The Sustainability of Medicare

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Canadian Federation of Nurses Unions

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This paper is an update of and expansion on a 2004 report prepared for the Canadian Federation of Nurses Unions and the Canadian Centre for Policy Alternatives by economist Armine Yalnizyan, *Can we afford to sustain Medicare? A strong role for federal government,* Armine Yalnizyan, Canadian Centre for Policy Alternatives, July 2004.

The authors are also indebted to many Canadian researchers and writers who have produced consistently excellent material dealing with the issues of Medicare's cost and sustainability. Much of that work, including ours, has been informed and inspired by the work of Professor Robert Evans of the University of British Columbia. Among his many excellent papers, we would note one in particular: *Economic Myths and Political Realities: The Inequality Agenda and the Sustainability of Medicare* written by Robert G. Evans of the UBC Centre for Health Services and Policy Research in 2007.


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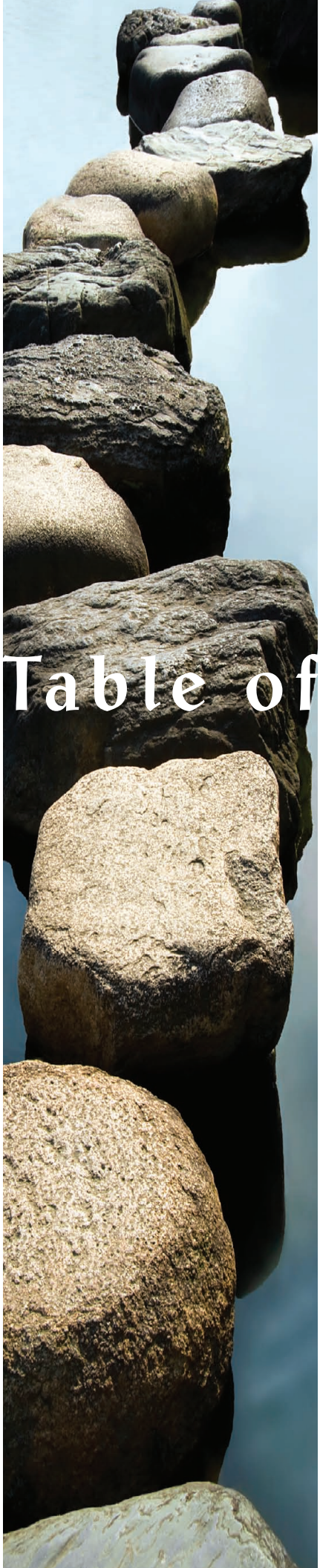

Table of Contents

Message from the President of CFNU	6
Executive Summary	8
Introduction	12
1. Medicare Sustainability – What Critics of Medicare Say	16
2. Canadian Health Care Costs in Perspective	30
3. The Impact of Aging on Health Care Costs	42
4. Canadian Health Care in an International Context	46
5. Implications for Canada's Health Care Debate	54
6. Funding Medicare and the Role of the Federal Government	58
7. Foundations for Medicare's Future	68
Conclusion	76
Notes	79
Afterword	82
About the Authors	84

Message

A generation ago, Canadians insisted that equal access and equal care be made central pillars of their health care system. In every budget cycle since then, we have debated its level of funding. For most, it has been a very emotional debate: "No money could ever be too much if it means saving my child or taking care of my parents..." However, for some, the issue has centered on operational budgets, leaving health care administrators and workers wondering: "Will there be enough resources and staff to take care of patients?" For many reasons, health care consistently ranks as one of the top priorities for Canadians; for politicians, this means the issue could be central to election platforms – possibly even determining their success or failure.

This paper moves away from the traditional debate and rhetoric on health care spending to bring the conversation down to the level of dollars and cents. Two of Canada's leading health and economic experts, Hugh Mackenzie and Michael Rachlis, here examine the changing costs of Canadian Medicare and their drivers, and consider the sustainability of the system as a whole.

Is our system sustainable? Roy Romanow once said, "Medicare is as sustainable as we want it to be." A long list of health specialists and economists including Dr. Robert Evans, Dr. Morris Barer, Dr. P. J. Devereaux, Dr. Steve Morgan, Armine Yalnizyan, Dr. Irfan Dhalla, Dr. Michael Rachlis, and now Hugh MacKenzie, have all analyzed our health care system and consistently reported that public health care is in fact sustainable. They will also tell you that we need to continue to build capacity for public health care programs: primary health care that keeps Canadians healthy; and support programs like home care, long-term care, and Pharmacare.

In 2004, the Canadian Federation of Nurses Unions urged the Premiers to:

- Put tax dollars toward not-for-profit health care;
- Support a national Pharmacare program and control the rising cost of drugs;
- Implement a plan to attract new health professionals; and
- Improve wait times by increasing staffing levels, enhancing access to primary health care and community-based health care, and ameliorating the determinants of health.

In response to public pressure, the Council of the Federation issued the Premiers' Action Plan for Better Health Care, in which premiers agreed that a significant shift in the delivery of Pharmacare programs was necessary. Furthermore, they acknowledged that a key component of health care is a robust public drug plan and called on the federal government to assume full responsibility for such programs across the country.

On September 16, 2004, the First Ministers Health Accord was negotiated with the federal government. Although this Accord is projected to end in 2014, we need to be back at the negotiating table now. We acknowledge that the Accord was a good first step, but it is now time to create a successor agreement that builds on that foundation.

from the President of CFNU

We ask that this agreement:

- Improve the position of the federal government in funding Medicare;
- Provide opportunities for system change and improvement that are rooted in public funding and delivery of health care;
- Establish a basis for federal leadership in the creation of a national, universal Pharmacare plan.

As nurses, our primary commitment is to our patients. However, this commitment does not end at care delivery. We recognize our responsibility to advocate for patient care at a systems level. Part of this responsibility involves understanding and participating in the wider health care debate. We also must critically question why a fight should persist against the Canadian ideal of equitable access to health care for all Canadians, regardless of where they live or their economic means. In particular, the CFNU has argued for equal access to care for those in Aboriginal and remote communities who still lack health care services many of the rest of us take for granted.

We must realize that tax cuts are not a "gift" or "bonus" handed down by politicians without consequence; the existing pressures on our public health care system have been created by tax cuts – not increased health care costs. Stakeholders and policy-makers alike must resist the pressure to accept uncritically the myth of unsustainable public health care, and rise to the challenge of finding needed improvements within a publicly funded and delivered system.

This examination of the economics of health care in Canada reveals that the alleged "Medicare cost crisis" does not exist. Additionally, we need to be wary of the shifts in policy and practice toward both private financing and/or private delivery of health care, as they are likely to drive costs much higher, creating a crisis of sustainability where none previously existed. This crisis would further burden lower-income Canadians who already struggle with purchases of pharmaceuticals and dental care. I invite you to review this comprehensive economic analysis of health care in Canada, and urge you to stand up for a single-payer system that is not only more fiscally efficient, but also more equitable to Canadians.

To conclude, I would like to acknowledge the authors for their hard work along with the National Executive Board of the CFNU and our advisory committee for their valuable guidance and vision in this project.

Finally, sincere thanks go to all health care providers (nurses, physicians, physical and occupational therapists, dentists, pharmacists, technicians – the list is too long to capture) for the tireless work they do every day, as well as all those who, in public or private life, advocate on behalf of the principles of Medicare. Most importantly, I thank all of you, both health care providers and the advocates of the system we depend on, for coming to work… tomorrow!

Linda Silas

Executive

Medicare is far and away Canada's most popular public program. It enjoys extraordinarily high approval ratings and its security consistently ranks at or near the top of the list of Canadians' political concerns.

Despite that popularity, or perhaps because of it, Canadian Medicare is almost constantly under political pressure. Waiting lists for medical services are scrutinized closely. Questions are raised about access to services like family physicians. Stories about the few Canadians seeking care in other countries are virtually guaranteed to make the headlines and lead the evening news. Invidious comparisons between the health care system in Canada and those in other countries are a staple of talk shows. Participants in the ongoing debate over health care in the United States regularly entertain Canadians with ludicrous tales about a health care system north of the border, that is unrecognizable to the actual residents of this country.

In recent years, the argument about Medicare has narrowed to a focus on financial sustainability. At its core, the argument is that at current rates of growth, health care costs will soon consume an unacceptably large proportion of public services spending/public revenue. While the prescriptions proposed vary, they consistently involve some combination of shifting a portion of health care costs from the public sector to individuals and/or substituting public management or delivery of health care services with privately managed or delivered services.

This paper looks at the data on health care spending in Canada in order to assess the validity

Summary

of the core premise of the argument that health care costs are escalating uncontrollably; to consider the factors that are influencing developments in health care costs; and to examine the relevance and likely impact of the proposals typically advanced by Medicare's critics. Based on what can be learned from the data, it then explores options for change that respond directly to health care cost factors, options that would both reduce costs and improve quality.

The data speak clearly. Based on trends in health care and Medicare spending, the sustainability crisis does not exist. The oft-cited increase in health care spending as a share of total public spending reflects not an extraordinary increase in health care spending, but rather decisions by governments to cut taxes and public spending in areas other than health care. The cuts in government fiscal capacity, amounting to $90 billion or about 6% of GDP (gross domestic product, the total value of all goods and services produced in the economy), dwarf by a sizeable margin even the most pessimistic estimates of health care cost escalation projected over the next 25 years.

In the context of the generally accepted measure of a society's ability to pay – its GDP – health care costs generally and Medicare costs in particular have been remarkably stable.

Moreover, the data make it clear that the point of departure for these health care cost ratios is political, not economic. The trends to which the critics incessantly refer date back only to the mid-1990s, when governments at all levels began to cut expenditures and taxes.

The data provide valuable insights into other aspects of the health care debate. Canada is not by any means an outlier relative to other similar countries. The share of our GDP devoted to health care is within the range of the northern European countries with which we often compare ourselves, and substantially below that of the United States. The share of our health care costs that is paid for publicly is similarly in the middle of the pack, at around 70%. Interestingly, the public sector health care percentage in France – often cited as an example of private delivery to be emulated – is actually substantially higher, at nearly 80%.

The data tell us a lot about the drivers of cost increases in the health care system. The two most important contributors to health care cost increases are prescription drugs and payments to physicians. Prescription drugs have increased as a share of Medicare spending from 2% to 9% since 1975 and by themselves account for one-quarter of the increase in health care costs as a share of GDP since 1975. Payments to physicians have increased only slightly as a share of health care costs over the past 35 years, but because they make up 20% of total costs, that increased share has a notable impact on health care costs.

The key to controlling costs and improving quality in the health care system, as unexciting as it sounds, is better management of the system in the public interest.

The evidence also indicates that wages and salaries are not an important independent driver of health care costs. Statistics Canada input-output data for the hospital sector show that wages, salaries and benefits have declined as a share of hospital operating costs from a high of 75% in the late 1970s, to just over 60% in 2008.

The data also indicate that the likely impact of the aging of the population on health care costs is overstated. Using Statistics Canada population projections and data from the Canadian Institute for Health Information on health services utilization, over the next 25 years, we can expect to see an increase in health care costs of one percent per year, driven by changes in the age distribution of the population. While the impact of aging is greater than in the recent past (0.8% per year between 2001 and 2010), it does not add up to the looming financial crisis that many are forecasting.

Furthermore, the proposals typically advanced in response to the "crisis" of sustainability would almost certainly make things worse. Proposals

to shift financial, delivery or management responsibility from the public sector to the private sector do not reduce costs. Indeed, by shifting costs and control from the public sector to the private sector, these proposals would reduce our ability to manage costs in the system, likely resulting in higher, not lower, total costs. The system in the United States illustrates clearly what can happen when the institutions in control of the system have no incentive to control costs.

More importantly, proposals for change to Canada's health care system, almost invariably advocated by Medicare's critics, merely shift costs rather than reduce them. In a publicly funded health care system, high-income individuals typically pay more for health care services through the tax system than the value of the services they use; healthy individuals receive less from the health care system than individuals who suffer from illness or injury. All of the major proposals – from premium-based pre-funding to health care utilization taxes to user charges and co-payments – result in shifts in income and wealth from low- and moderate-income individuals to wealthy individuals and from those who suffer from ill health to those who do not.

These cost-shifting proposals are directly opposed to the values that underlie Canadian Medicare and to the principles set out in the *Canada Health Act*. They will also be ineffective in achieving their stated cost-saving objectives.

The key to controlling costs and improving quality in the health care system, as unexciting as it sounds, is better management of the system in the public interest.

Our federal government has a vital role to play, both in ensuring the long-term financial security of Canada's Medicare system and in leading improvements in that system.

The 2004 federal-provincial agreement was an important milestone, signaling the end of more than a decade of cuts and neglect and re-establishing the role of the federal government as a reliable and credible funding partner in Canadian Medicare. That agreement must be extended on terms that ensure that the federal government's Medicare funding role is maintained. Just as important, the agreement must build on the credibility of the federal government to lever improvements in management and service delivery at the provincial level.

Introduction

The idea that Canadian Medicare is not sustainable has become a staple of public discourse in Canada. It was initially adopted as a kind of political fallback position by opponents whose attempts in the 1990s to weaken Medicare's financial base collapsed with the adoption of the federal-provincial funding agreements in the early 2000s. Since then, the assertion that Medicare in its current form is not sustainable has come to be so broadly accepted that it is treated as a kind of received wisdom – yet it is patently untrue.

The essence of the non-sustainability argument is as follows: the costs of Medicare have been escalating at an alarming rate; cost pressures are only going to increase as our population continues to age; unless something drastic is done soon to slash the growth in health care costs, the system will bankrupt us.

The evidence offered for this position invariably begins with projections which purport to show that, if costs continue to escalate at current rates, Medicare will account for an unreasonable share of public spending or of government revenue or of Canada's GDP. "Unreasonable" is defined in this context as either resulting in unacceptable levels of taxation, or crowding out other important areas of public investment.[1]

The numbers may be eye-catching; they are not particularly illuminating. To begin with, the projections that form the basis of the critics' evidence are little more than a demonstration of the fact that, if you start with any two numbers and

increase them at different rates, the number that increases at the higher rate will eventually reach a level much higher than the other number.

The important questions are more complex:

- What do the data tell us about the trends in Medicare costs?
- What are the factors that underlie those trends?
- To what extent are those factors amenable to change through public policy?
- What should be the public policy response to those trends?

In this paper, we first examine the changing costs of Canadian Medicare and evaluate the cost drivers. Second, we step back to consider the contexts – both domestic and international – within which the unsustainability claims are made. Third, we consider the implications of the policy options advanced by sustainability critics. And finally, we

> ...the assertion that Medicare in its current form is not sustainable has come to be so broadly accepted that it is treated as a kind of received wisdom – yet it is patently untrue.

outline some policy responses which would improve health care quality and outcomes while controlling costs.

In summary, the facts do not support the contention that Medicare costs are increasing uncontrollably or unexpectedly. The alleged Medicare cost crisis does not exist. Medicare costs have indeed been increasing, however modestly, because of the changing age structure of our population and the failure to control certain cost drivers. However, the main problem remains the failure to fulfill Medicare's original vision for a transformed delivery system.

...the facts do not support the contention that Medicare costs are increasing uncontrollably or unexpectedly. The alleged Medicare cost crisis does not exist.

By contrast, many of the changes suggested are likely to create a crisis of sustainability where none previously existed. Proposed changes often include a shift in emphasis towards both private finance – through user charges, utilization taxes, restricted public insurance coverage and increased reliance on private insurance – and private, for-profit delivery within the publicly financed system.

Our investigation suggests that rather than reduce costs, many of these measures would actually drive health care costs higher. More importantly, many of these policies run against the basic values of Medicare. Lower income Canadians already have greater difficulty purchasing drugs and dental care. Families coping with catastrophic illness already face daunting financial challenges. More private financing would make our system less equitable than it is now. Moving away from our single-payer system would make Medicare less efficient by increasing administrative costs and making it more difficult to manage and control the very cost increases about which Medicare's critics are so concerned.


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Medicare Sustainability –

Critics of the sustainability of Canadian Medicare tend to choose as their point of departure data that purport to show that provincial spending on Medicare is on a trajectory to absorb an unacceptably large proportion of total program spending by some date in the future. For example, a report released by TD Economics in May 2010 includes the following assertion in its foreword:

> *If current trends prevail, health care expenditures would make up 80 per cent of total program spending by 2030 …*[2]

These statements are often accompanied by a chart that looks very much like Figure 1.

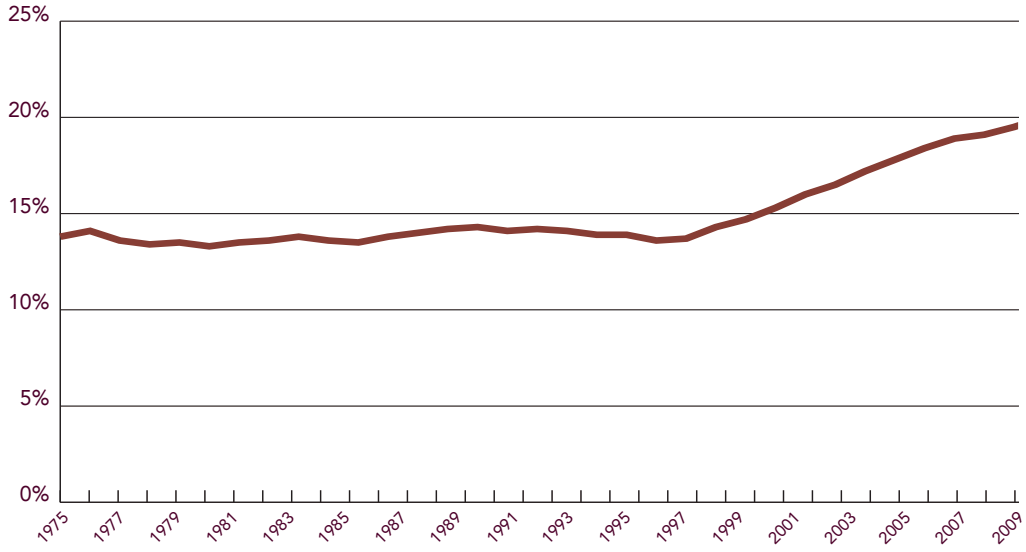
Medicare and the economy

At face value, the data appear to show that the share of Medicare expenditures in total government outlays began to increase in the mid-1990s, after twenty years of remarkable stability. A closer look at the critical time period in question, however, demonstrates that what appears to be a sudden jump in Medicare costs actually reflects other changes taking place at the same time in Canada's public economy.

Figure 2 compares total government outlays as a share of GDP in Canada and the United States. It shows total government outlays declining as a share of GDP in Canada, from a peak in the early 1990s of 53%, to just less than 40% in 2008. On this measure,

What Critics of Medicare Say

Figure 1: Medicare expenditures as a percentage of total government outlays
Canada, 1975-2009

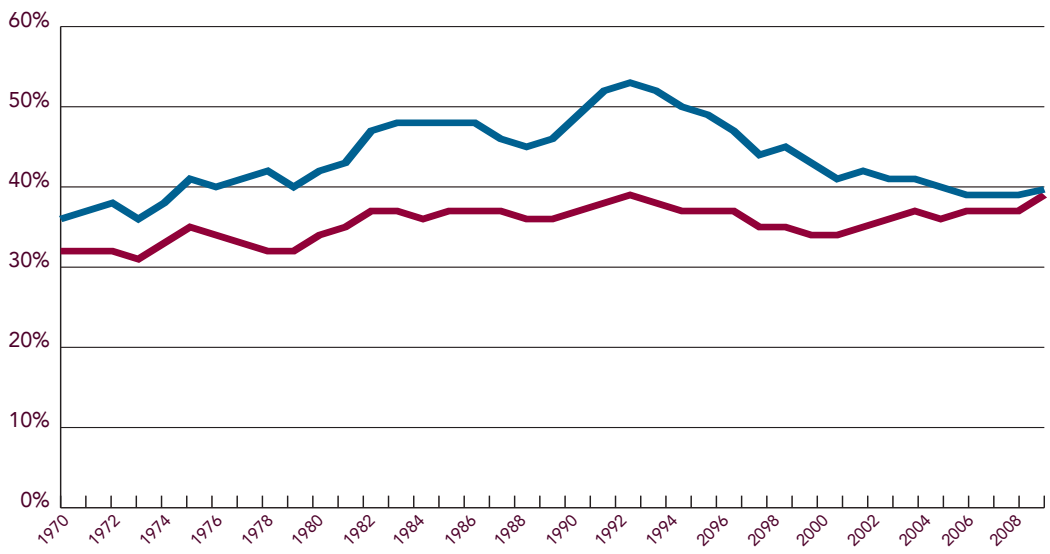


Sources: *National Health Expenditure Trends, 1975 to 2009*, Canadian Institute for Health Information, Ottawa, Ont.: CIHI, 2009
Fiscal Reference Tables 2009, Finance Canada, October 2009.

the retrenchment in the relative size of the public economy that took place in the 1990s and 2000s was significant – enough to wipe out the expansion of the public economy that took place in the 1970s and 1980s. It is noteworthy, in light of oft-repeated complaints from those concerned about the size and growth of government in Canada, that in 2008 total government outlays as a percentage of GDP were almost identical between Canada and the United States.

This suggests that the change in the ratio of health expenditures to total government outlays has been driven by changes in the denominator of the fraction: total government outlays; rather than by changes in the numerator: health expenditures. In other words, the data suggest that Medicare expenditures have not increased as a share of public spending, because they have been increasing uncontrollably as some critics suggest. The explanation is that the cuts that were made

Figure 2: Government outlays as a percentage of GDP
Canada and United States, 1970 to 2009



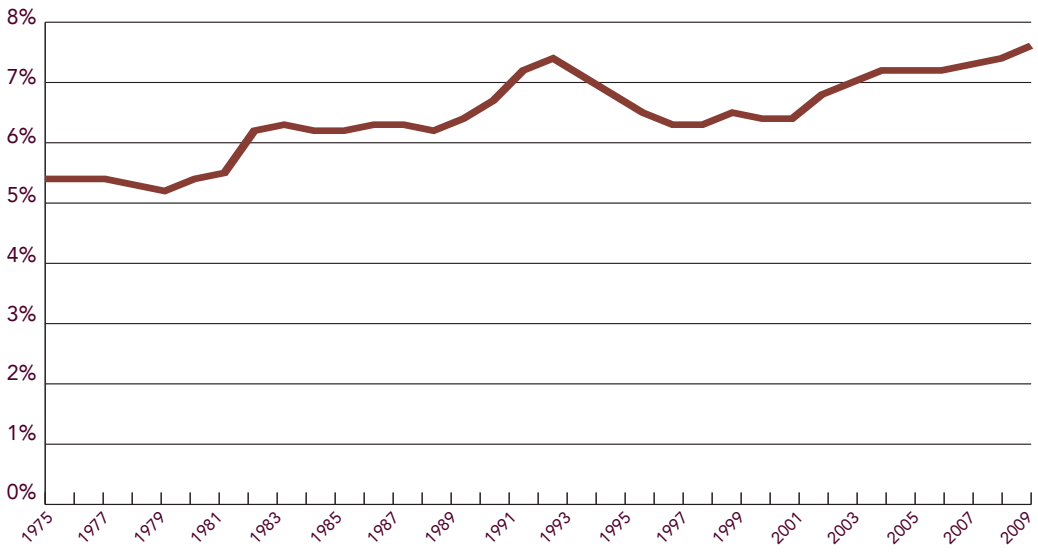
Source: *Fiscal Reference Tables 2009*, Finance Canada, October 2009.

to Medicare in the 1990s were less draconian than those made to other areas of public spending. Further, public pressure in the early 2000s forced governments to retreat from those Medicare cuts.

To illustrate the point consider this story: an epidemic had swept through a community and killed one of a family's children. A few months later, the father looked across the dinner table and said to the remaining child, "Sonny, this family cannot afford you any more. You used to eat only one quarter of the food in the household, but now you are eating one third! You're unsustainable!"

Of course the remaining child was not eating any more than previously. Rather there are only three people in the family instead of four. During the 1990s, Canadian governments literally killed off Medicare's siblings such as the National Housing Program. Now Canadians with conservative views blame Medicare's perceived insatiable appetite for an inability to fund other programs.

Figure 3: Medicare expenditures as a percentage of GDP
Canada, 1975 to 2008

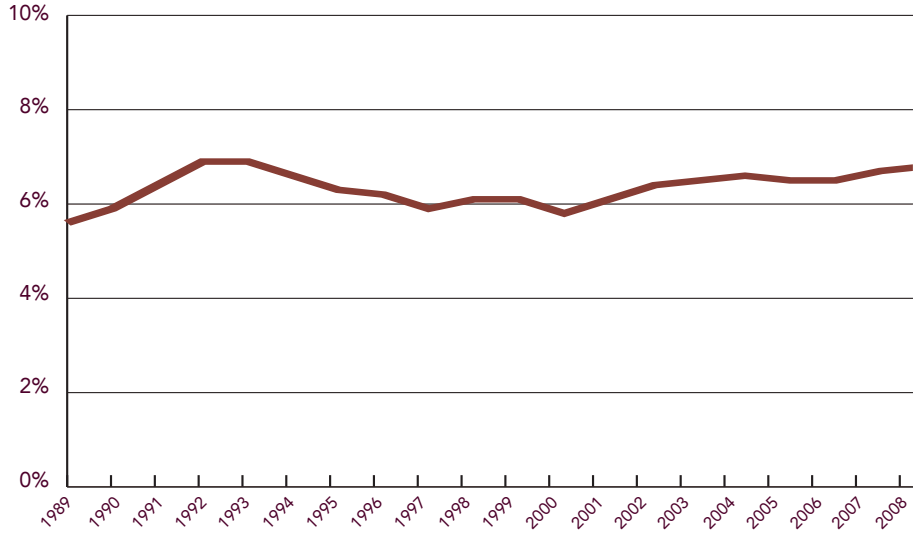


Sources: *National Health Expenditure Trends, 1975 to 2009,* Canadian Institute for Health Information, Ottawa, Ont.: CIHI, 2009
Fiscal Reference Tables 2009, Finance Canada, October 2009.

The most comprehensive measure of a nation's ability to pay is its gross domestic product, or GDP. It is also the measure that is used most commonly in international comparisons. The data show that, since the program's introduction in the early 1970s, Medicare expenditures have increased as a share of GDP. Most of that increase, however, took place between 1975 and 1990. Furthermore, as Figure 3 shows, much of the increase in Medicare's share of GDP since the late 1990s actually reflects a return to the level previously reached in the early 1990s.

It is evident from Figures 2 and 3 that significant changes took place both in Canada's public economy generally and in expenditures in health care specifically.

Figure 4: Total provincial health expenditures as a percentage of GDP
1989 to 2008



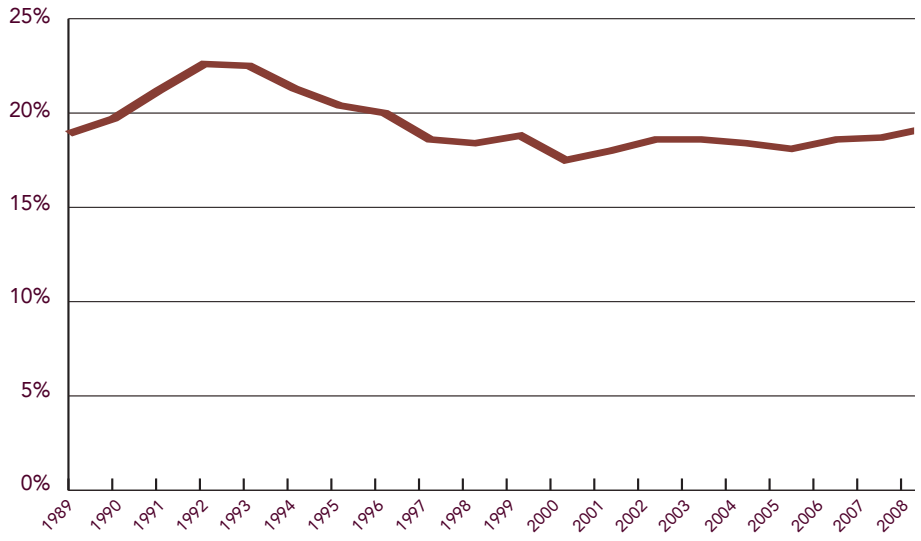
Sources: *Fiscal Reference Tables 2009*, Finance Canada, October 2009
CANSIM Table 385-0001, Statistics Canada, 2010.

Medicare and public spending

A closer look at provincial government expenditures as a share of GDP in the period 1989-2008 demonstrates a decline in spending in areas other than health rather than an unusual increase in spending on health itself. Figures 4, 5 and 6 focus on provincial government expenditures in the crucial period from 1989 to 2008.

Figure 4 shows total provincial government health expenditures as a share of GDP. Provincial government health expenditures have been remarkably stable as a share of GDP in the past 20 years, showing an economic cycle peak-to-peak increase from just under 6% in 1989, to just over 6% in 2008.

Figure 5: Total provincial program expenditures as a percentage of GDP
1989 to 2008



Sources: *Fiscal Reference Tables 2009*, Finance Canada, October 2009
CANSIM Table 385-0001, Statistics Canada, 2010.

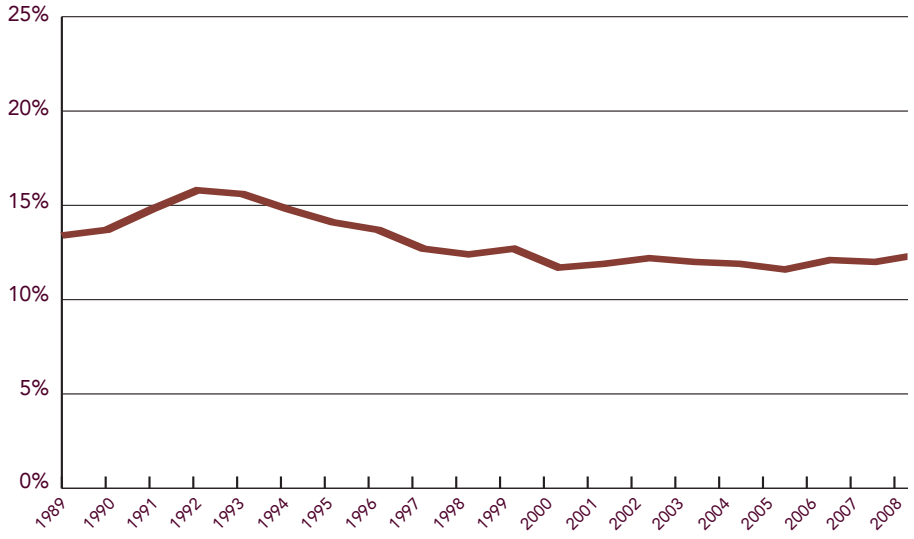
As Figure 5 shows, total provincial government program expenditures made up almost exactly the same share of GDP in 2008 as they did in 1989.

The big change took place in provincial government expenditures in areas other than health, as Figure 6 shows.

Medicare and fiscal capacity

Looking more directly at claims concerning Medicare's affordability, a similar story emerges. Health care costs have been increasing as a share of public revenue, not because health care costs have been going up relative to the size of our economy, but because government revenue from taxation has been going down relative to the size of our economy. That decline is attributable to Canadian

Figure 6: Provincial program spending other than health
1989 to 2008



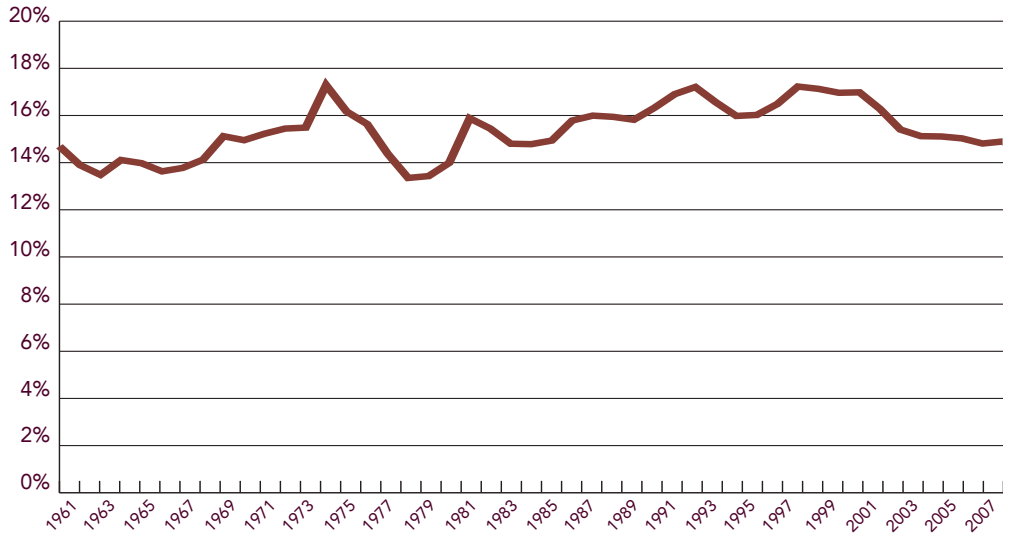
Sources: *Fiscal Reference Tables 2009*, Finance Canada, October 2009
CANSIM Table 385-0001, Statistics Canada, 2010.

governments at all three levels having chosen to cut taxes consistently over the past 15 years.

Figures 7, 8 and 9 show the impact of tax cuts on our fiscal capacity.

Figure 7 shows federal government revenue from taxation as a share of GDP, from 1961 to 2008. The fluctuations between 1961 and the late 1990s reflect both public policy changes and changes in the economy. The implementation in the late 1960s and early 1970s of the recommendations of the Carter Commission on Taxation tended to increase the fiscal capacity of the federal government; the transfer of corporate and personal income tax "points" from the federal government to the provinces in the late 1970s reduced federal fiscal capacity. The peaks and troughs in the early 1980s and the early 1990s reflect federal government revenues that both lag and exaggerate economic cycles.

Figure 7: Taxation revenue as a percentage of GDP
Federal government, 1961 to 2008

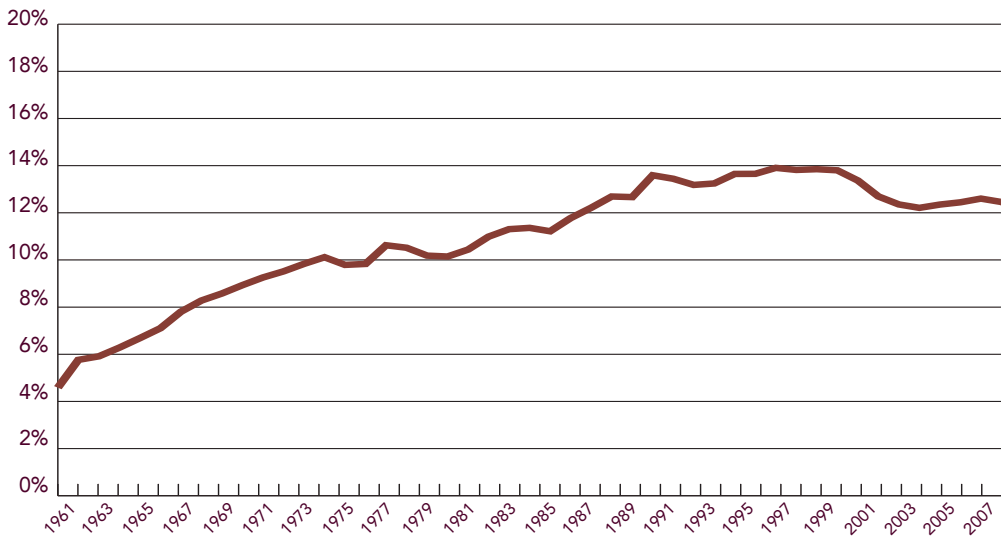


Source: *Fiscal Reference Tables 2009,* Finance Canada, October 2009.

The period after 2000 shows a consistent downward trend, reflecting successive tax cuts introduced by the Chrétien, Martin and Harper governments in the 2000s. That trend is likely to continue as corporate tax cuts continue to be phased in. Compared with the norm reached in the late 1990s, federal government taxation revenue has declined by about 3% of GDP.

While federal government revenue fluctuated within a relatively narrow band of 13% to 17% of GDP during the 1961 to 2008 period, provincial government taxation revenue reflects the two trends that have dominated changes in Canadian fiscal capacity since the early 1960s. The steady increase in provincial government fiscal capacity from 1961 to the mid-1990s, followed by a decline in provincial fiscal capacity from the late 1990s to the late 2000s, amounted to a full 2% of GDP, a loss in provincial government fiscal capacity of nearly $30 billion annually. Figure 8 shows provincial

Figure 8: Taxation revenue as a percentage of GDP
Provincial governments, 1961 to 2008



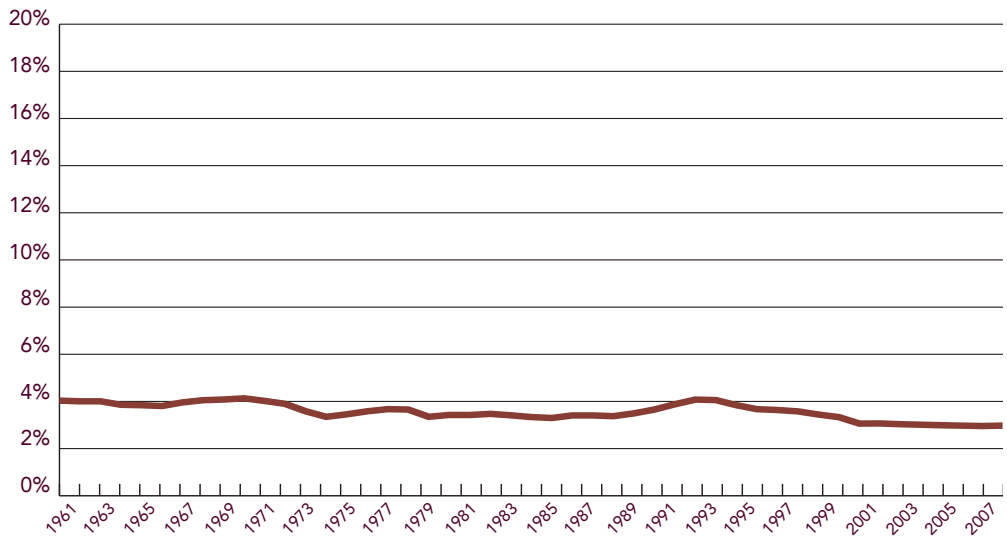
Source: *Fiscal Reference Tables 2009*, Finance Canada, October 2009.

government revenue from taxation as a share of GDP, from 1961 to 2008. Figure 9 shows the same data on taxation for local governments. Over the same period, local government revenue from taxation declined by approximately one percent of GDP from the early 1990s to 2008.

Taken together, the three orders of government in Canada have made fiscal choices since the mid-1990s, that have reduced their combined fiscal capacity by approximately 6% of GDP – a loss of a massive $90 billion per year of fiscal capacity. Recovering even half of that lost fiscal capacity would generate an additional $45 billion in revenue.

To provide some context for the Medicare sustainability discussion: whereas tax cuts since the mid-1990s amount to 6% of GDP, Medicare costs have increased by approximately 1.5% of GDP and total provincial health care costs by one percent of GDP.

Figure 9: Taxation revenue as a percentage of GDP
Local governments, 1961 to 2008



Source: *Fiscal Reference Tables 2009,* Finance Canada, October 2009.

Accordingly, to the extent that the data show that health care expenditures are increasing relative to public sector revenue, that increase is attributable not to rising health care expenditures, but rather to declining public fiscal capacity. In other words, Medicare funding pressures have been created by tax cuts rather than by increased health care costs.

All provinces participated in the tax cut competition of the late 1990s and early 2000s, but not to the same extent. Tables 1 and 2 summarize the projected 2005-2006 revenue losses from provincial corporate and personal income tax cuts established in provincial budgets between 1995 and 2002 in absolute dollars and as a percentage of actual provincial government revenue in 2005-2006, for each province.

For example, Table 1 shows that in British Columbia, corporate income tax cuts introduced in budgets between 1996 and 2002, when fully

Table 1. Corporate Income Tax Cuts

	Impact of cuts to 2005-6 (millions of dollars)	2005-6 actual revenue (millions of dollars)	Relative impact of cut
Newfoundland and Labrador	0	198	0.0%
Prince Edward Island	2	38	5.3%
Nova Scotia	0	363	0.0%
New Brunswick	-73	165	-44.2%
Québec	-1,099	3,667	-30.0%
Ontario	-3,978	8,296	-48.0%
Manitoba	-81	352	-23.0%
Saskatchewan	-39	393	-9.9%
Alberta	-565	4,728	-12.0%
British Columbia	-461	1,570	-29.4%
TOTAL	-6,294	19,770	-31.8%

Sources: *Income tax cuts, by province, budgets between 1996 and 2002 – annual revenue loss,* unpublished data, Finance Canada, October 2002. *CANSIM Table 385-0001,* Statistics Canada, 2010.

implemented, reduced the province's revenue in fiscal year 2005-2006 by an estimated $461 million. That cut represents 29.4% of the province's actual fiscal year 2005-2006 revenue from corporate income taxes. Table 2 shows the estimated annual revenue loss in fiscal year 2005-2006 from personal income tax cuts implemented in budgets between 1996 and 2002. For example, New Brunswick's personal income tax cuts introduced between 1996 and 2002 reduced the province's personal income tax revenue by an estimated $269 million in 2005-2006 as compared with actual 2005-2006 personal income tax revenue of $1,080 million. The estimated value of the cuts in 2005-2006 represents 24.9% of the province's actual personal income tax revenue in 2005-2006.

While the dollar revenue losses in aggregate were substantial both in absolute and relative terms, there were significant differences among provinces, both in the relative size of the cuts and

Table 2. Personal Income Tax Cuts

	Impact of cuts to 2005-6 (millions of dollars)	2005-6 actual revenue (millions of dollars)	Relative impact of cut
Newfoundland and Labrador	-62	821	-7.6%
Prince Edward Island	-22	205	-10.7%
Nova Scotia	-241	1,565	-15.4%
New Brunswick	-269	1,080	-24.9%
Québec	-5,395	19,527	-27.6%
Ontario	-12,129	24,291	-49.9%
Manitoba	-411	1,941	-21.2%
Saskatchewan	-673	1,449	-46.4%
Alberta	-2,210	2,889	-76.5%
British Columbia	-2,744	5,943	-46.2%
TOTAL	-24,155	59,711	-40.5%

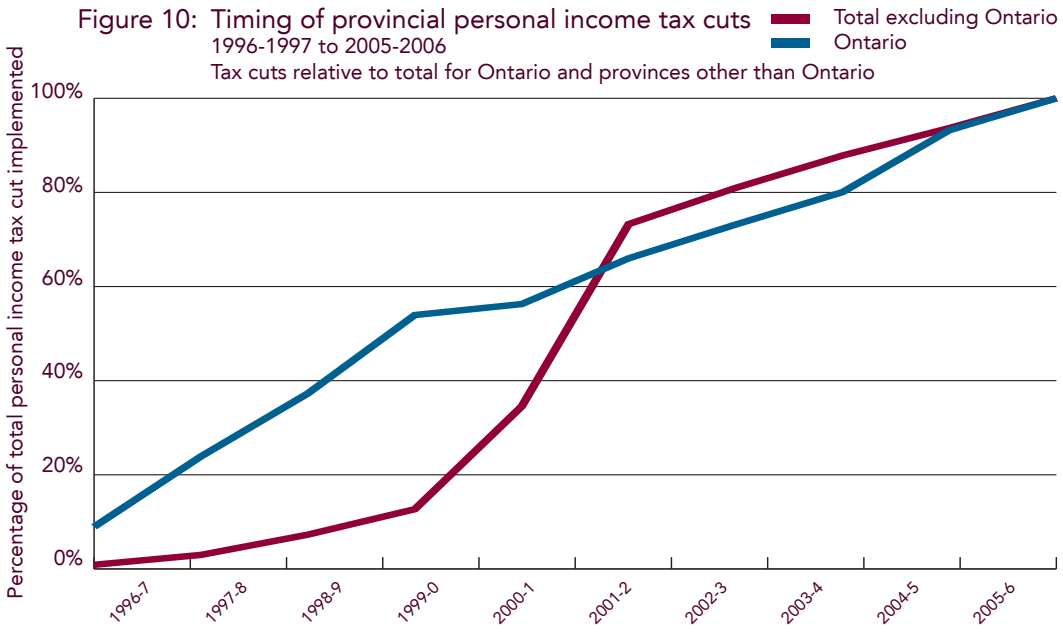
Sources: *Income tax cuts, by province, budgets between 1996 and 2002 – annual revenue loss,* unpublished data, Finance Canada, October 2002. *CANSIM Table 385-0001,* Statistics Canada, 2010.

their timing. In that period, three of the four Atlantic Provinces did not implement substantial cuts in either personal or corporate income taxes; Ontario made the deepest corporate tax cuts (Table 1) and the second-deepest personal income tax cuts (Table 2).

The timing of the cuts is revealing.

In particular, the role of Ontario as the tax cut leader is evident from the timing of provincial level personal income tax cuts announced in budgets up to and including 2002. Based on the Finance Canada estimates of annual revenue losses from these tax cuts up to and including fiscal year 2005-2006, Figure 10 shows for each fiscal year beginning in 1996-1997 the percentage of the 2005-2006 estimated total revenue loss that had been incurred by that year. For example, it indicates that by 1999-2000, Ontario had already implemented nearly 60% of its eventual total personal income tax cut, whereas the other provinces as a group had implemented less than 15% of their eventual total cuts.

Figure 10: Timing of provincial personal income tax cuts
1996-1997 to 2005-2006
Tax cuts relative to total for Ontario and provinces other than Ontario



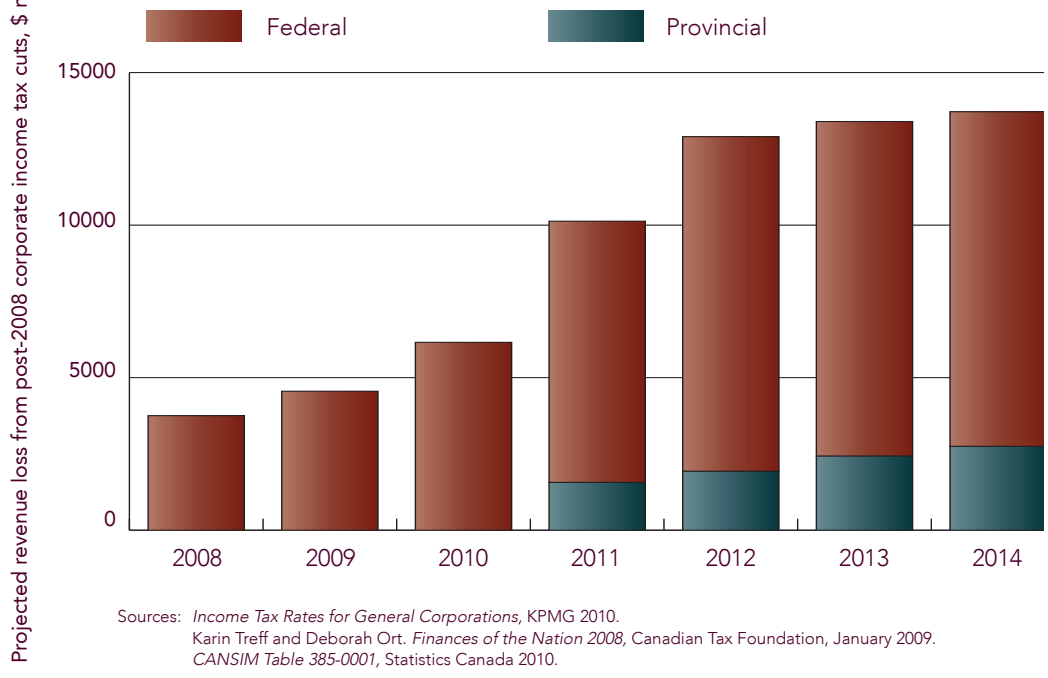
Sources: *Income tax cuts, by province, budgets between 1996 and 2002 – annual revenue loss,* unpublished data, Finance Canada, October 2002.
CANSIM Table 385-0001, Statistics Canada, 2010.

Ontario introduced its cuts in the late 1990s, with the other provinces for the most part following in the early 2000s. This illustrates the impact of tax jurisdiction competition among provinces.

Despite the fiscal pressures that tax cuts had created prior to the mid-1990s, and despite the fiscal situation currently faced by governments at all levels in Canada, the process is by no means complete.

Corporate tax rate cuts scheduled by the federal and provincial governments, taking effect between 2008 and 2014, will remove a further $15 billion (based on 2007 corporate tax revenue) in fiscal capacity once they are fully implemented. Figure 11 shows the growing impact of corporate tax cuts on public fiscal capacity in Canada.

Figure 11: Impact of post-2007 corporate income tax cuts
Federal and provincial governments; 2007 revenue basis



Sources: *Income Tax Rates for General Corporations*, KPMG 2010.
Karin Treff and Deborah Ort. *Finances of the Nation 2008*, Canadian Tax Foundation, January 2009.
CANSIM Table 385-0001, Statistics Canada 2010.

Canadian Health

While there may not be anything like the financing crisis facing Medicare that its critics are decrying, health care costs in Canada have been increasing. Understanding the underlying drivers of those cost increases is critical to any evaluation of proposals for change.

The data show that the key contributors to health care cost increases in Canada are: the higher rate of inflation for health expenditures than for the economy as a whole; the changing composition of health care costs; and the aging of the Canadian population.

Indicators of health costs

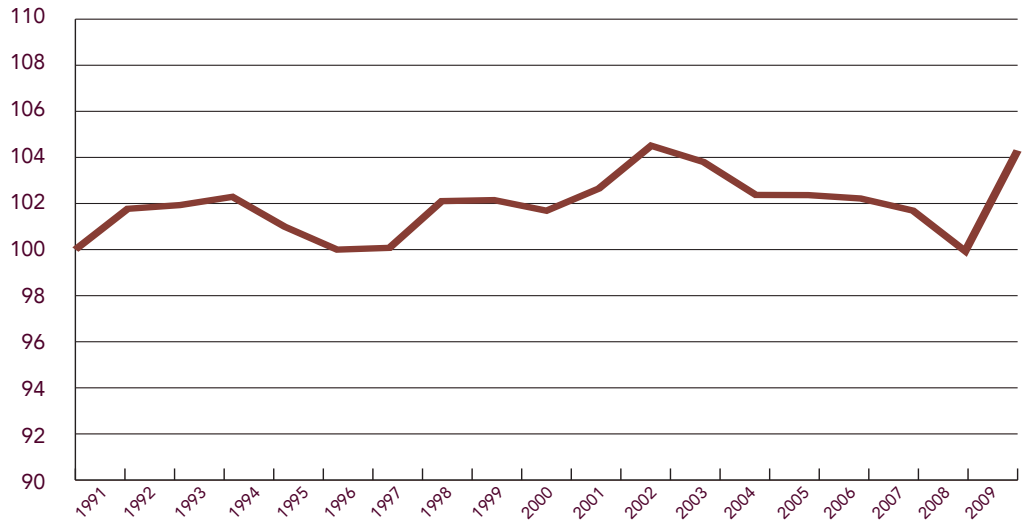
While there is no direct measure of sector-wide health care costs corresponding to the Consumer Price Index, Statistics Canada's National Accounts data include implicit price indices for the health care sector and for the economy as a whole. Figure 12 compares health care price increases with overall increases in prices in the economy, beginning in 1991. An index value of more than 100 means that health sector prices have increased relatively more than prices generally since 1991. When the index is increasing, health care unit costs are rising more rapidly than unit costs generally; when it is decreasing, health care unit costs are rising more slowly than unit costs generally.

Figure 12 shows that, over the period 1991 to 2008, health care prices have fluctuated relative to general price levels in the economy. During the recession of 1991 to 1993, health care prices rose 2% more quickly than prices generally. That trend reversed in the early stages of the recovery, but by 2001, health care prices – both public sector and private sector – were 4% above where they would

Care Costs in Perspective

Figure 12: Health expenditure relative prices

Health care price increases relative to overall price increases (1991=100)



Sources: *National Health Expenditure Trends, 1975 to 2009,* Canadian Institute for Health Information, Ottawa, Ont.: CIHI, 2009
CANSIM Table 380-0056, Statistics Canada 2010.

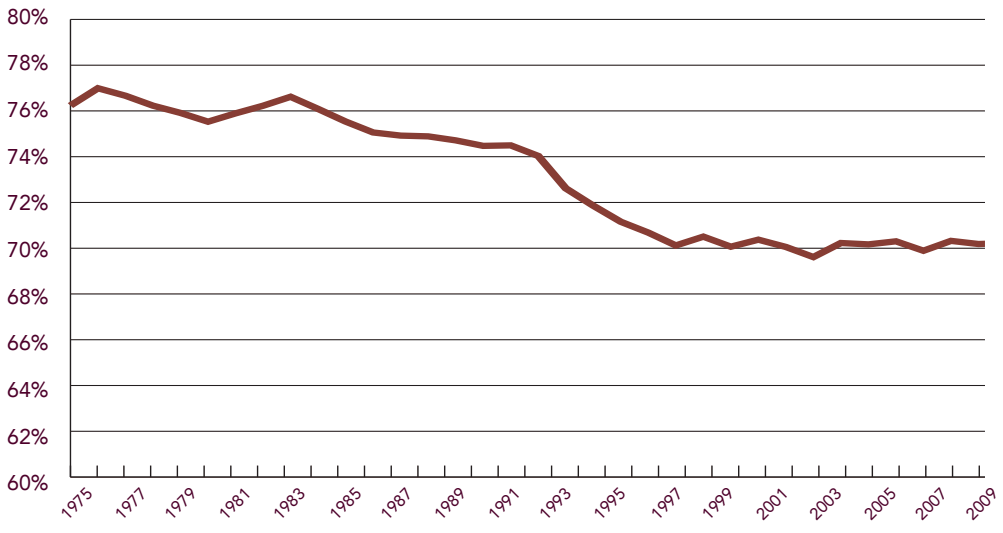
have been had they grown at the general rate of GDP inflation. From that peak, the health care implicit price index declined relative to the implicit GDP price index so that by 2008 it was back in the same relative position as it was in 1991, only to increase sharply in 2009 as the implicit GDP price index actually declined. Over the entire 18-year period, GDP inflation averaged 1.9%; health sector inflation averaged 2.1%.

While health care prices have been increasing more quickly than costs in the economy generally, the difference could hardly be described as significant.

The changing composition of health care expenditures in Canada

A review of the composition of health care expenditures offers some insights into the underlying drivers of health care cost increases.

Figure 13: Health care expenditures
Public share of total, 1975 to 2009



Source: *National Health Expenditure Trends, 1975 to 2009,* Canadian Institute for Health Information, Ottawa, Ont.: CIHI, 2009.

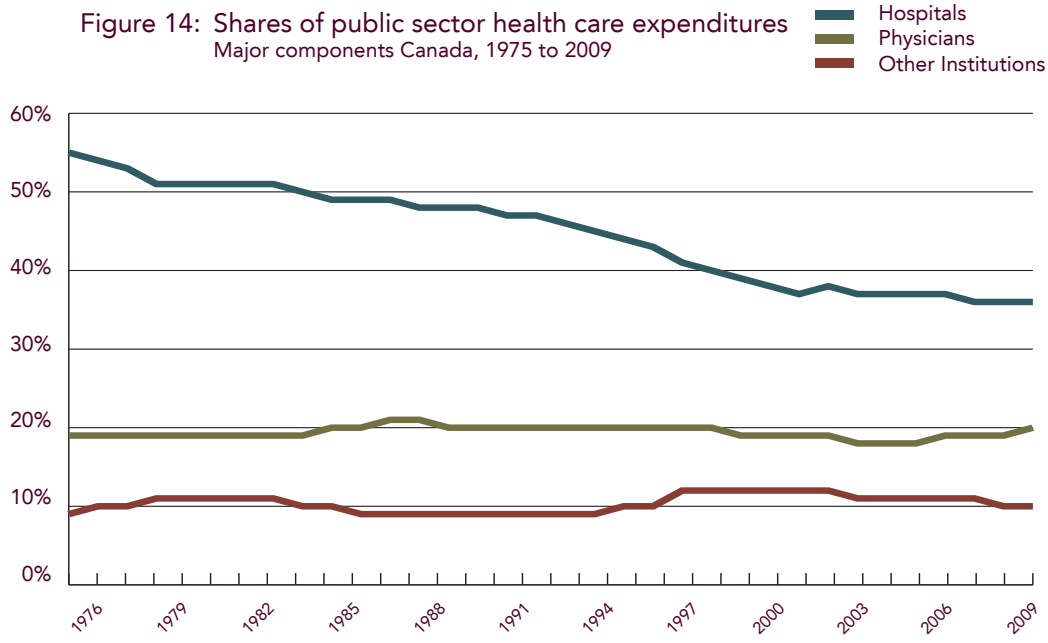
Overall, the share of the public sector in total health care expenditures has declined since the mid-1970s, as Figure 13 shows.

Over the period 1975 to 2009, the public share of health care expenditures declined from approximately 76% to 70%. The decline was compressed in a 15-year period between 1982 and 1997, with the most rapid decline taking place between 1992 and 1997.

There were also shifts of costs within the public sector during that period. Trends in the shares of the major components of health care expenditures – physicians' services, hospitals and other institutions – are shown in Figure 14.

While the shares for physicians and other institutions remained in a very tight band around 20% and 10% of total costs respectively, the share represented by hospitals declined substantially,

Figure 14: Shares of public sector health care expenditures
Major components Canada, 1975 to 2009



Source: *National Health Expenditure Trends, 1975 to 2009,* Canadian Institute for Health Information, Ottawa, Ont.: CIHI, 2009.

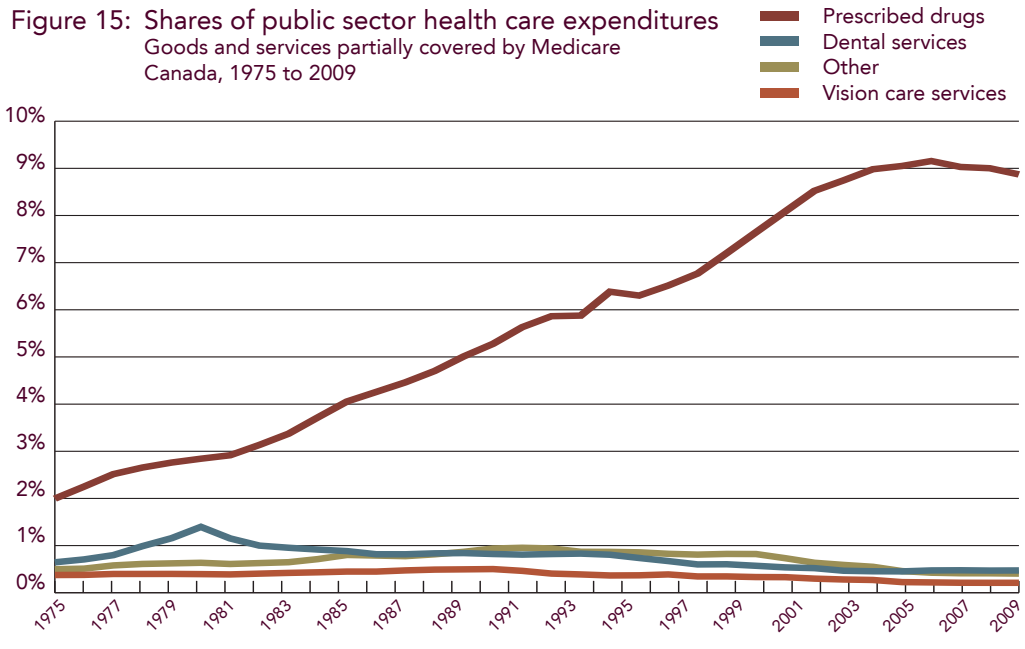
from 55% of public health care costs in 1975 to 36% in 2009.

A look at the share of public health care costs represented by goods and services only partially covered by Medicare explains part of the shift.

Figure 15 shows the changing shares of public sector health care spending represented by dental services, vision care services, other health care services, and prescription drugs.

While three of these four categories of expenditures maintained a consistently small share of public sector health care expenditures over the period from 1975 to 2009, the share accounted for by prescribed drugs increased substantially from 2% of total costs to 9% of total costs. To put this into perspective, pharmaceuticals alone have been responsible for 25% of the increases in Medicare costs as a share of GDP since 1975. The growth in

Figure 15: Shares of public sector health care expenditures
Goods and services partially covered by Medicare
Canada, 1975 to 2009

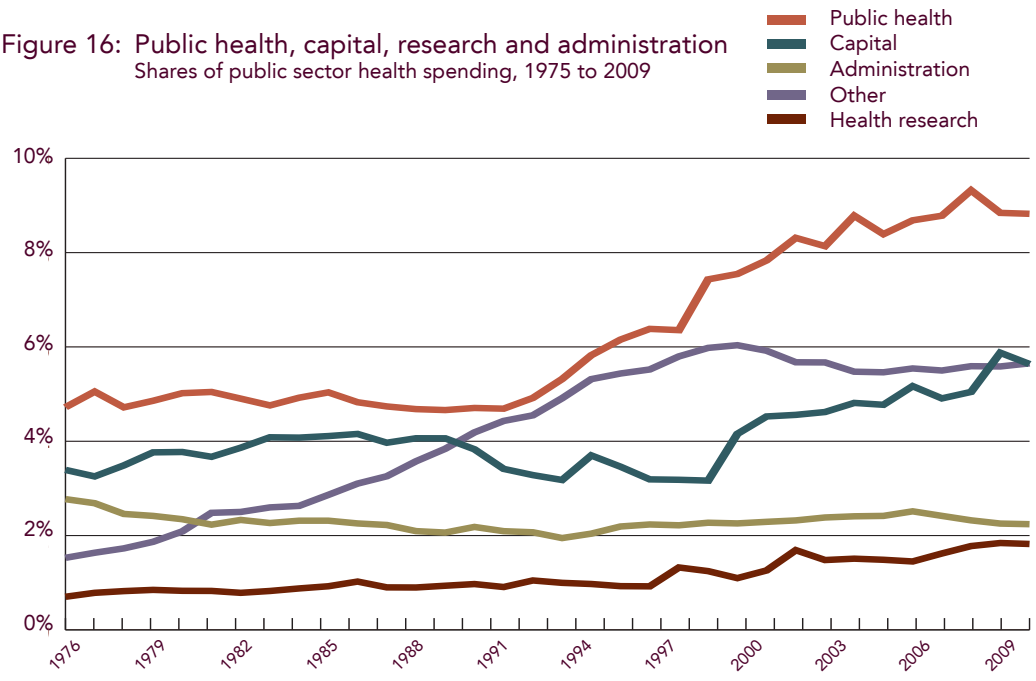


Source: *National Health Expenditure Trends, 1975 to 2009,* Canadian Institute for Health Information, Ottawa, Ont.: CIHI, 2009.

the share of prescription drugs in public health care costs is particularly important from a cost-control perspective because they are goods produced in the private sector and funded from public revenue. This highlights the importance of efforts by governments in Canada to move to negotiated prices for prescription drugs and to regulate the arrangements between the pharmaceutical industry and drug retailers.

The share of public health in public sector health spending has also increased, reflecting an increased emphasis over time in public health investments generally and immunization programs and the like in particular. Figure 16 shows the share of public health, capital investment, and administration in public sector health spending from 1975 to 2009.

Figure 16: Public health, capital, research and administration
Shares of public sector health spending, 1975 to 2009



Source: *National Health Expenditure Trends, 1975 to 2009,* Canadian Institute for Health Information, Ottawa, Ont.: CIHI, 2009.

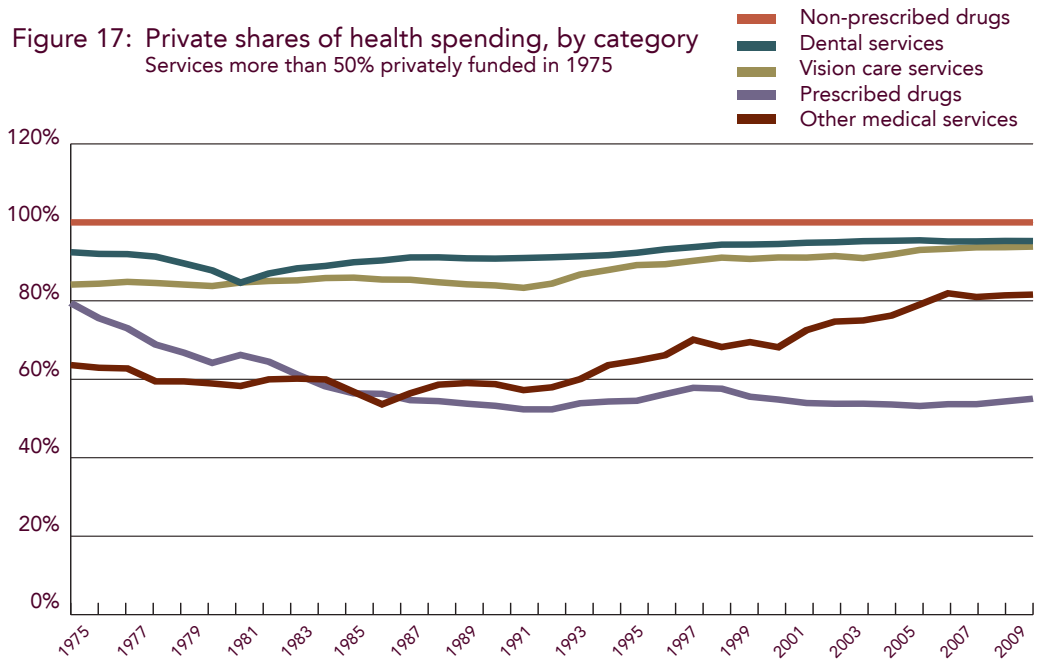
In addition to these shifts in the composition of public spending on health care, there have also been shifts between public and private responsibility for components of total health care spending, as Medicare coverage is broadened and narrowed and as newer non-covered services become more prominent.

We look at two categories of health care services: services which were largely privately funded in 1975; and services which were largely publicly funded in 1975.

Figure 17 shows the private/public share of total expenditures for categories of expenditures that were more than 50% privately funded in 1975.

Of these services, only prescribed drugs show an increase in the public share, reflecting the introduction and growth of provincial drug plan

Figure 17: Private shares of health spending, by category
Services more than 50% privately funded in 1975



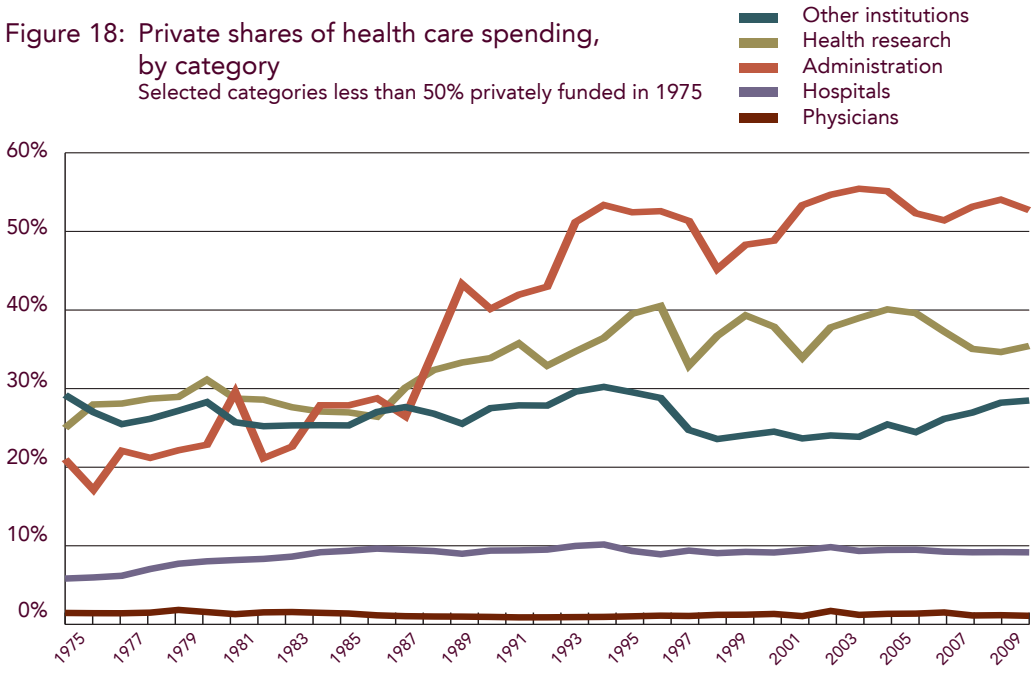
Source: *National Health Expenditure Trends, 1975 to 2009,* Canadian Institute for Health Information, Ottawa, Ont.: CIHI, 2009.

coverage since 1975. In 1975, 80% of drug costs were funded privately; by 2009 that percentage had dropped to less than 60%. The proportion of vision care costs funded publicly has declined slightly, reflecting various provincial government cost-cutting measures. The category "other medical services" has shown the largest increase in private funding, from 60% to 80%.

Figure 18 shows the public/private share of total expenditures for categories of expenditures that were less than 50% privately funded in 1975.

Three categories stand out as showing shifts from public to private funding: hospitals, reflecting the gradual shift from fully-covered ward accommodation to partially-covered semi-private and private accommodation; health research,

Figure 18: Private shares of health care spending, by category
Selected categories less than 50% privately funded in 1975



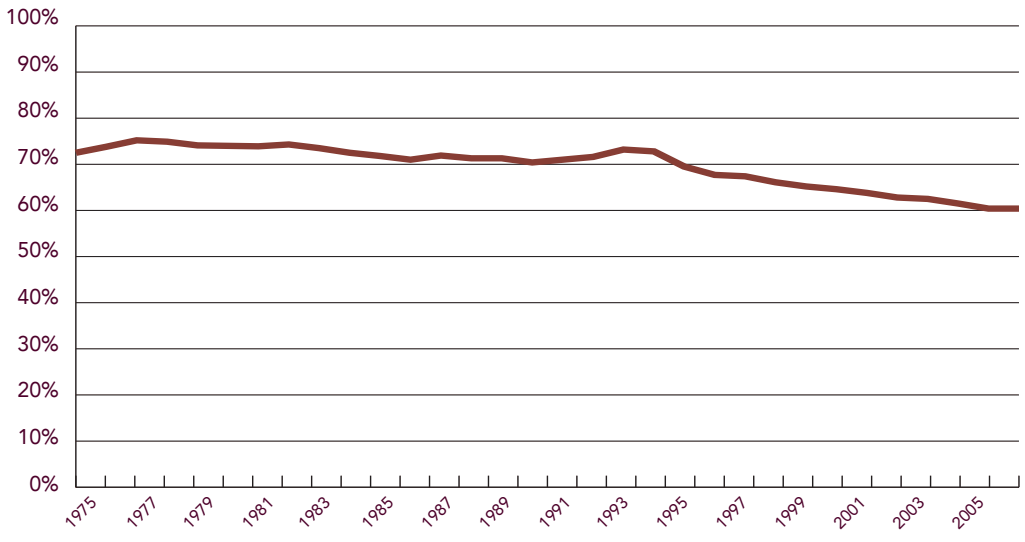
Source: *National Health Expenditure Trends, 1975 to 2009*, Canadian Institute for Health Information, Ottawa, Ont.: CIHI, 2009.

reflecting the growth in the relative importance of the pharmaceutical industry as a source of funding for health sector research; and administration, reflecting the shift from Medicare, with its relatively low administrative overhead, to private insurance, with its higher administrative costs.

Hospital costs

Although data are not available that break all health care costs into functional components, the breakdown available through Statistics Canada's input-output tables for the hospital sector offers some insights.

Figure 19: Wages & salaries as a percentage of total expenditures
Hospitals, 1975 to 2006



Source: *CANSIM Table 381-0009*, Statistics Canada 2010.

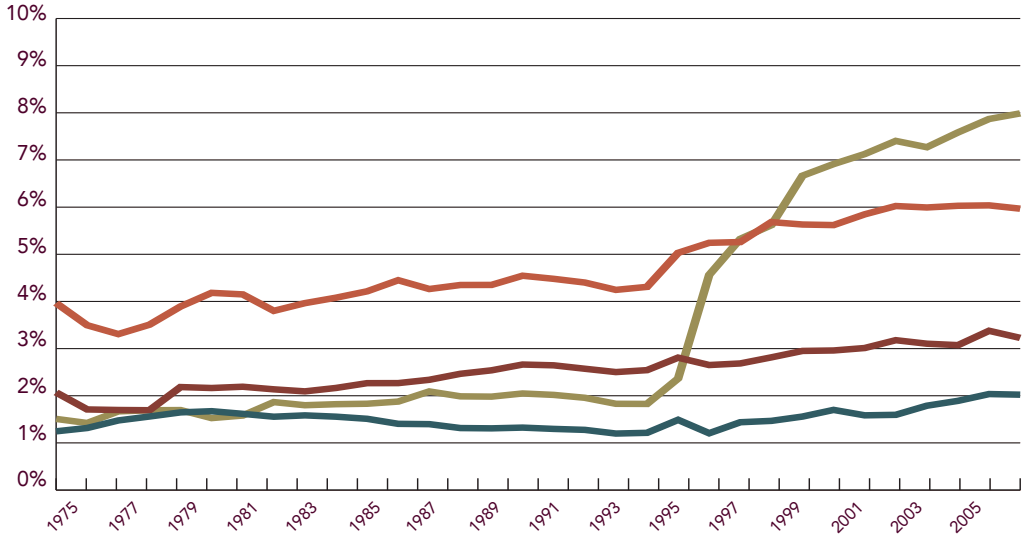
First, Figure 19 shows that in the hospital sector, wages and salaries (including benefits classified as supplementary income) have dropped from 75% of hospital sector costs in 1975 to 60% in 2006, the most recent year for which data are available.

Figure 20 shows shares of total expenditures in the hospital sector for selected smaller expenditure categories: utilities, pharmaceuticals, technology, and contracted services.

Utilities increased only slightly as a share of hospital expenditures; the share of pharmaceuticals increased modestly. However, the shares represented by technology and contracted services increased substantially.

The different rates of increase for various categories of hospital expenditures are also instructive.

Figure 20: Selected expenditure categories other than wages & salaries as a percentage of total expenditures
Hospitals, 1975 to 2006



Source: *CANSIM Table 381-0009*, Statistics Canada 2010.

In Table 3, costs that have increased at a rate greater than the overall average annual rate of increase (7.1%) have pushed costs up relative to the average; costs that have increased at a rate lower than the overall average rate of increase have held costs down relative to the average. Labour costs have increased at a rate lower than the overall average increase in hospital costs. Contracted services costs have tended to increase at a rate greater than the overall average increase in hospital costs. For example, many hospitals contract out food and laundry services.

Table 3. Selected hospital sector expenditure categories, 1975 to 2006

Input-output category	Annual rate of increase 1975 to 2006	Percentage of 2006 inputs
Pharmaceuticals	8.7%	3.2%
Measuring, photo, medical and scientific instruments	9.1%	3.6%
Electric power	9.5%	1.1%
Repair service for machinery and equipment	13.3%	1.3%
Miscellaneous health care and social assistance services	15.6%	5.9%
Meals	8.8%	1.2%
Other professional, scientific, technical, administrative, support and related services	13.3%	1.7%
Spare parts and maintenance supplies	3.4%	1.0%
Office supplies	9.8%	1.4%
Cafeteria supplies	4.7%	1.3%
Laboratory supplies	9.1%	1.8%
Other indirect taxes on production	12.5%	1.0%
Wages and salaries	6.2%	50.9%
Supplementary labour income	9.0%	9.5%
Other operating surplus	7.3%	5.1%
Average of itemized details	7.8%	89.8%
Overall average increase	7.1%	

Source: *CANSIM Table 381-0009*, Statistics Canada 2010.

The Impact

Canada's population is aging.[3] Statistics Canada's population projections indicate that the proportion of Canada's population that is over 65 years of age will increase from 13% in the 2001 Census to 23.4% by 2036.[4] We also know that Canadians' consumption of health care services tends to increase as they get older. For example, the Canadian Institute for Health Information (CIHI) estimated that health care costs in 2007 averaged $7,636 per capita for Canadians aged between 65 and 79 as compared to $2,778 per capita for Canadians aged between 45 and 64.[5]

These two sets of facts suggest that Canada's health care system will face cost pressures over and above normal inflation and population growth as the population bulge moves into its retirement and high-health-care-cost years.

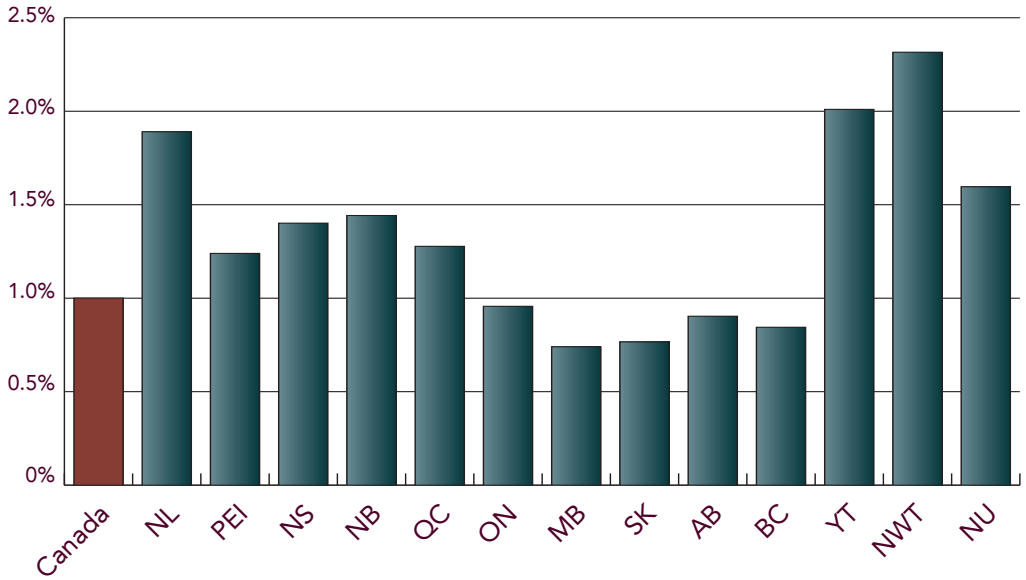
Critics of Medicare have seized on these facts to suggest that Canada faces a massive cost crisis related to our aging population that can only be addressed through a draconian curtailment of the scope of our public Medicare system. But a review of the facts does not bear out these conclusions.

To measure the effect of the aging of the population on health care costs, it is necessary to isolate the impact of changing demographics from other factors. Using statistics on health care utilization by age and sex for 2007, published by the CIHI, census population data and Statistics Canada's latest population projections, we measured the impact of demographic shifts alone on total health care costs, holding other factors constant.

Our analysis asked two related questions. First, based on the latest Medicare cost data, what would the total cost be, if instead of the actual population structure by age and sex in 2007, we had the population structure forecast by Statistics

# of Aging on Health Care Costs

Figure 21: Impact of aging on health care costs between 2010 and 2036
Annual growth rate attributable to changing age composition of population



Sources: *Projected population by age group and sex according to three projection scenarios for 2010, 2011, 2016, 2021, 2026, 2031 and 2036, at July 1,* Statistics Canada, Cat. No. 91-520-X, June 2010, projection M4
National Health Expenditure Trends, 1975 to 2009, Canadian Institute for Health Information, Ottawa, Ont.: CIHI, 2009

Canada for 2036? Second, what would the total cost of Medicare have been if instead of the actual population structure of 2007 we had the population structure measured in the Census of Canada 2001?

The results of the analysis are summarized in Figure 21.

Based on Statistics Canada's medium-growth population projection (M4), we estimate that Canada's changing demographic structure will increase at a rate of one percent per year between 2010 and 2036.

Looking back at the period between 2001 and 2010, we estimate that structural demographic change over that period increased costs by just under 0.8% per year.

Our analysis identifies modest annual cost pressures related to the aging of the population, but not at a level that is inconsistent with recent experience and certainly not at a rate that could be characterized as a looming crisis.

Our analysis does, however, reveal an aspect of demographic change and Medicare costs that has received little or no attention: the fact that the impact of demographic change on Medicare costs varies considerably among Canadian provinces. The average annual impact is projected to be one percent per year, but that amount varies from a low of 0.7% in Manitoba to a high of 1.9% in Newfoundland and Labrador among provinces, with well-above-average impacts in all three of the territories.

Canadian Health

The aging of the population is rivaled only by carefully selected international comparisons in the rhetorical arsenal of Medicare's critics. From holding up France as a paragon of virtue when it comes to privatization of health care services, to making the most of every story that surfaces about a Canadian going to the United States for a medical procedure, and those carefully cherry-picked anecdotes about how medical care is provided in other countries — all these play a significant role in the debate over health care in Canada.

Health care finance data from the OECD are helpful, both in putting the claims of Medicare's critics into perspective, and in suggesting the underlying economic motives behind much of the public criticism of Canadian Medicare.

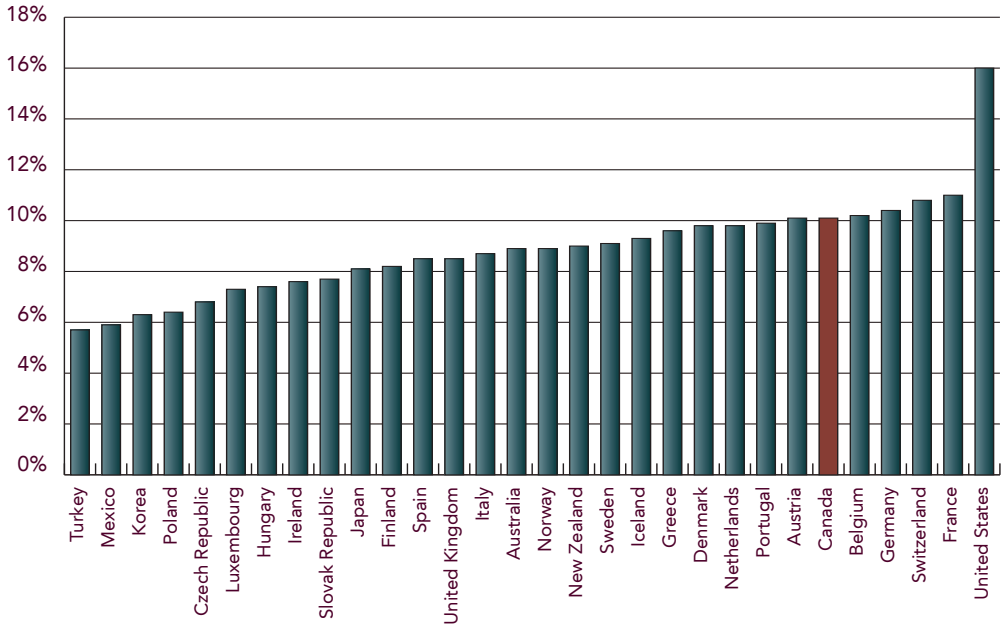
First, Canada's health care expenditures as a share of GDP are not out of line with those of most major countries in the OECD, as Figure 22 shows.

In most of the economically advanced countries within the OECD, total health care expenditures account for between 8% and 10% of GDP. Canada, at 10%, ranks 6th. The United States is a clear outlier, with health care expenditures of 16% of GDP – five percentage points above the share in any other country.

Interestingly, despite the well-documented gaps in health care affordability and access in the United States, Figure 23 shows public sector health care spending is higher as a share of GDP in the United States than it is in Canada.

Care in an International Context

Figure 22: Total health expenditures as a percentage of GDP
OECD countries, 2007



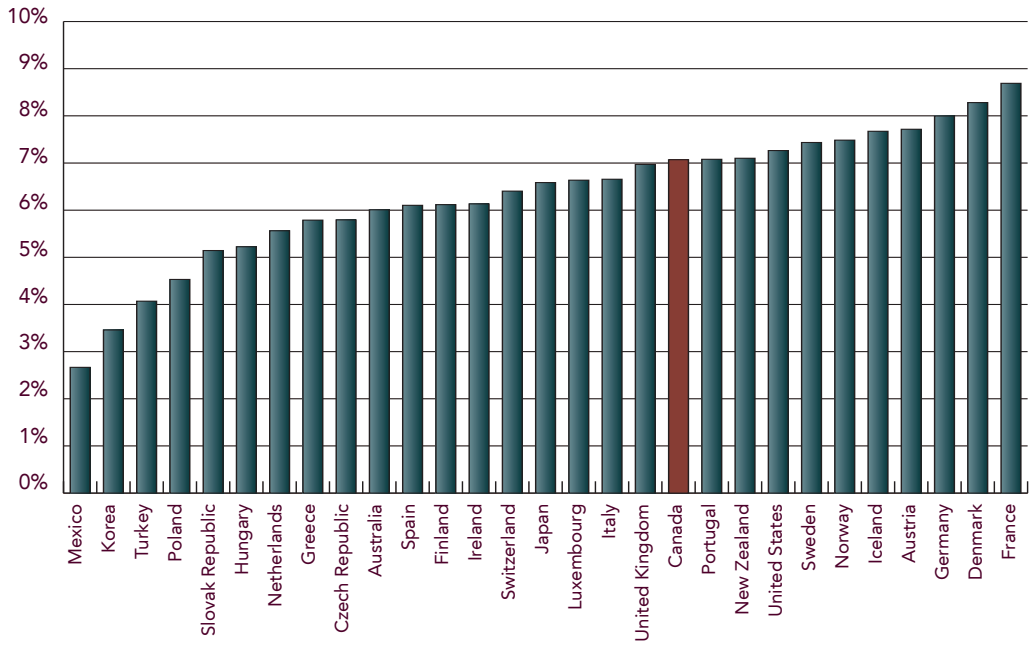
Source: *OECD Health Data 2009,* Organization for Economic Cooperation and Development, June 2009.

At 7% of GDP accounted for by public sector health care spending, Canada ranks 11th among the OECD countries for which data are available. The United States, at 7.3% of GDP, ranks 8th. In France, often held up by Canadian Medicare pundits as an example of private sector involvement that should be emulated, public sector spending accounts for the highest percentage of GDP in the OECD, at 8.7%.

Public and private health care spending in the OECD

At 70%, the share of total health spending publicly funded in Canada is one of the lowest among OECD countries, shown in Figure 24, although substantially above the 44% reported by the United States.

Figure 23: Public sector health expenditures as a percentage of GDP
OECD countries, 2007



Source: *OECD Health Data 2009*, Organization for Economic Cooperation and Development, June 2009.

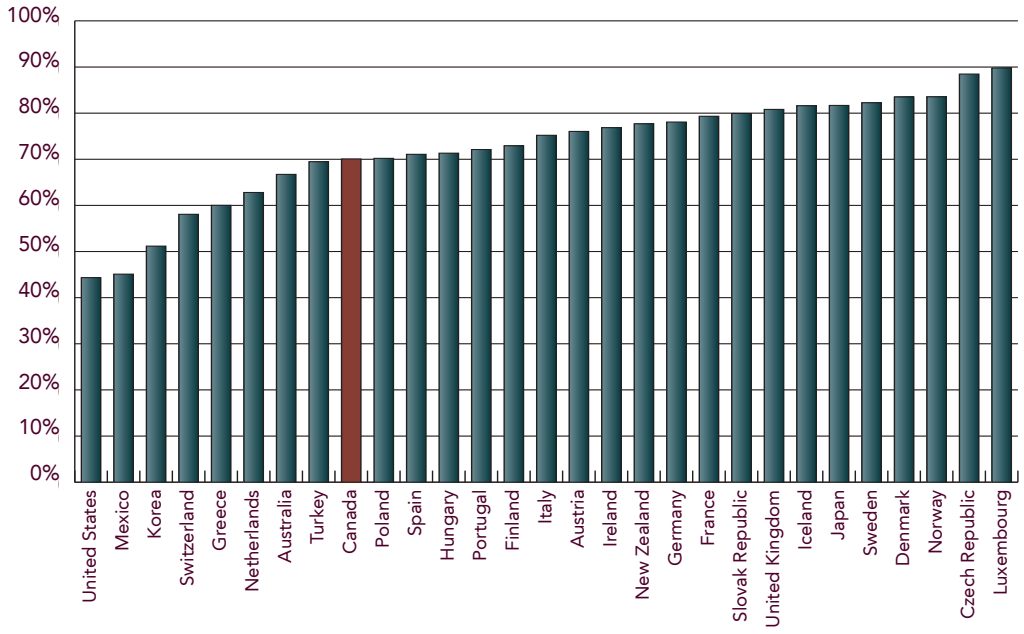
Two further data points from the OECD offer an additional perspective on the debate within Canada over our system.

Figure 25 shows the proportion of total health care spending that consists of out-of-pocket costs (costs not covered by either the public sector or private insurance plans).

Out-of-pocket expenses account for 15% of total health care costs in Canada, compared with 12% in the United States, 7% in France and only 5.5% in the Netherlands, with its unusual combination of public and mandatory private coverage.

Figures 26 and 27 shed a revealing light on the economic pressures that motivate those of Canada's Medicare critics who look longingly towards the United States.

Figure 24: Share of total health expenditures, public
Average 2000-2007, OECD countries



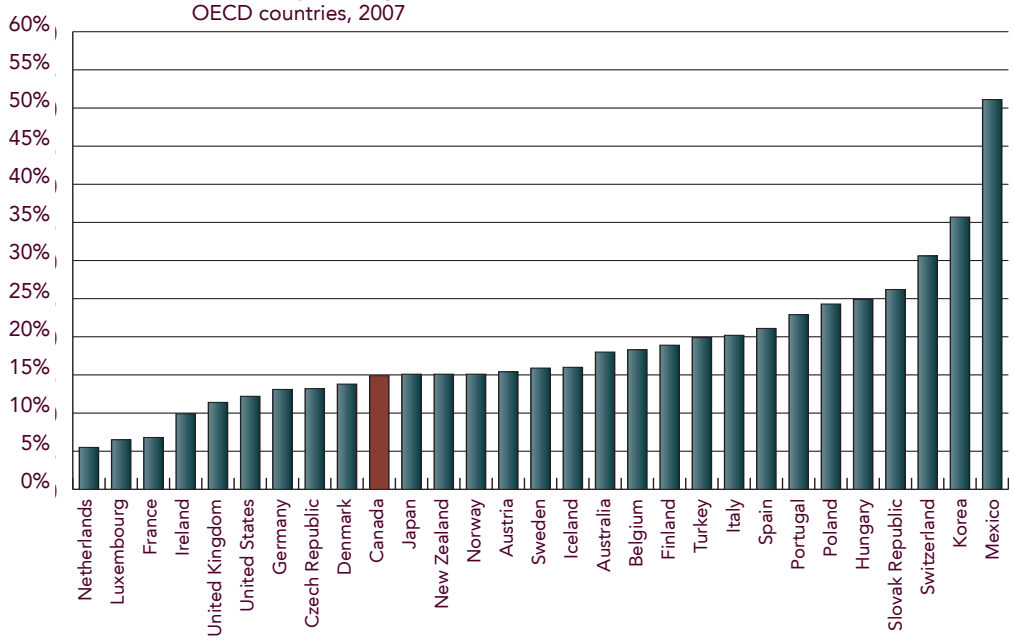
Source: *OECD Health Data 2009,* Organization for Economic Cooperation and Development, June 2009.

Figure 26 shows the percentage of health care costs accounted for by private health care insurance.

Canada is at the high end of the spectrum in its reliance on the private insurance industry for health care costs; the United States an outlier with private insurance at 42% of total health care spending.

Figure 27 highlights the enormous financial stakes in the health care debate in the United States, as well as the potential opportunities seen by privatization advocates in Canada. In the United States, the private health care insurance industry accounts for 6.8% of GDP. At 6.8% of the largest economy in the world, the health care industry in the United States has a lot at stake in debates about health care reform, and would have a lot to worry about if comparisons with Canada developed any traction. In Canada, private insurance accounts for only 1.5% of GDP.[6]

Figure 25: Private out-of-pocket health expenditures as a percentage of total spending
OECD countries, 2007

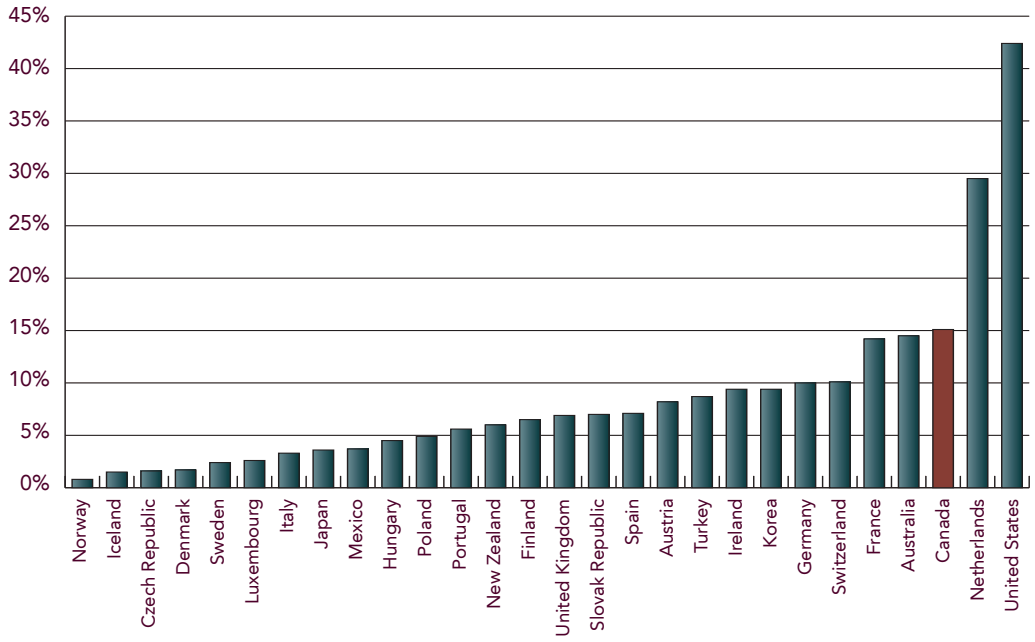


Source: *OECD Health Data 2009*, Organization for Economic Cooperation and Development, June 2009.

What do the international data have to say to Canadians engaged in our own debate about health care policy?

First, the data tell us that Canada's commitment to health care, relative to GDP, is not out of line with the norms in similar countries. Second, at 30%, Canada is already on the high side of the spectrum in its reliance on private financing for its health care needs. Indeed, Canada relies relatively heavily on private out-of-pocket payments for health care, relative to the situation in other countries. Third, the United States, the most obvious point of comparison for Canadians, is actually a world-wide outlier in both its cost and its reliance on private sector funding. And finally, the data tell us that the cherry-picked comparisons often used by participants in the health care debate in Canada are not always what they seem.

Figure 26: Private health insurance as a percentage of total health care spending
OECD countries

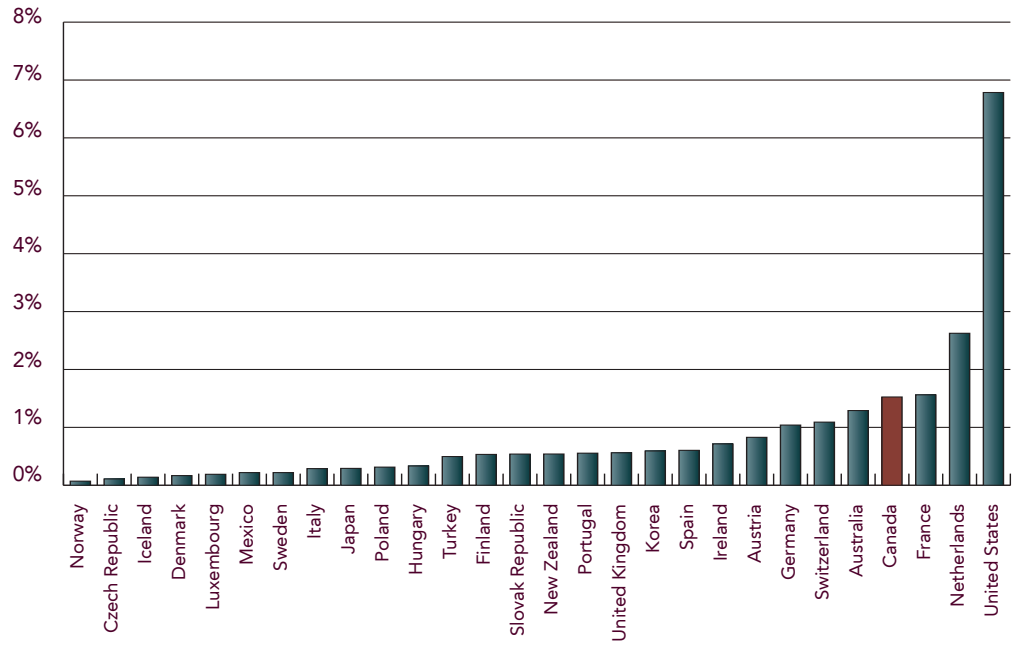


Source: *OECD Health Data 2009,* Organization for Economic Cooperation and Development, June 2009.

For example, France is often cited as a model of private sector involvement in health care that Canada should consider following. In fact, however, France spends more than Canada on health care as a share of GDP (11% vs. 10%), funds a larger proportion of its health care costs in the public sector (79% vs. 70%), and is only 1/3 as dependent on private out-of-pocket expenditures as Canada (see Figure 25).

Another example of the pitfalls of international comparisons is the Netherlands, whose combination of public and mandatory tightly regulated private coverage makes their insurance system the most comprehensive in the OECD, with the OECD's lowest reliance on out-of-pocket payments for health care funding.

Figure 27: Private health care insurance as a percentage of GDP
OECD Countries, 2007



Source: *OECD Health Data 2009*, Organization for Economic Cooperation and Development, June 2009.

Implications

The gap between rhetoric and reality in Canada's health care debate would be little more than a political curiosity if it were not for the potentially disastrous implications of the policy prescriptions that accompany some of the arguments.

Not only would many of these prescriptions make the very problems highlighted by Medicare's critics worse, they would divert attention, political energy and funding away from investments that would make Canadian health care better and more affordable as well as improve the health of Canadians generally.

A great deal of attention is focused on escalating costs, and the accompanying suggestion that the solution is to cut back on public Medicare. In concrete terms, however, few of the suggested changes would actually reduce health care costs overall; what they would do is redistribute costs from Canadians collectively to individuals. The basis of funding for an increasing proportion of health care costs would shift from an individual's ability to pay through the tax system, wherein those with the means pay relatively more; to an individual's health status, wherein those who are sicker would pay relatively more. Rather than have the universal access provided by the current system, access would shift towards those with either the ability to pay or access to private insurance. The basis for allocating health care resources would shift from need to personal financial resources.

As Professor Robert Evans, Canada's leading health economist, has put it:

> *[U]nder Canada's universal tax-financed Medicare, higher-income people contribute proportionately more to supporting the health care system, without*

for Canada's Health Care Debate

receiving preferred access or a higher standard of care. Any shift to more private financing would reduce the relative burden on those with higher incomes and offer (real or perceived) better or more timely care for those willing and able to pay.[7]

Proposals to shift health care costs are generally framed as responding to a need to build disincentives into the system to discourage overutilization. Implicit in this framing is the assumption that the need for health care services is more or less regularly distributed among Canadians. That assumption is not supported by the facts. In a 2002 *Canadian Medical Association Journal* article, Evelyn Forget, Raisa Deber and Leslie Roos reported that health care expenditures are highly skewed. Based on data for the province of Manitoba for the period 1997 to 1999, they found that the 10% of the population with the highest health care costs had per-capita costs of approximately $5,000, 80% of which were for hospitalization. They also found that 40% of the population consumed less than $100 per capita for physicians' and hospital services combined;

The issue is not how much we pay, but who pays how much. In other words, the drive for greater private financing is really a fight against the Canadian ideal of equitable access to health care.

80% consumed less than $600 per capita.[8] The implications of such a skewed distribution of costs are clear: any policy which rewards the healthy and/or penalizes the sick will produce modest gains for a large number of Canadians through the imposition of significant financial hardships on a few of the very ill. Any policy which shifts costs from the universal public plan to private resources will generate significant savings for a small number of high-income taxpayers at the expense of a small number of extremely ill Canadians. The issue is not how much we pay, but who pays how much. In other words, the drive for greater private financing is really a fight against the Canadian ideal of equitable access to health care.

Furthermore, shifting costs from the public sector to the private sector has the effect of shifting costs from a funding delivery system in which costs can be controlled, to a system in which there is no incentive whatsoever to control costs. As the high-profile and long-overdue efforts of the Government of Ontario in 2010 to break up the cozy relationship between the generic pharmaceutical industry and drug retailers demonstrate clearly, the bargaining power that resides in public funding can have a material impact on costs.[9]

Similarly, the public payer's role as the primary source of financing for Canadian hospitals and the primary source of income for physicians in private practice provides a vastly more powerful basis for cost and service management than is possible in a fragmented privately-funded system. As we suggest later in this paper, the Canadian system could be improved if governments made more effective use of their leverage in a single-payer system, but it is absurd to suggest that weakening the potential for that leverage would improve either the performance or the cost of the system.

The data do indicate that our aging population is a built-in, but modest, ongoing driver of increased health care costs. They point to the need to improve productivity and effectiveness in the system, a topic to which we return in a later section of this paper.

Funding Medicare and

Provincial government programs like Medicare are funded from two broad sources of revenue: transfer payments from the federal government; and provincial "own-source" revenue. Each of these broad categories is further subdivided. Own-source revenue is divided between taxation and other forms of provincial government revenue, classified as sales of goods and services (user fees and the like) and investment income.

Transfer payments are either special-purpose transfers – the Canada Health Transfer and the Wait Times Reduction Transfer, for example – or general-purpose transfers such as equalization payments.

It is helpful before getting into the details of funding formulae to take a longer-term look at how provincial revenue sources have developed in the modern era of government services in Canada.

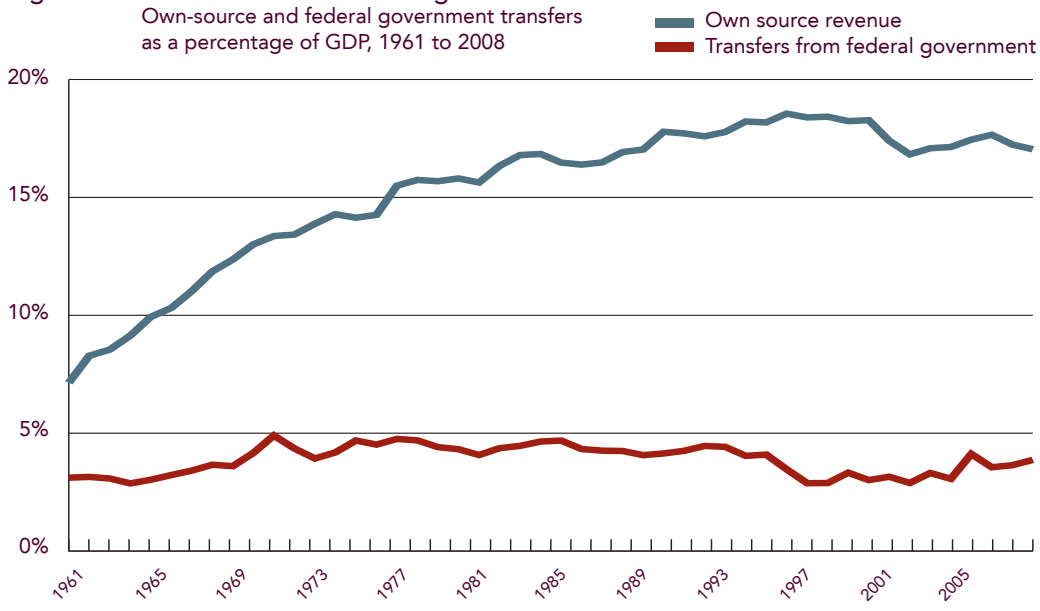
Figure 28 shows the evolution of the two main components of provincial government revenue over the nearly 50 years since 1961. It is clear that while federal government transfer payment income has fluctuated over the period, it has done so within a relatively narrow range of between 3% and 5% of GDP. Federal transfers certainly do not exhibit a consistent trend, either upwards or downwards over the long term.

With respect to provincial own-source revenue, the chart shows two clearly identifiable eras: the period from the beginning of the 1960s to the mid-1990s, when provincial governments' own-source revenue increased steadily as a share of GDP as provincial government services expanded; and the period after the mid-1990s, when the tax cut era led to a notable decline in provincial governments' own-source revenue as a share of GDP.

Figure 29 shows the evolution of the main components of provincial own-source revenue over the same time period.

the Role of the Federal Government

Figure 28: Provincial and territorial government revenue
Own-source and federal government transfers as a percentage of GDP, 1961 to 2008



Source: *Fiscal Reference Tables 2009*, Finance Canada, October 2009.

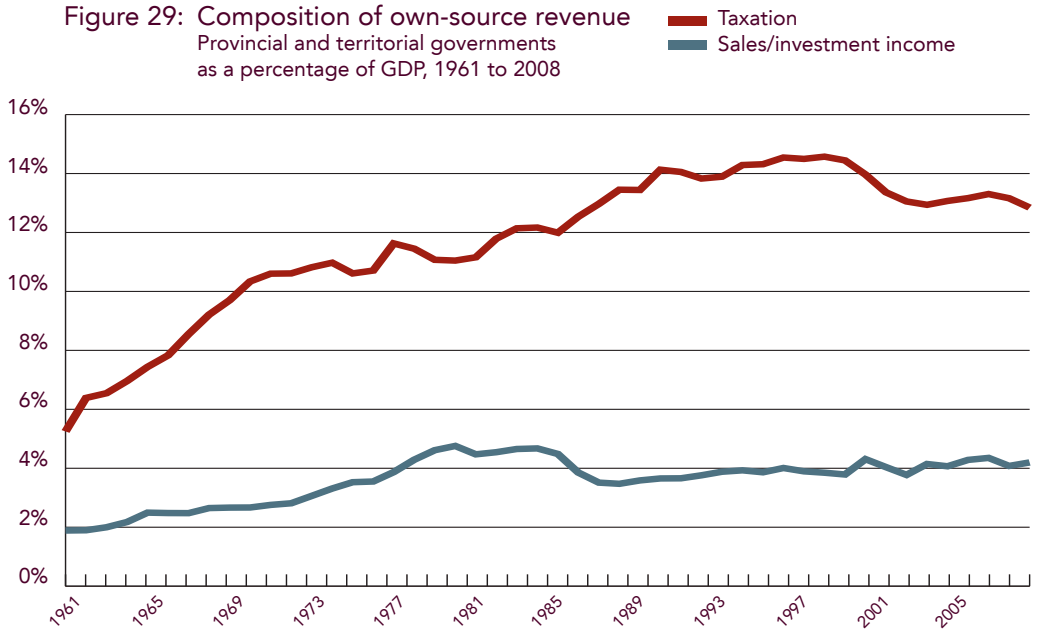
Revenue from sales of goods and services and investments grew steadily as a share of GDP in the first 20 years of the period, from 2% to 4% of GDP, and then stabilized in the neighbourhood of 4% of GDP thereafter.

The main driver of the own-source revenue trends identified in Figure 29 was taxation.

Figure 30 presents transfer payment revenue on its own scale, to support a more precise identification of trends.

Before we delve in more detail into the data for federal government transfer payments, two general observations are relevant. Although the decline in federal government transfer payments in the mid-1990s was significant in relative terms – dropping from 4% to 3% of GDP – the decline in provincial government revenue from taxation was greater as a share of GDP. Furthermore, by 2008, federal transfers had nearly recovered to their early-1990s level, whereas provincial government revenue from taxation had not.

Figure 29: Composition of own-source revenue
Provincial and territorial governments
as a percentage of GDP, 1961 to 2008



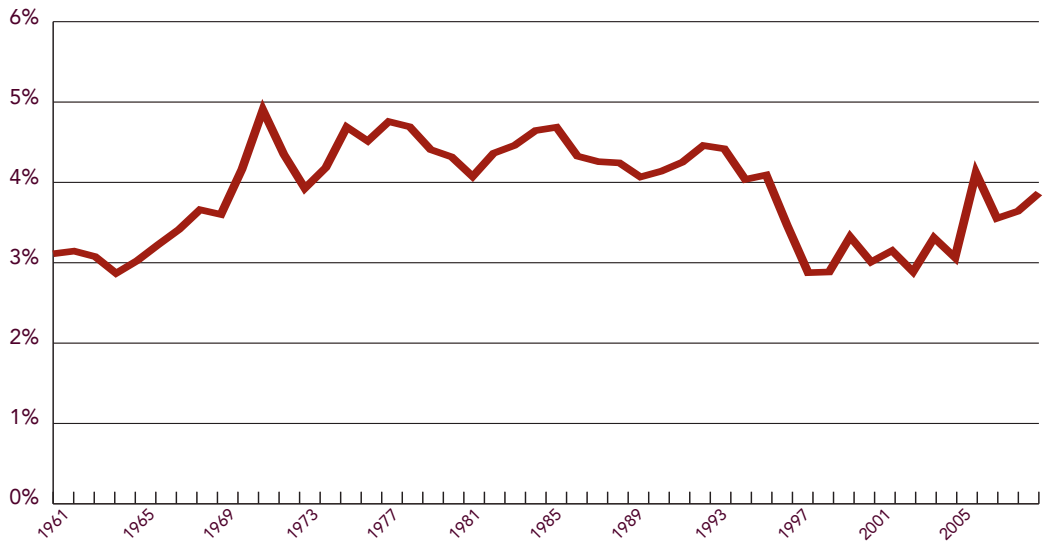
Source: *Fiscal Reference Tables 2009*, Finance Canada, October 2009.

Figure 31 focuses specifically on fiscal years 1988-1989 to 2008-2009, breaking federal transfers down between general-purpose and special-purpose transfers. The substantial drop in special-purpose transfers in the mid-1990s reflects the change from program-specific transfer payments to the (smaller, in total) Canada Health and Social Transfer, which was classified as a general transfer because it was not attached to any specific program or program requirements. The rebound in the special-purpose transfer line in the mid 2000s reflects the introduction of the Canada Health Transfer.

Elements of federal government transfers for health care

Although it has placed less emphasis on it in recent years, the federal government has historically taken the position that the value of changes in the relationship between federal and provincial

Figure 30: Provincial and territorial government revenue
Federal government transfers
as a percentage of GDP, 1961 to 2008



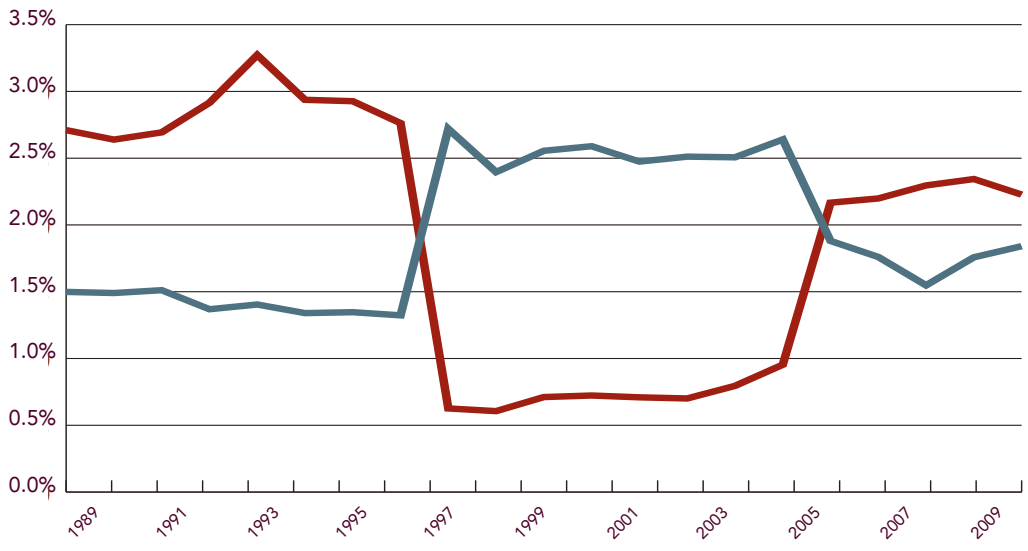
Source: *Fiscal Reference Tables 2009*, Finance Canada, October 2009.

personal and corporate income taxes implemented in the late 1970s should be included in any calculation of federal financial support for provincial programs.

In the most recent material making this assertion, covering the years 1993-1994 to 2003-2004, the value placed by the federal government on the "tax point" component of its support for provincial government programs amounted to 11-12% of provincial tax revenue for most provinces.

This claim refers to an arrangement in the late 1970s under which the federal government reduced its corporate tax rate by one percentage point and its personal tax rate by 13.5 percentage points, thereby creating tax "room" for provincial governments to occupy by increasing their tax rates. While the claim may be technically valid, it is economically and politically irrelevant. The arrangements that included the tax point transfer were made more than 30 years ago as part of a package of changes in other federal-provincial transfer payment programs, none of which is applicable today. In the 1970s, provincial income tax systems (with the exception of Quebec's) were

Figure 31: Federal transfers to provinces and territories
General-purpose and special-purpose transfers as a percentage of GDP 1989 to 2009



Source: *CANSIM Table 385-0001*, Statistics Canada, 2010

based on a straightforward percentage of federal tax; however, since the late 1990s, provincial governments have taken advantage of increased income tax design flexibility to create their own tax systems no longer linked directly to federal taxes. Finally, as this paper makes clear in earlier sections, any impact of those arrangements has been superseded by subsequent changes in provincial tax policies.

Accordingly, while in some circumstances the history of the tax point transfer may serve the federal government as a useful debating point, it is not relevant to a discussion of future federal government involvement in health care funding.

The core of the federal government's funding for health care is delivered through the Canada Health Transfer, introduced in the early 2000s. It had become clear that the federal government would not be able to sustain politically the transfer payment cuts that it had introduced in the mid-1990s. In addition, the federal government was under intense pressure both from provincial governments and the public to re-establish a direct role in funding health care.

Since it was introduced in 2004, the Canada Health Transfer has covered approximately 20% of provincial health care expenditures. The federal-provincial agreement that created the CHST also committed the federal government to increase the transfer at an annual rate of 6% over the ten-year agreement period. However, its composition will change over time as the transfer is converted gradually into an equal per-capita grant.[10]

Implications of this analysis for federal health transfer payment design

The data indicate clearly that federal transfer payments have recovered to their share of GDP in the mid-1990s. However, while the federal government's financial commitment to health care has recovered, its influence over the health care system has not. The federal government's withdrawal from specifically identified health care funding, and the coincident dramatic reduction in its overall allocation to provincial transfer payments, eliminated its leverage over the system and damaged its credibility as a leader of change in the health care system.

To put it bluntly, the substantial increase in federal funding for health care since the late 1990s has not bought either change or influence over the direction of change. Indeed, in light of the fact that provincial governments continued to cut their taxes after 2000, it would appear that at least some of the increase in federal health care funding has been used by provincial governments to fund tax cuts. Not all provincial governments have been as blatant in that regard as the Charest Government in Quebec, which introduced a significant tax cut only days after a federal budget announcement of a transfer payment increase, but overall the combination of transfer payment increases and tax cuts amounts to the same thing.

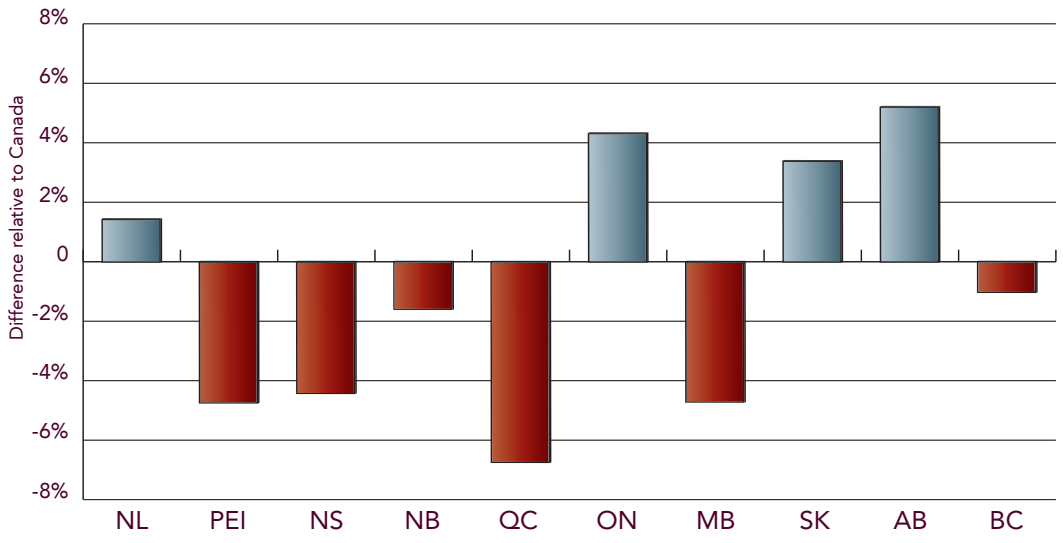
While it is critical that the federal government maintain a significant direct position in the funding of health care in Canada, it is just as important that

the federal government use the leverage created by its support to protect the principles of access and coverage under the *Canada Health Act* and to drive needed service delivery and productivity improvements.

Our analysis also raises questions about the current direction of change in health care funding towards equal per-capita funding. While this approach has the virtues of simplicity and apparent fairness, it does not link federal funding either to the quality of health care available to Canadians or to the recognized drivers of the costs of delivering that care.

Two examples serve to illustrate the point. Employment earnings make up a significant share of the health care costs: roughly 60% of hospital costs alone and a comparable or higher proportion of the costs of other segments of the health care system. However, employment costs in health care are not uniform across the country. Figure 32 compares weekly earnings in health care and social assistance at the provincial level with the Canadian average.

Figure 32: Weekly earnings, health care and social assistance, by province
2009 Index (Canada=100)



Source: *CANSIM Table 281-0027*, Statistics Canada, 2010

For example, the chart shows that average weekly wages and salaries in health care and social assistance are nearly 7% below the national average in Quebec and 4% above the national average in Ontario.

A funding formula that ignores the costs of providing services will tend to underfund care in higher-cost jurisdictions and over-fund care in lower-cost jurisdictions, relative to the Canadian average. Prince Edward Island, Nova Scotia, Quebec and Manitoba gain significantly while New Brunswick and British Columbia gain slightly. Ontario, Saskatchewan, Newfoundland and Labrador, and Alberta lose, relatively speaking, from per-capita funding.

In a similar vein, in our analysis of the impact on health care costs of the changing age profile of Canada's population, we concluded that population aging, by itself, will tend to push costs up by one percent per year. As Figure 21 on page 43 shows, aging will have a much greater impact on health care costs in Eastern Canada and the Territories than in Ontario and the West.

A fair system for federal government funding assistance to provincial Medicare plans should take these and other differential factors into account in determining funding levels.

More importantly, the federal government has a clear role in fostering improvements in delivery and productivity in the health care sector in Canada, and the funding system for Medicare is an obvious way to build in incentives for change. Medicare may fall under provincial jurisdiction, but it is clear that Canadians view portable, comprehensive, accessible and equitably funded health care as a vital national project. Public opinion results regularly confirm the importance that Canadians attach to Medicare. For example, a poll released in August 2009 by Nanos Research found that 86.2% of Canadians supported "public solutions to make our public health care stronger," with the strongest support in Quebec at 87.6% and the lowest in Ontario at 84.1%. In another poll released in November 2009, Nanos Research summarized the findings as follows:

> *These numbers are way beyond any margin of error. There are very few, if any, pillars of Canadian public policy of which Canadians approve as strongly as the principle of universal health care, which has been with us since it was first adopted by the Pearson government in the 1960s...*
>
> *Fully 89.9 percent of Canadians support or somewhat support universal health care, and within those two response groups, the vast majority, 79.9 percent or four Canadians in five, give their unqualified endorsement, while another 10 percent are somewhat supportive.*
>
> *There are really no important regional variations on this theme. Unqualified support for universal health care is strongest in Ontario (83 percent), and weakest on the Prairies (76.8)...*

Looking at the question of universal health care by demographics, unqualified support is actually strongest in the youngest cohort of 18 to 29 years of age, where 82.3 percent expressed unreserved support, closely aligned with 81.4 percent of clear supporters among the 60-plus age group. The first demographic, the least likely to need or even think about needing public health care, is every bit as supportive as the cohort most likely to be in need of it.[11]

The key to any national initiative that falls under provincial jurisdiction is for the federal government to commit itself, long term, to playing a constructive role as a consistent and reliable funding partner....

The key to any national initiative that falls under provincial jurisdiction is for the federal government to commit itself, long term, to playing a constructive role as a consistent and reliable funding partner to the provincial and territorial governments.

In the absence of a commitment to funding, the federal government's ability to influence the evolution of Medicare in Canada – indeed the very viability of Medicare as a national project – is compromised. That is exactly what happened in the late 1990s, when federal government funding cuts undermined its ability to enforce the provisions of the *Canada Health Act*.

Against that background, the federal-provincial agreement for the period 2004 to 2014 represented a significant positive step in re-establishing the role of the federal government as a partner in funding Medicare and in rebuilding federal credibility as a leader in Medicare as a national project while respecting provincial and territorial jurisdictions. To build on that foundation, it is critical that the federal government maintain the relative value of its commitment to Medicare funding and ensure both that the terms under which that funding is advanced reinforce the values on which Medicare is based, and that federal funding buys change. It is by no means too early to begin negotiating for the successor to the ten-year agreement that ends in 2014.

Sustainability of Medicare

Foundations

As we noted in the previous section, the typical line of argument about the non-sustainability of Medicare goes something like this:

- The costs of Medicare have been escalating at an alarming rate.
- The aging of our population will fuel the cost crisis.
- Unless something drastic is done soon to slash the growth in health care costs, the system will bankrupt us.

Many commentators reveal their true colours by calling for privatization of finance and for more for-profit delivery of services. Sometimes these are tempered by calls for reforms to doctors' payment systems, more electronic health records, and other recommendations from health commissions for thirty years. Few commentators note any active role for the federal government to facilitate reform.

In the last few months, the Quebec budget floated the notion of user fees. David Dodge, former governor of the Bank of Canada, warned the Liberal Party of Canada that the only options were higher taxes, user fees or poorer services.[12]

Indeed, given the evident political popularity of Medicare among Canadians – Medicare is often described as the "third rail" of Canadian politics[13] – it is apparent that the real goal of the non-sustainability rhetoric is to frame the issues in a way that limits the available options for change.

In fact, neither the claim that Medicare is unsustainable, nor the limited frame in which the options have been set, is valid. As we documented in the first section of this paper, health care expenditures have been a relatively stable share of government spending for several years. Furthermore, aging of the population has only a moderate impact on costs, raising them a mere one percent per year.

for Medicare's Future

The opportunities for change in Medicare open to Canadians are neither as limited nor as limiting as those put forward by Medicare's critics.

The opportunities fall under three broad categories: changing the relative roles of the public and private sectors in the management of the health care system; using the leverage provided by Medicare to modernize the delivery of health care in Canada; and focusing on improvements in the determinants of health in Canada.

Cost management

Both under and outside the umbrella of Medicare, Canada relies heavily on the private sector for the funding, management and delivery of health care services. In some instances – the manufacturing and distribution of pharmaceuticals, for example – the issue is not so much with private sector involvement itself, but more with the terms under which that involvement takes place. Without careful monitoring and management, those terms can become unfavourable to the public interest. The system of payments by generic drug manufacturers to drug retailers recently curtailed by the Government of Ontario is an example of the kinds of unnecessary costs that can be incurred if the public-private relationship is not carefully managed and controlled.

In other instances, the mixture of public and private finance leads to inefficiency, higher cost and gaps in service. Prescription drug insurance coverage is a good case in point. The lack of a national pharmacare program means that drug coverage is fragmented and incomplete. Drugs administered in hospital are covered by Medicare; provincial drug plans may cover seniors, families

receiving social assistance, and/or catastrophic drug costs associated with chronic illnesses. Private drug coverage for those not covered by public plans is expensive, often limited, and generally associated with employment. This system causes three problems: it creates gaps in coverage; it limits our ability to negotiate economic issues with drug manufacturers; and it puts the health system as a whole in a passive position when it comes to the use of costly new drugs that may not offer an enhanced therapeutic value.

> ...drug coverage in Canada is a lot like the whole health system in the US. Not everyone has insurance and some Canadians suffer grievously because they can't afford needed drugs.

In fact, drug coverage in Canada is a lot like the whole health system in the US. Not everyone has insurance and some Canadians suffer grievously because they can't afford needed drugs. There are multiple payers resulting in high administrative costs and uncontrolled prices.

Canada has come close to creating a national pharmacare plan twice before. Justice Emmett Hall's 1964 Royal Commission, which led to the creation of the Medicare system, also recommended a pharmacare program. And in 2004, provincial governments reached an unusual consensus in support of federal government action in this area. It has been estimated that a first-dollar coverage pharmacare plan would actually save Canadians ten percent of what we currently pay for drugs because public management would make possible reduced prices and lower administrative costs.[14]

Similar issues arise from the provision of diagnostic tests. Private sector delivery of these services has developed not because of a strategic vision, but by default. Medicare is paying most of the costs of these services. The terms under which those services are delivered should be determined publicly and managed strategically.

Modernizing delivery and focusing on prevention

During the first fifty years of Canadian Medicare we have achieved much. When Tommy Douglas was still the premier of Saskatchewan, Canada had pretty much the same health status and health care system as the US. Health care also accounted for about the same share of national output in the two economies.

Today, Canada spends much less on health care, yet we get more doctor visits and have more hospital beds.[15] Everyone in Canada is covered by

public health insurance, while in the US 50 million people have no insurance[16] and tens of millions have such inadequate coverage that over one million Americans declare personal bankruptcy every year because they can't afford to pay their medical bills.[17] In head-to-head studies, Canada's health care quality is as good as, or even better than, that found south of the border.[18]

Finally, Medicare dramatically lowers the cost of doing business in Canada and is directly responsible for hundreds of thousands of our country's best jobs being located here instead of another country.

Of course, our health care system does have its problems. Canadians rarely wait for emergency care; but too many Canadians wait too long for doctor appointments, diagnostic tests, and elective procedures. Our hospital care seems to be as good as anywhere; but our primary health care and community care systems aren't up to others. We also don't manage chronic illnesses like diabetes well, compared with other countries. As a result our hospitals and long-term care facilities are full of patients whose illnesses could have been prevented with better management in primary health care.

Some of Medicare's critics have highlighted problems with wait times and community care as proof that Medicare doesn't work. However, these evident problems have nothing to do with Medicare and everything to do with our failure to follow through on Tommy Douglas's original vision for Medicare to reform the delivery system.

This section outlines Canada's health system's strengths and weaknesses. Then we detail the original vision for Medicare and explain why we should still be using it for inspiration to fix today's problems. If we rebuild our system according to the principles of the Second Stage of Medicare, we can fix most of Medicare's current problems and control costs. If we focus mindlessly on cost control, as we did too often during the 1990s, we will damage the delivery system and erode Medicare's political support.

Canada has world-class hospital care but community and primary care lag.

A 2007 study identified 38 studies comparing care (mostly hospital care) in the US and Canada.[19] Overall 14 studies had results which favoured Canadian care, five favoured US care and 19 showed equivalent or mixed results.

However, Canada does a poor job managing chronic diseases and we wait longer for care than people in other OECD countries. The New York City-based Commonwealth Foundation 2009 report recounted a questionnaire administered to primary care physicians in eleven wealthy countries, including Canada. This survey and previous ones indicate that Canadian primary care scores poorly overall and especially regarding electronic health records, access, and chronic disease management and prevention.[20]

Canadians do not tend to wait for urgent or emergent care. But the Commonwealth Fund annual studies indicate that Canadians tend to

wait longer for elective care than patients in other countries.[21]

As a result of these problems managing chronic disease in the community and delivering elective care in a timely manner, Canadian hospitals are overwhelmed by sick patients whose acute illnesses could have been averted.

Why does the Canadian health system do a poor job managing chronic disease and waits and delays?

Poor results for chronic disease management and timely care stem from the failure to update an inefficient care model. Justice Emmett Hall's 1964 Royal Commission, his 1980 Medicare update, and the 2002 Romanow Royal Commission all highlighted the need to reform primary health care delivery. Reports at the provincial level have echoed these themes for four decades. A 1987 report to former Ontario Premier David Peterson noted:

> *There is a remarkable consistency and repetition in the findings and recommendations for improvements in all the information we reviewed. Current submissions and earlier reports highlight the need to place greater emphasis on primary care, to integrate and coordinate services, to achieve a community focus for health and to increase the emphasis on health promotion and disease prevention. The panel notes with concern that well-founded recommendations made by credible groups over a period of fifteen years have rarely been translated into action.*[22]

The Original vision for Medicare: an integrated system based upon prevention

Few Canadians know that the original vision of Medicare went well beyond what we have now. *The Canada Health Act* only includes physicians and hospital care, leaving some Canadians with large bills for their own pharmaceuticals, continuing care, dental, and optical services. Justice Emmett Hall's 1964 Royal Commission recommended drug and home care coverage and a children's dental plan.

The original vision of Medicare also included new ways of delivering care with a focus on primary health care, group medical practice, and high-functioning teams. But, as Tommy Douglas explained to the SOS Medicare conference in November 1979:

> *I am concerned about Medicare – not its fundamental principles – but with the problems we knew would arise. Those of us who talked about Medicare back in the 1940s, the 1950s and the 1960s kept reminding the public there were two phases to Medicare. The first was to remove the financial barrier between those who provide health care services and those who need them. We pointed out repeatedly that this phase was the easiest of the problems we would confront... The phase number two would be the much*

more difficult one and that was to alter our delivery system to reduce costs and put an emphasis on preventative medicine…[23]

In some provinces there have been some new models of care developed based upon these principles. The Saskatoon Community Clinic, founded in 1962, employs 160 staff and provides medical services to 33,000 patients and community-based preventive services to thousands of others.[24] A 1981 study of the Saskatoon Community Clinic found that the community clinic patients had 17% lower overall costs and 31% fewer days in hospital.[25]

In 1964, a Sault Ste. Marie community group, led by the United Steelworkers of America, opened the Group Health Centre.[26] The centre now has over 60,000 patients, 70 doctors, 110 nurses, 50 other health professionals and 150 other employees. Group Health has been a font of innovation for over forty years.[27, 28, 29] Roy Romanow referred to it as a "jewel in the crown of Medicare." Studies from the 1960s and 1970s found that Group Health had lower overall health care costs because their patients spent 20-25% fewer days in hospital.[30, 31, 32] In the 1980s, research in the US also indicated that these models of care can reduce costs by 25% – due almost entirely to lower hospital utilization.[33, 34]

The Second Stage of Medicare could fix today's problems

If we could implement Second Stage of Medicare models of care everywhere in Canada, we could much more effectively reduce the burden of chronic disease and reduce the delays to access that distress too many Canadians seeking care.

If we could implement Second Stage of Medicare models of care everywhere in Canada, we could much more effectively reduce the burden of chronic disease and reduce the delays to access that distress too many Canadians seeking care.

Because of a lack of effective community care, up to 15-20% of older Canadians are re-admitted to hospital within one month of discharge.[35, 36] However, a Group Health nurse-led community program has reduced Sault Ste. Marie's re-admissions for heart failure by nearly 50%.[37] Since 1997, Group Health also has been using an electronic registry of its diabetes patients to better manage their care and reduce their rates of complications.[38]

In 2004 the Saskatoon Community Clinic implemented its Advanced Access model of

booking patients with its family doctors and nurse practitioner. Now most patients are seen the day they want to be seen and many are seen the same day. The community clinic went on to assist the Saskatchewan Health Quality Council in their work taking advanced access province-wide.

In Hamilton, the HSO Mental Health and Nutrition Program integrates the practices of over 100 family doctors, with 17 psychiatrists, 80 counsellors (most of whom are social workers), and 20 dietitians.[39, 40] In the mental health component, the counselors are based with family doctors. As a result of the program, eleven times more patients with mental health problems are managed in primary health care while referrals to the psychiatry specialty clinic have dropped by 70%. All patients are given standardized assessments and the program has documented improvements in depression scores as well as general health and functioning.

We can even decrease wait times for elective surgery. The Ontario Wait Times Strategy has been the most effective of the provincial wait time initiatives. It has demonstrated significant reductions in wait times for joint replacements, cataract surgery, and many other elective procedures.[41]

We can't fix Medicare without an active federal role

Different provinces are at different stages of the implementation of the second stage of Medicare. Some are even dismantling the first stage by tolerating and even encouraging for-profit private care.[42] However, the problems which affect the provinces are quite similar. Quite simply, Canada could not have achieved what it has in health care without the active participation of the federal government. And, we will not achieve the modernization of our health delivery system without some sort of active federal partnership.

The Romanow Royal Commission urged the federal government to use new money to buy needed change in the health care delivery system.[43] However, follow-up reports by the Health Council of Canada have not found that the provinces have met their goals in the 2004 *Federal Provincial Health Accord*.[44]

We won't be able to control costs and improve quality without better management of the system. We won't get this better management without an active federal government ensuring Medicare's long-term financial security and leading improvements in the health care delivery system.

Sustainability of Medicare

The message from the data on health care spending in Canada could hardly be clearer. Health care costs may be increasing gradually, as our population ages and as technological advances lead to more and more expensive medical interventions, but there is no Medicare sustainability crisis.

Health care costs in general, public sector health care costs and Medicare costs in particular, have been remarkably stable as a share of GDP over the past 20 years. Health care costs in Canada as a share of GDP fall comfortably in the mainstream among advanced industrial countries, with the United States being a notable outlier at the top of the scale.

To the extent that the cost of health care has been increasing relative to other government expenditures or to government revenue generally, that increase is attributable not to extraordinary increases in health care costs but to cuts in areas of public services other than health and to reductions in public fiscal capacity. These reductions are attributable to ongoing cuts in corporate and personal income taxes at both the federal and provincial/territorial levels of government and in the Goods and Services Tax by the federal government in the mid-2000s.

The phantom crisis of Medicare sustainability would be merely a political curiosity, were it not for the limited and limiting options being put forward as "solutions." While the responses advocated are varied, they have much in common. They shift costs from Medicare to individuals. They shift delivery and funding from the public sector to the private sector. They shift costs from the healthy and wealthy to the less wealthy and less healthy. They weaken the influence of public policy in the management and delivery of services in the health

Conclusion

care system. Generally speaking, they actually do not reduce health care costs. At best, they just move those costs around; at worst they threaten to drive costs higher by weakening the ability of the public to manage the system.

That health care costs in Canada do not amount to the crisis claimed by Medicare's critics and that the critics' responses are non-solutions to a non-problem, however, do not mean that we lack opportunities to reduce costs, improve efficiency and enhance service in Canadian health care.

There are two approaches open to us to achieving these goals. First, we can rationalize the relationship between the private and public sectors in the management and delivery of health care in Canada. This can be achieved by: bringing key components such as pharmacare, home care and long-term care under the Medicare umbrella; by taking a strategic approach to decisions about what services to deliver through the private sector; and by using the economic power inherent in publicly financed health care to improve the terms under which health care services are delivered. Making pharmacare and home care a part of Medicare coverage would be a good first step.

Second, we can modernize the delivery of health care in Canada and invest more heavily in prevention. We can move on to a second stage of Medicare in which we go beyond public funding to public management of and public leadership in the development of our health care system.

In each of these broad categories of opportunities for improvement, the federal government has a crucially important role to play.

Medicare may not be an area of public service under federal jurisdiction. However, it is unquestionably seen by Canadians as a nation-building project. Canadians expect their federal

government to be a leader in the development of that project.

The 2004-2014 federal-provincial funding agreement was a positive initiative. It re-established a formal and credible role for the federal government as a funder of the Medicare project and created funding envelopes intended to pay for change. Canadians need a successor agreement that builds on that foundation. First, in total value, the funding provided must be sufficient to enhance the relative position of the federal government in Medicare finance. Second, the first agreement having re-established the federal government's position as a credible funding partner, the successor agreement must include conditions designed to provide incentives for system change and improvement. Third, the agreement must establish a basis for federal leadership in the development of a national Pharmacare plan as a component of the Medicare system.

Notes

1 One notable example of the crowding-out argument is found in "Who killed Canada's education advantage?" by Roger Martin (*The Walrus,* November 2009). The cover headline "Healthy but stupid" captures the crowding-out argument perfectly.

2 "Charting a path to sustainable health care in Ontario," *TD Economics Special Reports,* May 27, 2010.

3 For a detailed review and analysis of aging and other health care cost drivers, see: Lee M, *How sustainable is Medicare? A Closer Look at Aging, Technology and Other Cost Drivers in Canada's Health Care System*, Canadian Centre for Policy Alternatives, 2007.

4 Statistics Canada, *Cat. No. 91-520-X,* projection M4, June 2010.

5 *National Health Expenditure Trends, 1975 to 2009,* Canadian Institute for Health Information, 2009.

6 Evans R. "Public health care is as sustainable as we want it to be," *Toronto Star,* June 1, 2010.

7 Ibid.

8 Forget EL, Deber R. and Roos LL. "Medical Savings Accounts: Will They Reduce Costs?" *Canadian Medical Association Journal,* July 23, 2002: 167 (2) p. 143.

9 Effective 1 July 2010, the Government of Ontario has disallowed payments referred to as "professional allowances" from generic drug manufacturers to pharmacies. Government estimates indicate that elimination of fees totaling $750 million will result in a 50% cut in the prices of generic drugs provided under the provincial drug plan. Ontario Ministry of Health. http://www.health.gov.on.ca/en/public/programs/drugreforms/our_plan.aspx
Accessed July 20, 2010.

10 The initial CHT included both a per-capita grant and a grant for "associated equalization."Associated equalization was a remnant of a 1977 change in which half of the amount that the federal government had previously been transferring to provinces in cash was converted to a "tax points" transfer in which the federal government reduced its personal and corporate income tax rates, creating room for provincial governments to increase their taxes. To ensure that poorer provinces were not disadvantaged by this change, an additional "associated equalization" transfer was created to offset revenue losses in the switch from cash to tax points. This "associated equalization" transfer is to be phased out over the term of the ten-year CHT agreement as all of federal equalization transfers are consolidated under that heading.

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The idea that the costs of Canadian Medicare are out of control and that we as a society can no longer afford the promise of health care security implicit in the program has been repeated so often that it has come to dominate public discourse on the future of our health care system.

That deeply-entrenched belief now serves as the justification for proposals that would open the system up to the kind of private sector domination that has made the system in the United States the most expensive and inequitable in the OECD and that would shift costs from those who have a greater ability to pay, to those who have a lesser ability to pay; and from those who are healthy, to those who suffer ill-health.

The fundamental problem is that the premise behind these arguments is not valid. It is not true that health care costs are out of control. It is not true that health care costs are increasing beyond our ability to pay.

The increases in health care costs as a share of public spending cited by critics of Medicare are attributable not to increases in health care costs, but to decreases in public spending in other areas. The increases in health care costs as a share of public revenue are attributable not to health care costs but to cuts in taxes that have reduced the fiscal capacity of governments at all three levels by $90 billion per year, in today's dollars.

Far from out of control, health care costs have been remarkably stable as a share of GDP for the past 20 years. There is no sustainability crisis.

Argument after argument and anecdote after anecdote evaporate in the face of the facts. The critics claim that our aging population will cause health care costs to explode. The facts show that over the next 25 years, as the baby boom moves through and out of the system, health care costs will increase by only one percent per year as a result of demographic shifts.

Afterword by Hugh Mackenzie

The critics point to the need for greater private sector involvement in health care financing and delivery to control costs. The evidence says that it is the public sector, with its clear fiscal and political incentive to control costs, that is best placed to manage costs and improve quality in the system.

The critics point to cherry-picked examples from other countries to justify their positions. France, for example, is cited as a paragon of private sector involvement in health care. The facts tell us that 79% of health care costs in France are in the public sector – nine percentage points more than the share in Canada.

That is not to say that Canada's Medicare system cannot be improved. Over the nearly forty years of Medicare's history in Canada, we have transformed the way health care is financed. We have had relatively little impact on the way that care is delivered and paid for. The key is management of the system in the public interest. Initiatives, like the move to change the way generic drugs are marketed in Ontario and other provinces, highlight the substantial gains that could be made through better management. However, these initiatives are just scratching the surface.

A better health care system is "as sustainable as we want it to be." The sustainability of Canada's health care system is simply a matter of political will. The consistent strength of Canadians' support for Medicare demonstrates that the support of the public will be there for those governments who have the will to support Medicare.

As a first step, it is time we got beyond the "don't confuse me with the facts" arguments that have come to dominate public debate.

The war in Afghanistan is a crisis. The oil spill in the Gulf of Mexico is a crisis. There is no Medicare crisis. There are opportunities to build a better health care system and a healthier society for all Canadians and we should take advantage of them.

Hugh Mackenzie

Hugh Mackenzie is principal in an economic consulting business, Hugh Mackenzie and Associates, based in Toronto. He conducts research projects on economic and public policy. He has worked for over 35 years in a variety of capacities related to public policy development in the trade union movement, the private sector, and at all three levels of government. He is also a Research Associate of the Canadian Centre for Policy Alternatives.

He is presently part of a team at the CCPA conducting a series of research studies on income and wealth inequality in Canada and its consequences. In 2009, he co-authored with statistician Richard Shillington *Canada's Quiet Bargain: The Benefits of Public Spending* (published by the Canadian Centre for Policy Alternatives), an in-depth analysis of the benefits Canadians receive from public services. He is a frequent public commentator on fiscal policy issues, most notably as the author of several op-ed pieces and essays advocating an "adult conversation" about taxes and public services.

He is Co-Chair of the Ontario Alternative Budget and the author of a periodic in-depth review of the funding of elementary and secondary education in Ontario. He has also written frequently on issues related to funding and tuition for postsecondary education, the financing of health care and the role of public private partnerships in the financing of public infrastructure. From 1991 to 1994, Hugh Mackenzie was Executive Director of the Ontario Fair Tax Commission.

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Dr. Michael Rachlis

Dr. Michael Rachlis was born in Winnipeg, Manitoba, in 1951, and graduated from the University of Manitoba medical school in 1975. He interned at McMaster University and then practiced family medicine at the South Riverdale Community Health Centre in Toronto for eight years. He completed training in Community Medicine at McMaster and was made a fellow of the Canadian Royal College of Physicians and Surgeons in 1988.

Dr. Rachlis practices as a private consultant in health policy analysis. He has consulted to the federal government, all ten provincial governments, and two royal commissions. He also holds an adjunct associate professor appointment with the University of Toronto Department of Health, Policy, Management and Evaluation, and the Dalla Lana School of Public Health. In 2010, the University of Manitoba conferred upon Dr. Rachlis a Doctor of Laws (honoris causa) in recognition of his service to Canadian health policy.

Dr. Rachlis has lectured widely on health care issues. He has been invited to make presentations to committees of the Canadian House of Commons and the Canadian Senate as well as the United States House of Representatives and Senate. He is a frequent media commentator on health policy issues and the author of three national bestsellers about Canada's health care system.