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Health care financing: squandering billions is not the answer

Canada's health care system suffers from many ills. Waiting lists that keep getting longer, overcrowding in emergency rooms, shortages of medical staff – none of this will come as news to anyone. The situation has continued to deteriorate even as the resources spent on health care have grown over the last few years and governments have injected tens of billions in additional funds. Health care spending by the provinces increased by \$30 billion between 1993 and 2003 despite cuts in federal transfer payments in the 1990s.

In the current debate, the position adopted by nearly every political party and by people in the health care field is that the existing system can be maintained provided a few adjustments are made to the way it is organized and a few billion extra dollars are injected. Disagreement lies mainly in how power and financing should be shared between levels of government. And yet there is reason to wonder if the system in its current form is financially viable.

The current situation

Total health care spending in Canada reached \$121.43 billion in 2003, or \$3,840 per person. This represents 10% of gross domestic product (GDP), placing Canada sixth among OECD countries in the scope of spending. Adjusting for population may even put Canada at the top of the list of countries with universal access to health care.¹ The public sector accounts for 70% of total spending.²

Health care spending in Canada has continued to balloon in recent years. Funds spent in this sector by provincial governments are up by 194% over the last two decades, or 5.9% per year on average. In real terms, i.e., adjusted for

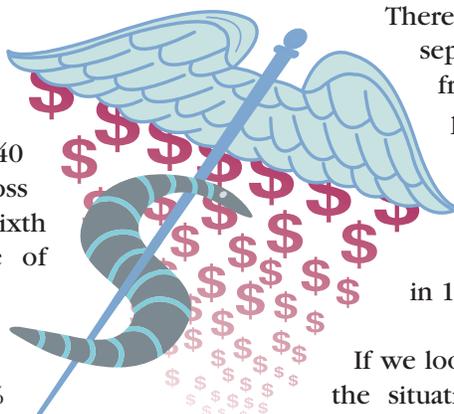
inflation, spending has grown by 88%, an annual average of 3.4%, which is higher than the 3.08% annual growth in Canadian GDP.

Health care spending is swallowing an increasingly large share of provincial budgets. Program spending (all budgeted spending items apart from debt service) grew at an average annual rate of 2.1% between 1983 and 2003 in real terms.

There thus exists a gap of 1.3% a year that separates growing health care requirements from the resources spent on government programs as a whole. Program spending on items other than health care grew by only 1.3%, or less than half the rise in health care spending. Health care as a share of total program spending went from 32.1% in 1983-84 to 41.3% in 2002-03.³

If we look at the evolution over the last five years, the situation is even more troubling. Growth in provincial health care spending in real terms averaged 5.5% a year over this period while program spending as a whole grew by an average of only 3.1%.

Ottawa's financial contribution to provincial health care spending has increased substantially in recent years, despite



¹ Canada has a younger population than most European countries, and it could be expected to spend less than these countries, which is not the case. Fraser Institute researchers have examined health care spending compared to GDP by adjusting for different age structures, particularly the share of total population aged 65 or older. With this adjustment, Canada heads the list of countries with universal access to health care, in other words all OECD countries minus Mexico and the United States (Nadeem Esmail and Michael Walker, *How Good is Canadian Health Care?*, The Fraser Institute, Vancouver, 2004).

² The provinces spend \$79 billion (65% of the overall spending) on health care. This includes funds transferred by Ottawa. A further \$6 billion is spent directly by the federal government (for example, on military personnel), by workers' compensation boards and by municipalities. Public spending thus totals \$85 billion. The private sector accounts for 30% of overall spending, largely for medication and the services of certain health care professionals such as dentists.

³ See the appendix on the MEI Web site for data sources and calculations (www.iedm.org).



budget cuts between 1993 and 1999 aimed at cleaning up federal finances. In September 2000, the federal government announced an investment of \$23.4 billion over five years. The latest agreement between Ottawa and the provinces, reached in February 2003, calls for an additional amount of \$34.8 billion over five years, and the 2004-05 federal budget contains an immediate addition of \$2 billion to this sum. Discussions are under way between the two levels of government, and we can expect further announcements of increased federal contributions in the near future.

Future increases

Projections on how this spending will evolve suggest that increases in the coming years

will be at least as great. Forecasts of higher costs, economic growth and technological change are difficult to evaluate and are relatively uncertain. It may be useful to look first to the most predictable dimension, namely the effects of an aging population. This provides the most solid data that can enable us to predict cost increases. Demo-

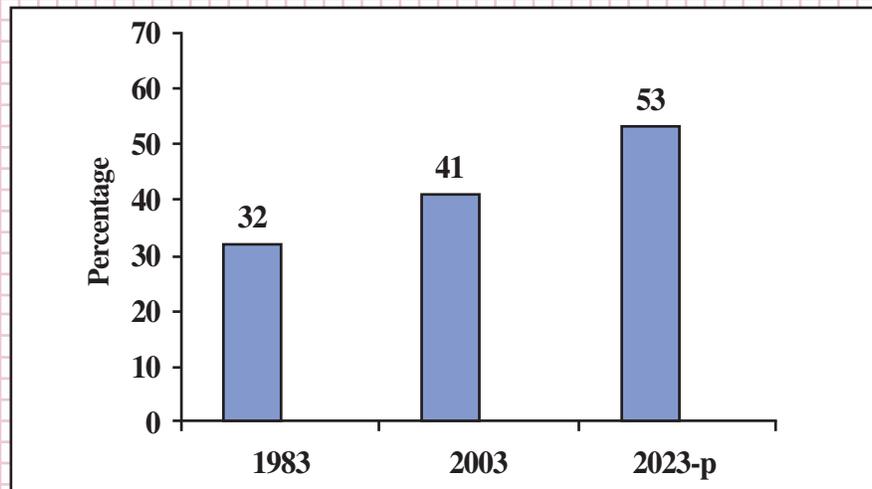
graphic forecasts are relatively exact. Barring some unforeseen catastrophe, we can tell quite easily what proportion each age group will account for in 20 years, in particular the 65-plus age group. The proportion of people 65 or older in the Canadian population will go from 12.5% in 2000 to

18.4% in 2020 and 21.4% in 2026. About 50% of total health care spending in a person's life takes place after age 65.

Taking account only of the aging of the population as projected by Statistics Canada, we can forecast that spending in 2020 will be about 23% higher than in 2000-01. In other words, by applying the 2020 age structure to the 2000 population, and using 2000-01 data on per capita spending by age group, we see that total public spending would be 23% higher.⁴ These results are comparable to others from the Conference Board of Canada showing, for example, that aging will produce 1% average annual growth over the next 20 years.⁵

Figure 1

Share of health care spending in provincial program spending



Sources: Canadian Institute for Health Information, Canadian Department of Finance and the author's calculations
Note: p = projections

This increase in health care costs due to aging of the population is difficult to curb. It is caused by natural factors over which we have no control, unless some miraculous cure is discovered giving 85-year-olds the health of 18-year-olds. The phenomenon of aging will really start to be felt in 2011, when the first baby-boomers reach age 65. This effect will increase in the succeeding

years right up to the late 2020s. In 2026, for example, aging alone will cause a 33% increase in public health care spending compared to 2000.

This does not take account of other factors with the potential to raise spending such as the price of medication, added costs caused by more effective but costlier new technologies, inefficiencies in system management, etc. It also fails to take account of possible improvements in the

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⁴ See the appendix on the MEI Web site for data sources and calculations (www.iedm.org). 2000-01 is the most recent year for which detailed data on spending by age group are available. Some authors note that it is necessary to take account not only of the overall number of elderly people but also of the number of elderly people nearing death; otherwise, there is a risk of overestimating the effect of aging on public spending since a large share of spending on elderly people takes place in the final year before death. A study for the United States suggests that overestimates could reach 15% if the forecasts extend to 2020. (See Sally Stearns and Edward C. Norton, "Time to include time to death? The future of health care expenditure predictions," *Health Economics*, 13, April 2004, p. 315-327.)

⁵ Glenn Brimacombe, Pedro Antunes and Jane McIntyre, *The future cost of health care in Canada, 2000 to 2020. Balancing affordability and sustainability*, Conference Board of Canada, 2001.



quality of service provided or reductions in waiting lists compared to the current situation. Billions of extra dollars could be spent meeting new needs without solving the waiting list problem.

It is difficult to project government spending over the next 20 years when so many factors are uncertain. Any linear projection provides information that will be oversimplified insofar as it excludes possible policy changes. But if we extrapolate the evolution of the last two decades up to 2023, it is certain that public health care spending will continue growing in relative terms. As we have seen, with health care accounting for 32% of total program spending in 1983-84 and 41 % in 2002-03, this proportion could climb to 53% in 2023.⁶

Half of program spending would then be going to health care, leaving the other half for all other items combined. Despite an element of exaggeration, Quebec Premier Jean Charest was correct in sounding the alarm recently when he stated that “the way things are going, there will be just one government department in 15 years, the Department of Health.... The others will no longer exist.”⁷

A performance that fails to measure up

Even though Canada spends more in relative terms than many countries with older populations, such as Sweden or Japan, its performance is less impressive in several respects if we rely on international comparisons. Canada ranks 26th among OECD countries in number of doctors at 2.1 per

1,000 inhabitants (the average is 2.9). It ranks 15th in number of magnetic resonance imaging (MRI) units per million inhabitants.

The waiting time for various services has continued to rise. The median time between referral by a general practitioner and a visit to a specialist reached 8.3 weeks in 2002-03, taking all specialties into account, compared to 3.7 weeks in 1993. A waiting time of 4.8 weeks is considered reasonable.⁸ The waiting time between a visit to a specialist and the start of treatment was 9.5 weeks in 2002-03 compared to 5.6 weeks in 1993. The waiting time for an MRI test averaged 12.7 weeks in 2003 compared to 7.7 weeks in 1994. Prolonged waiting times for treatment or diagnostic tests

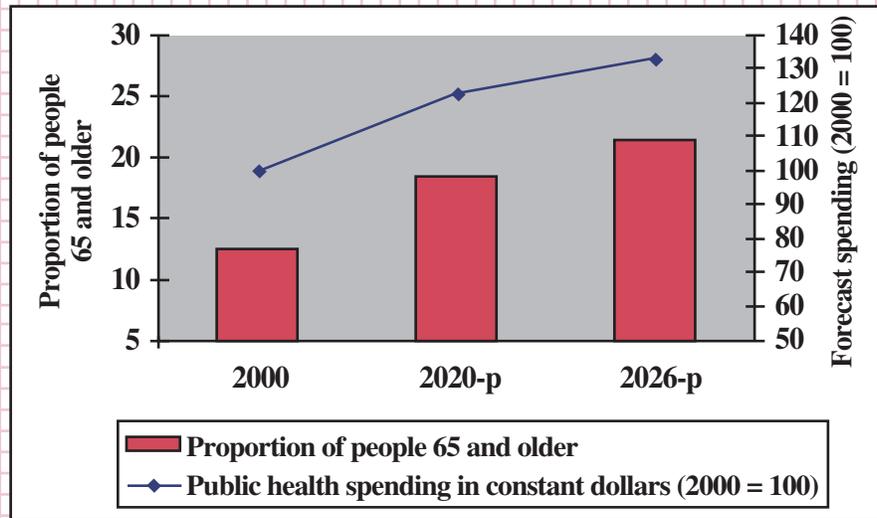
unquestionably have very negative effects on patients - pain, suffering, medical complications, psychological effects. And this does not take account of economic consequences caused by lower productivity, absences from work and loss of income.

A study comparing how the situation has changed in five countries shows a worse decline in Canada than in

the other countries studied.⁹ The percentage of people requiring elective surgery who have to wait four months or longer went from 12% in 1998 to 27% in 2001. As for the problem of emergency room overcrowding, another cause of concern that can harm individual health, international comparisons can be tricky, but Quebec data show a

Figure 2

Effects of aging on forecast public health care spending



Sources : Canadian Institute for Health Information, Statistics Canada and the author's calculations.
Note : -p = projections

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⁶ Conference Board projections in the study by Brimacombe, Antunes and McIntyre point toward similar results.

⁷ Denis Lessard, “La santé accaparera tout dans 15 ans,” *La Presse*, April 6, 2004, p. A4.

⁸ Nadeem Esmail and Michael Walker, *Waiting your Turn: Hospital Waiting Lists in Canada*, Fraser Institute, 2003. The waiting time considered reasonable is an average of responses from specialists on how long they judge to be acceptable from a clinical standpoint.

⁹ Blendon et al. “Inequalities in Health Care: A Five-Country Survey,” *Health Affairs*, Vol. 21, No. 3, May-June 2002.



deterioration in this area as well. The percentage of people occupying a stretcher in an emergency room for 24 hours or more during the first half of the year went from 13% in 1995 to 20% in 2002. For the second half it went from 14% to 22%.¹⁰

Steps toward a solution

The Canadian health care system has deteriorated in recent years despite the injection of billions of extra dollars in government funds. A simple increase in public spending will not be sufficient to solve the problems or to meet the needs of an aging population. Major changes are required to limit costs by improving efficiency in the provision of health care. This goal could be achieved by among other things improving individual incentives for health care users and suppliers and by allowing competition. Up to now, cost limitation has relied mostly on the rationing of services and on coercion.

Even admitting that the system's financial requirements will increase, it is deceptive to think that governments alone can meet these needs. A "health premium" similar to what the Ontario government imposed in its most recent budget, or the creation of a "health fund" separate from the government's consolidated fund with larger amounts at its disposal, are in fact just tax increases. Canadians' tax burden is already excessive and, without a considerable improvement in the public health care system, governments cannot count indefinitely on the willingness of taxpayers to keep shelling out.

Canada remains one of the few countries in the world that maintain a public monopoly in the provision of health care services judged medically necessary. European countries such as France or Sweden have parallel private sectors, and their health care systems work better than ours. Why not allow patients to pay for all their health care (through RRSPs or private insurance, for example), including care currently covered by the public system?

Why not allow patients to pay for all their health care, including care currently covered by the public system?

A Léger Marketing poll conducted for the MEI shows that 51% of Canadians, and more than two-thirds of Quebecers, want the government to allow people who wish to obtain health care more quickly in the private sector to pay for it themselves. Citizens will have a stronger incentive to spend additional resources if their health is directly involved and if they have the impression they are getting better control over results rather than sinking more of their tax dollars into an inefficient and uncontrollable system. This would also help clear up the public sector since new resources would be available.

Many avenues of reform can be envisaged, even within the framework of the Canada Health Act.¹¹ It is time to get rid of the taboos that prevent us from seriously considering these alternatives.

¹⁰ Government of Quebec, Institut national de santé publique, *Éco-Santé Québec 2003*. This is software that can be downloaded free from <http://www.inspq.qc.ca/pdf/publications/eco-sante2003.asp?E=p>. It appears that stays of more than 48 hours in emergency rooms are down in 2004 compared to 2003 (see Pascale Breton, "Les urgences soufflent un peu," *La Presse*, July 14, 2004). It is premature, however, to announce major reductions given the absence of sufficiently detailed data.

¹¹ See the Economic Note *Health Care Reforms: Just How Far Can We Go?*, Montreal Economic Institute, April 2003, available at http://www.iedm.org/etudes/etude17_en.html.

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