Financing the Health Care System: Is Long-term Sustainability Possible?

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Sean Burnett received his Bachelor of Arts degree from the University of Regina in 2006, majoring in Sociology. Sean remains at the University of Regina currently completing his Master of Public Administration from the Johnson-Shoyama School of Public Policy. Much of Sean's graduate studies have focused on health policy and health program delivery. Sean is involved with several non-profit groups in Regina demonstrating his commitment to his community and the voluntary sector.

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Introduction

The Canadian public health care system is being attacked in two, contradictory ways. Critics of the system simultaneously claim that public health care is too costly and that there is not enough investment in health care (Gibson and Fuller 2006, Rachlis 2004 p.43). The primary argument against the public health care system is that costs are increasing faster than the rate of economic growth and government revenues. This in turn creates cost restraints which affect the public health system's ability to provide quality care.

This paper focuses on the current and projected cost of health care. Its objective is to analyze health care spending to determine whether a public system is sustainable. A brief review of the health care debate and major health policy initiatives will set the context for the analysis. The analytical tools used include a historical economic analysis of health expenditures in Canada and a review of future cost drivers and their potential effects on the health care system. Policy recommendations are discussed with in the scope of the financial structure of health care as a means to meet the challenge of providing health care into the future.

Categories of Health Spending

Distinguishing between total health expenditures and public health expenditures is important to gain an understanding of the extent of government's financial support of the health system. In Canada health care costs are not all paid through the public system.

Marchildon (2007) divides health care financing into four categories. The first is hospital and physician services, which are legislatively protected under the Canada Health Act (CHA). Hospital and doctor services covered under the CHA are what is considered to be 'Medicare'. Medicare represents about 42 per cent of total health care costs (Marchildon, 2004).

The second category is specialized health services provided by the federal government. These services include public and preventative health initiatives, monitoring and regulation of drug and food safety, and health care services for the Armed Forces, RCMP, First Nations and Inuit communities. These specialized federal services only account for five per cent of total health care costs (Marchildon 2007 and CIHI 2005).

The third kind of public financing is the non-CHA portions of the provincial health programs. Examples of provincial programs include mental health and addictions programs and drug plans. The non-CHA portions of provincial plans make up 25.2 per cent of total health care costs.

Privately financed health goods and services are the remaining portion of the health system. These goods and services include dental, eye care and other non-government funded health services. The costs are paid through a combination of out of pocket expenses and private insurance programs. Private health goods and services account for 27 per cent of total health care costs (Marchildon, 2007).

Jurisdictional responsibility for health lies with the provinces but part of Medicare financing comes from the federal government. Since the introduction of Medicare the federal funding formula has changed several times resulting in changing levels of funding. For a number of years the provinces have been calling attention to a declining federal government share of

Table One: Health System Expenditures by Category

Category	Medicare	Federal Non-CHA Programs	Provincial Non-CHA Programs	Private
Percentage of total health expenditures	42	5	25.2	27.8

Medicare funding and insist on the need for increased fiscal federalism.

History of Fiscal Federalism

Federal fiscal policy decisions impact the level and structure of funding that is provided to the provinces for health program delivery. Fiscal federalism for Medicare originally began as a 50-50 cost sharing. The federal government shifted from matching funding to block funding with the passing of the Established Programs Act in 1977 (Rachlis 2004). At the same time the federal government transferred revenue generated through income taxes to the provinces. The federal government cut federal income tax by 16 per cent and the provinces increased theirs by the same amount (Rachlis 2004). This transfer of tax points was a major area of contention between the provinces and the federal government because Ottawa counted the tax transfer as part of the health care transfer and the provinces did not. Following the tax transfer dispute there were further cuts by the Trudeau, Mulroney, and Chrétien governments.

In 1996, the Canadian Health and Social Transfer (CHST) combined block funding for health, social programs, and education programs. Funding was reduced again and the provinces were forced to prioritize where limited resources would go. Since the introduction of the CHST there have been modest increases in the health care funding with a five year deal being reached in 2003 that separated health and social and education programs into two different block funds (CIHI 2005). The block funds are now referred to as the Canadian Health Transfer and the Canadian Social Transfer.

The federal government's series of cuts to health funding led to constraints on health care systems and contributed to the growth of deficits in the provinces. These developments have fuelled debate regarding the quality and affordability of public health insurance and strained federal-provincial relations.

Moving Towards a "Two-Tier" System

The debate on public financing of health care has been largely shaped by think tanks, taxpayer associations, private health companies, politicians, and the media. The provision of private services is a controversial issue pitting those who support maintaining a largely publicly funded system against those who want an option to purchase private services.

A key issue with private service delivery is the impact that it will have on the public system. Two examples of the potential impact are the introduction of private for-profit services and the Chaoulli Supreme Court case regarding private funding for public services in Quebec.

It is useful in understanding the structure of the health system to consider it as two parts, one being financing and the other being service delivery. Each of these parts can be both private and public. The most significant impact on Canadian's would be a result of privatizing the financial part of the system. Much of healthcare delivery in Canada is already private, but not

necessarily for profit. (Canada 2002). Most health care providers are in private practice and most hospitals are not-for-profit private organizations; although both are primarily funded by government (Canada 2002).

In addition, there are more than 30 private diagnostic service centres in Canada. Services provided by the majority of these centres are paid for as 100 per cent out of pocket expenses (Madore 2005). The federal government has determined that these private diagnostic services violate the CHA principles of comprehensiveness, user charge provisions and accessibility.

A recent study by the Health Coalition (2008) revealed that of the 42 for-profit MRI/CT clinics, 72 for-profit surgical clinics and 16 boutique physician clinics (excludes unnecessary cosmetic surgery) in Canada; 89 clinics violate the CHA. The services that are provided by these clinics are recognized as a medical necessity within the comprehensiveness framework of the CHA. Therefore these services are to be paid for only through Medicare. Private payment violates the principal of no fees or user charges. Services are to be paid for based on need and not ability to pay. People who pay to use private clinic services are also queue jumping. These individuals receive their tests faster and then they can receive treatment in the public system ahead of those still waiting for public diagnostic testing (Madore 2005). Despite finding that private for-profit clinics contravene the CHA, the federal government has taken no action to enforce the Act.

The Health Coalition report (2008) also demonstrates that for-profit clinics are impacting the publicly funded health human resource pool and that provision of these services has not reduced aggregated wait times. As these clinics grow in numbers, there has been a shift in ownership from local physician led corporations to multinational investor owned chains. In areas that are dense with for-profit private clinics there has also been a growth in additional private health administration to link consumers to clinics.

The Chaoulli Supreme Court case provides evidence to support the notion that movement towards a parallel private or "two-tiered" system of health care can bare unintended consequences that significantly impact the public system. The Chaoulli case was a jurisdictionally unconstitutional decision by the Supreme Court of Canada that struck down the ban on private medical insurance being used to pay for basic services offered by the public health care system. While this decision applies only in Quebec it is expected that it will have an impact in other provinces (Flood, Roach and Sossin 2005). This case demonstrates how, without any parliamentary debate, our health system can move substantially towards private health financing.

Canada has experienced shifts toward privatization in the past decade; however, health expenses remain primarily publicly financed. Those that oppose the universal provision of Medicare mainly target the sustainability of the public system and issues regarding quality of care. The majority of quality of care issues surrounds wait time, inefficient delivery systems, insufficient labour supply, and outdated diagnostic and treatment equipment (Ruggeri 2006). One of the most commonly proposed solutions to improve the health care system involves change to the financing mix to increase the role of private insurance and introduce user fees.

Analysis of Health Care Expenditures

This analysis focuses on expenditures for health care as a determinate of sustainability. The first part looks at historical trends in spending, followed by estimated cost drivers and the expected influence these will have on total health care spending. Finally, financing options will be reviewed for their impact on public spending.

In a recent paper Ruggeri (2006) analysed sustainability of health care. He suggests there are several indicators of sustainability with three being the most useful:

1 The ratio of *total* health care spending to GDP.

2 The ratio of *public* spending on health care to GDP.

3 The ratio of *government* health expenditures to total government revenue.

These indicators provide a framework to determine sustainability using additional data to the original Ruggeri study. The chosen indicators are important because they can be used to refute claims by opponents of the public health care system that it is in fiscal crisis.

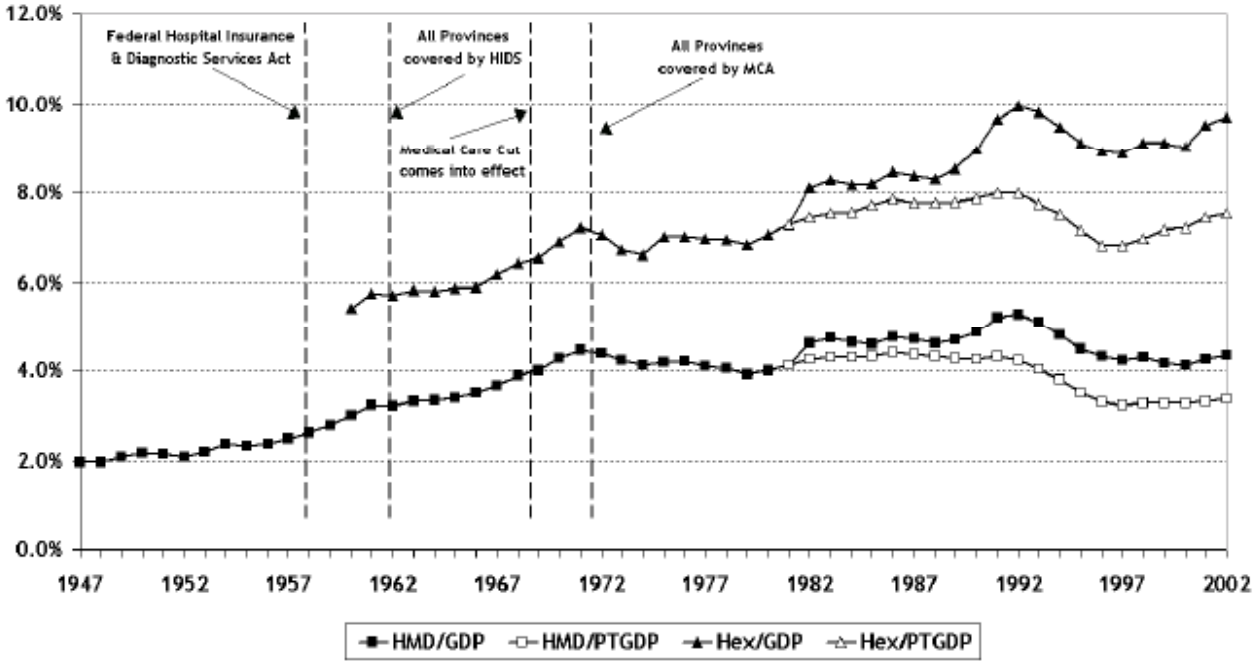
The first indicator is the ratio of total health expenditure over GDP. It establishes the capacity of the economy to handle public and private spending (Ruggeri 2006). Between 1984 and 2004 the cost of health care in Canada has increased by 94 billion dollars, an increase of 250 per cent (CIHI 2005). This figure at face value makes expenditures on health care seem unsustainable. This data is used by Medicare opponents to create arguments against the public system. However, 72 per cent of the $94 billion increase is due to structural change in the economy such as an increase in population, new services, and inflation (CIHI 2005). Analysing health care over GDP adjusts those factors in relation to percentage of real economic growth. Graph One demonstrates real growth in health expenditures:

The graph shows total health expenditures over GDP (Hex/GDP), total health expenditures over projected GDP (Hex/PTGDP), Canadian Health Act (CHA) expenditures over GDP (HMD/GDP) and CHA expenditures over projected GDP (HMD/PTGDP) (Evans 2003 and 2007). The data demonstrates two major increases in real total health expenditures. The first increase was in the early 1980s and the second at the start of the 1990s. These increases are due to recessionary periods in the Canadian economy. During the recessions real incomes fell, decreasing the income taxation base.

Historically, the real income base has recovered following recessionary periods; but it did not recover after the recessions of the 1980s and 1990s (Evans 2007). Data showing *projected GDP* demonstrates the adjusted share of health care expenditures had the income base recovered. Total health care expenditures have increased over the last several decades, but changes in the business cycle and resulting economic downturns caused the most impact on total health expenditures as a percentage of GDP. Apart from recessionary periods health costs have remained relatively stable. Health expenditures like all other goods and services fluctuate with the ebbs and flows of the market.

Canada has not had growth in total health expenditures to the degree the private insurance system has had in the United States. The two

Graph One: Canada Total Health, and Hospital and Physician Expenditures Over GDP



Source: Evans 2003 and Evans 2007

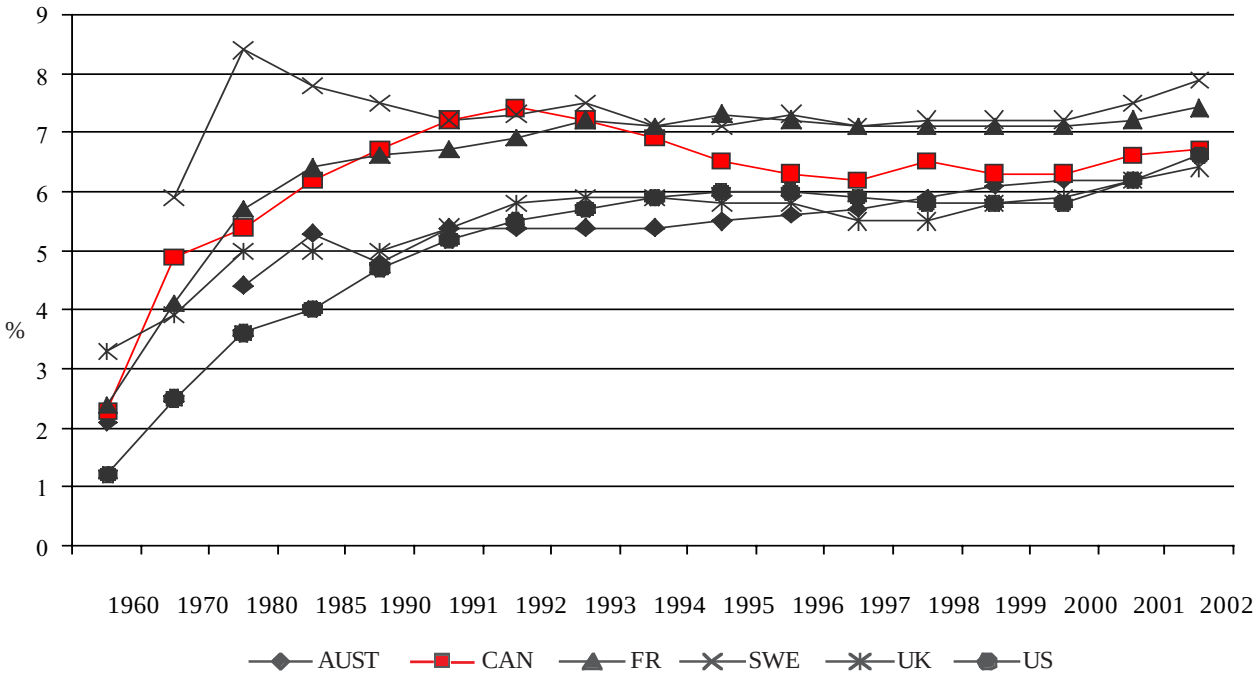
countries spent an equal amount on health care as a percentage of GDP in the early 1960s when Medicare came into being in Canada. Now the USA spends more than 4 per cent more of its GDP on health care than Canada. (14.7 per cent to 9.8 per cent) (Gibson and Fuller 2006). This demonstrates that the expansion of private insurance is not a more cost effective means to control total health expenditures.

The second indicator of sustainability is the ratio of total government or public expenditure on health care over GDP. Analysis of government expenditure will use two different measures. One measure isolates the CHA portion of government expenditure and the other includes all government expenditure. The reasoning behind this methodology of isolation of CHA spending is that the Medicare system is often the system that is under scrutiny by policy actors that argue for privatization. The data depicting the isolated CHA spending comes from graph one above. Secondly, an analysis of total health expenditures provides a more complete picture of total government expenditure based on all programming.

The bottom line of graph one represents expenditures on CHA services or Medicare over GDP. Medicare services grew steadily prior to 1972 when hospital and doctor services were finally covered by public insurance in all provinces. After the full introduction of Medicare governments applied cost controls and eventually reduced funding to 1970 levels by cutting spending in the mid 1990s. Currently, spending for Medicare is around 4 per cent of GDP, similar to rates of expenditure between 1972 and 1981.

Graph two shows total government health expenditures including Medicare and the costs of federal non-CHA and provincial programs as a percentage of GDP. Total government expenditure is a good measure of sustainability because it focuses on what all levels of government are spending and the growth rate of public funding for health care. The graph includes

Graph Two: Total Government Expenditures Over GDP, Between 1960 and 2002, for Selected OECD Countries



Source: Marchildon, 2008

spending for several other developed countries with varying systems of health care financing. The general trend is increased expenditures as a portion of the GDP from all countries starting in the 1960s and continuing into the 1990s regardless of the financing structure. The trend reflects enrichment and technology development as well as shared economic difficulty among interrelated economies.

In Canada, the increase of total public spending on health care as a percentage of GDP is largely due to a slowing of economic growth. The recessions of the 1980s and 1990s had a significant impact on public sector revenues leading to deficits for the federal government and the provinces. Due to perceived pressures related to the federal deficit the federal government significantly decreased spending in 1992-97. The funding cuts demonstrate that health care spending in Canada is a managed variable (Ruggeri 2006). Levels of health expenditures are, therefore, often controlled both by population demands and fiscal policies. The use of fiscal policy to control total government expenditures will be important in the future as a means to mitigate rapid increases in spending, particularly if GDP growth slows.

The third indicator, the ratio of total government expenditure to revenue analyzes the ability of the government to finance health programming in relation to total revenue and alternative programming options. Skinner (2007) states that comparison of expenditure and revenue is the only appropriate measure of sustainability. This study recognizes the importance of this variable and moves beyond a limited focus to include comparison of expenditures and revenues as one of the three variables to determine sustainability. Analysing revenue over expenditure provides insight into how governments are managing budgets. Government health care costs are increasing and consuming higher percentages of

budgets. The primary concerns with the increase in spending for health as a percentage of government expenditure are that it crowds out other programs or creates public debt.

Over the past several decades the percentage of public health care spending to total government expenses has fluctuated, but the general trend is that health is consuming larger percentages of government revenue. In 1988-89 health consumed 14 per cent of revenues, increasing to 16.3 per cent in to the early 90s (Evans 2003 and Ruggeri 2006). Health spending was reduced to 14 per cent of government revenues in 1996-97 and began rising again after that point (Evans 2003 and Ruggeri 2006). However, what these fluctuations do not reflect is that both provincial and federal governments have reduced revenue generation in recent years through tax cuts.

The provinces cut program spending from 12 per cent of GDP in the late 80s and 90s to 9 per cent in 2001/02 (Evans 2003). These savings were not directed to health spending; rather they provided fiscal opportunity for tax cuts. Between 1996 and 2002, provincial personal and corporate income taxes cuts decreased aggregate government revenues by $24 billion dollars annually.

Another factor is $5 billion in annual federal funding that was lost to the provinces with the introduction of the CHST (Evans 2003). At the time the federal government justified the cuts with the need to decrease the public debt. The next fiscal year after the reduction in funding (1996/97) the federal government had a budget surplus. Federal budgets have continued to be in surplus every year since the budget was balanced in 1996/97.

With its fiscal situation under control the federal government did not increase provincial transfers back to pre-1996 levels. The federal government has reduced its spending significantly over the past two decades from 22.7 per cent of GDP in 1984 to 14.8 per cent in 2002 (Ruggeri 2006). Historical fiscal policy decisions indicate sufficient federal fiscal capacity to increase Ottawa's share of health funding. This demonstrates that maintaining the public health care system is a matter of choice and political will, not government's fiscal capacity to balance revenue and expenditure ratios.

The Impact of Future Costs on Sustainability

The three indicators demonstrate the fiscal sustainability of the public health care system, but what is the impact of future cost trends? Health care expenditure growth is expected to continue over the next 30 years as a result of enrichment, an aging population, technological advancement and inflation. There is much debate and discrepancy among the projections on what the rates of growth will be. Over the past decade the cost of health care has increased at an average rate of 5.6 per cent per year and over the past two decades an average 5.4 per cent (Lee, 2007). It is expected that future growth will be between 6-7 per cent per year.

Aging has historically not been a primary health cost driver contributing to only 0.5 per cent of the average annual 2.5 per cent of growth of *real* health expenditures per capita between 1980 and 1997 (Hogan and Hogan 2004). Age is being closely monitored now due to the high per capita cost for people over 60 and the growing demographic that are reaching that age. Hogan and Hogan (2007) use 1997 per capita GDP and factor in population growth to conclude that aging will increase average per capita expenditure on health by 30 per cent from now to 2030. This is a marginal increase from the 20 per cent historical trend. Canada's aging population will not create a crisis in health care costs, but will remain a variable to be managed into the future.

The potentially most significant future cost driver in health care expenditure is technology. The main areas of technological development are: diagnostic imaging, vaccines, pharmaceuticals, genetic screening and gene therapy, and surgical techniques (Morgan and Jeremiah 2004). The most significant cost driver will be pharmaceuticals. Pharmaceuticals have been the highest rising cost in the health care system over the past decade (Marchildon, 2007). While technology is a cost driver it also provides opportunity to decrease the health care cost curve be improving health outcomes. Policy decisions regarding technology must be managed based on the evidence that produces decreased care costs or improved health outcomes.

Enrichment is another cost driver that will influence future health care expenditure. Enrichment costs are spending for improvements to the health care system. This may include new facilities, improved staffing ratios, and increased specialized services. Lee (2007) provides in his research two projections of 1 per cent and 2 per cent increase in GDP spending per year for enrichment.

Health cost increases are inevitable in the future and cost drivers need to be considered in decisions regarding health delivery and fiscal planning. These decisions will be based on the opportunity to provide increased value from health expenditures by increasing disease and injury free life expectancies.

The ratio of health care spending to GDP will increase over the next 30 years. It is estimated that in 25 years total health care will increase as a percentage of GDP by 7 per cent; 3 per cent for public and 4 per cent for private respectively (Marchildon 2004). These are projections and for a number of reasons the estimates could change. Variations may be caused due to changes in demographic trends, trends in population health, alternative palliative care practices, technological change, and policy induced change (Lee 2007). These projections do provide incentive for government to plan in advance.

Not a Public Health Care Fiscal Crisis

Our analysis demonstrates that there is no looming fiscal crisis for public health care. The rates of growth for health spending are expected to increase; but they will continue to be moderate and well within the fiscal capacity of governments as the Canadian economy grows. Health spending likely will grow relatively slowly over a long period of time and there are health care delivery and policy options that can be implemented along the way in order to relieve pressure on the health care system (Rachlis 2004, Marchildon 2004).

Saskatchewan's fiscal capacity as a case study demonstrates that while costs are increasing marginally they contribute to enrichment of the overall health care system not just Medicare. Coinciding with enrichment through investment service delivery changes can also lead to improved quality of care in Saskatchewan. Table two below shows the growth in the province's health expenditures, total government expenditures and GDP from 2002 to 2008.

According to Budget estimates, the Saskatchewan budget has increased on average 8 per cent every year. Over the five successive budget years, Health's share of expenditures has risen by 4.3 per cent each year. Saskatchewan's Gross Domestic Product (GDP) has increased on average by 8.3 per year. Thus the province's health care expenditures are far from being out of control and, in fact, are affordable.

Most residents indicate that access to health care is their primary concern. They understand that drug prices have increased greatly in the last decade. They indicate that they are willing to

Table Two: Saskatchewan Health and Government Expenditures and GDP Growth

Year	Health Expenditures $	Government Expenditures $	Saskatchewan GDP $
2002/03	2.33B	6.319B	34.33B
2003/04	2.526B	6.62B	36.653B
2004/05	2.687B	6.75B	40.417B
2005/06	2.892B	7.151B	43.773B
2006/07	3.178B	7.700B	45.922B
2007/08	3.446B	8.349B	51.166B

Sources: Saskatchewan Budget Estimates 2002-2007, Statistics Canada – Expenditure Based GDP, provinces and territories.

pay to retain and recruit health professionals, whose costs contribute to the increase in health expenditures. The health budget has not increased faster than the GDP on average and despite drug price and personnel cost inflation, has remained between 6 and 9 per cent per year. The GDP has increased by over 10 per cent some years and Saskatchewan is projected to lead the country in economic growth in 2008 and perhaps for the next several years.

A number of important developments are occurring in the health field in Saskatchewan, such as partnerships between health provider unions and the health regions in order to improve retention of health professionals. There is also an increased emphasis on providing efficient client-centred services to maximize outcomes for the patient or client. Systems are being redesigned to ensure that all delivered care a patient/client receives will contribute to a positive outcome.

As well, primary health service reform should lead to the most appropriate service being provided, with multiple points of entry into the health system rather than one governed by access to only one provider. The increasing application of information technology to communication and access to patient information will also increase flexibility and efficiency for patients.

Medicare opponents are concerned with the cost and quality of care. They suggest that Canada does not have the right financing structure to run an effective health care system. The choices that we make as a country on the fiscal policies for Medicare reflect the values that we hold. Experience in other countries indicates that changing the fiscal structure will not likely reduce the percentage of GDP spending on health care. It will, however, drastically change who pays and who receives in the system.

The four options for financing a modern health care system are general taxation, social insurance, out-of-pocket, and private insurance.

> "The very permanence of the controversy should tell us that it arises from a permanent conflict of embedded interests, not from a simple inability to find the right mix for everyone. In that sense, the choice of financing mechanisms is a matter of values, not a technical question" (Evans 2004, p 141).

Changing the financing of the Canadian health care system will have a drastic effect on the progressive nature of health delivery in the country. The wealthy will get more for less and the not so wealthy less for more because of the inverse relationship between income and health consumption (Evans 2003). Health care should remain as a public good providing universal and accessible health services for the citizens of Canada.

Policy Recommendations

Canada requires strong leadership from decision makers in order to maintain the values outlined in the Canadian Health Act (CHA). It is assumed that the status quo is not an option and the following policy recommendations deal with privatization and reform of the public health system.

Avoid Privatization

Canada should avoid expanding the role of private financing of the health system. Privatization has negative effects on the public system and may impact the ability to maintain the principles of the CHA. Here are several examples of negative impacts on health financing. The cost of private financing is higher than public financing. Premiums for health care insurance have been increasing at double the rate of inflation. There are substantially higher overhead costs in a private system. In Canada, public insurance overhead is 1.3 per cent of costs and private insurance overhead is 13.2 per cent of costs (Gibson and Fuller 2006). Increasing premiums and overhead costs will lead to an increase in per capita expenditures on health care.

Privatization is not the cure for an ailing health system. One of the largest concerns for the Canadian public is timely access to health services. Gibson and Fuller (2006) claim that "wait list concerns in Canada are symbolic of our sense of health care as a right" (p 68). A cross jurisdictional analysis demonstrates that 12 other Organization for Economic Cooperation and Development countries (Australia, Denmark, Finland, Ireland, Italy, Netherlands, New Zealand, Norway, Spain, Sweden and the United Kingdom) all with different public-private financing structures, are experiencing wait list problems (Gibson and Fuller 2006). There is no correlation that demonstrates that private financing will improve health care delivery. It will only change who pays and who receives. Evans' (2003) claim that moving away from a public system of financing,

> "boils down to saying that this pattern of burdens and benefits is morally wrong. People should not get care that they cannot afford. And people who can afford a higher standard of care for themselves, should not have to contribute, through taxation, to support a similar standard for others". (p 22)

This statement speaks to how increased privatization is a violation of the principles of universality and accessibility in the CHA which are strongly supported by Canadians. In order to avoid moral panic and increasing calls for abandonment of Medicare, both federal and provincial governments need to inform the public more consistently on actions taken to improve delivery of health services.

We must ensure and protect the services that are provided under the CHA. As demonstrated in graph one (p.9), Medicare has shown relative cost stability and is within government's ability to pay. Introducing user fees or private insurance for these services will not reduce health expenditures, but will reallocate the costs onto those with lower incomes. Medicare services need further protection to ensure that jurisdictionally unconstitutional court decisions or market-focused provinces do not make policy decisions that will harm the rest of Canada. One of the

primary considerations must be to keep Medicare as a protected good under international trade agreements. Should international private insurance companies become able to provide these services Medicare as a universal system is lost. Federal enforcement of the CHA in provinces that do not follow its principles will help prevent sliding down the slippery slope of privatization.

Reform the Public System

Reform within the public system is the best option for Canada. Providing more fiscal support to the provinces is one way of doing this. Policy decisions on where the revenue should come from to increase spending are challenging; but they must be made. Tax increases will not be a popular choice, but they may be a necessity if Canadians want to maintain a system that meets their basic needs and ever-increasing expectations.

Delivery reform will also improve the system. Planning for a national pharmacare program should begin now. Pharmaceutical prices are, and will continue to be, the fastest growing public and private health expenditure. A national pharmacare program would allow for the federal government to negotiate prices with pharmaceutical companies to supply drugs for the entire country. This will give government both bargaining power and quantity pricing and will help stabilize the price for pharmaceutical products reducing their effects as a Medicare cost driver.

Finally, there needs to be a strong federal presence in the financing of public health care. The federal government receives a much larger share of personal income tax revenues than the provinces. Income tax is one of the fastest growing revenue sources in the country and it provides the federal government with the capacity to meet its obligations to support provincial programming through fair fiscal federalism. The optimal method for funding would be a funding formula based on population and age demographics for each province (Gibson and Fuller 2006). This will ensure that the provinces with the fastest aging populations will be able to cover their relatively higher health costs. Increases in government expenditure are a necessary component of providing a quality public health system in the years ahead.

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