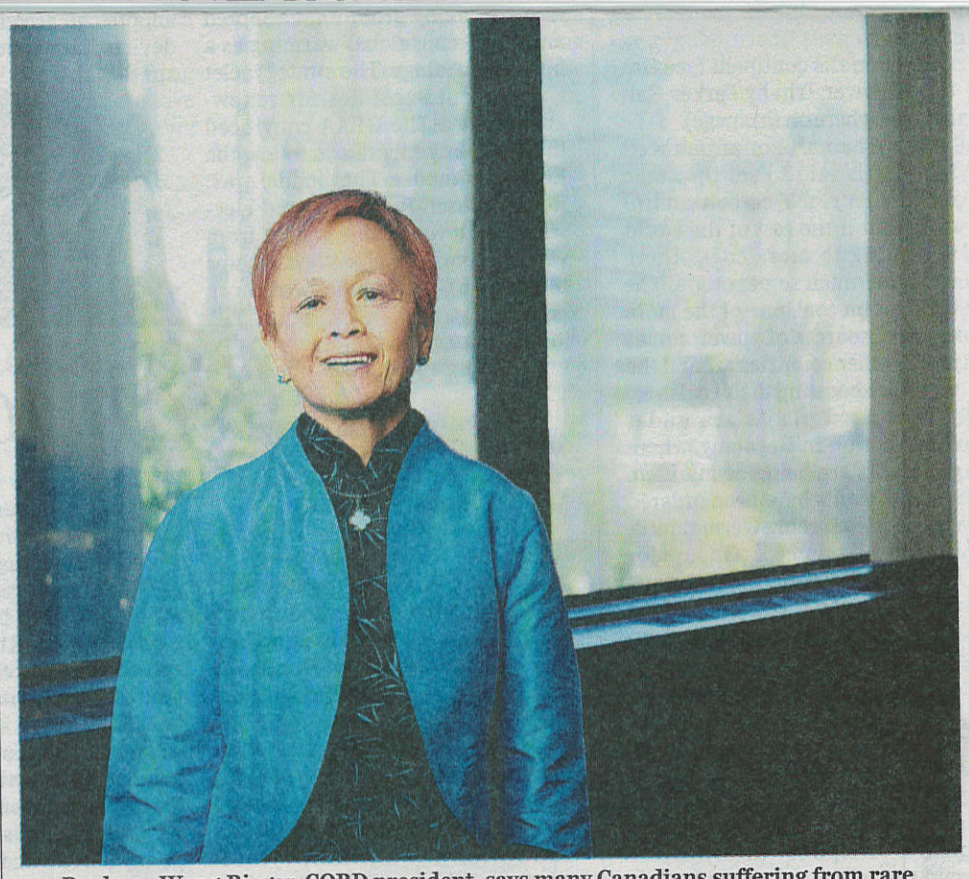
Karen Palmer, adjunct professor and researcher at Simon Fraser University's Faculty of Health Science, points out that there can be less incentive to innovate or find efficiencies when funding levels are fixed by a global budget. But she also expresses concern about the possible consequences of moving to ABF. For example, she notes the UK's National Health Service found a tendency to "cherry pick" patients who need the most profitable procedures — rather than prioritizing based strictly on medical need — to maximize reimbursement.

More broadly, Ms. Palmer cautions against trying to copy another healthcare system by looking at any one element in isolation.

to establish payment schedules and these agreements have to comply with federal regulations about services and fees. The government doesn't act directly in health care, but it sets limits on how much fees can increase, for instance. It's really the result of almost a century and a half of evolution, and it's very organic to Germany," says Mr. Jost, adding the negotiations between all the interested parties — rather than direct competition between the funds — are the critical key to keeping prices low.

While best practices in clinical care, such as facilitating earlier discharges post-surgery by boosting funding for home care and medical rehabilitation, can be adopted from other jurisdictions, changes that involve long-held values about health care and its provision are harder to graft onto a new jurisdiction. Both Mr. Jost and Ms. Palmer caution against ignoring the Canadian context around issues such as how health care is funded, and its providers compensated, when proposing healthcare reforms.

Financial Post



Durhane Wong-Rieger, CORD president, says many Canadians suffering from rare disorders are missing out on treatments available in other countries.

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SETS THE STAGE

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