



UBC CENTRE FOR
HEALTH SERVICES AND
POLICY RESEARCH

Economic Myths and Political Realities

The Inequality Agenda and the Sustainability of Medicare

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THE UNIVERSITY OF BRITISH COLUMBIA

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The Centre for Health Services and Policy Research (CHSPR) is an independent research centre based at the University of British Columbia. CHSPR's mission is to advance scientific enquiry into issues of health in population groups, and ways in which health services can best be organized, funded and delivered. Our researchers carry out a diverse program of applied health services and population health research under this agenda. The Centre's work is:

- Independent
- Population based
- Policy relevant
- Interdisciplinary
- Privacy sensitive

CHSPR aims to contribute to the improvement of population health by ensuring our research is relevant to contemporary health policy concerns and by working closely with decision makers to actively translate research findings into policy options. Our researchers are active participants in many policy-making forums and provide advice and assistance to both government and non-government organizations in British Columbia (BC), Canada and abroad.

Funding and Support

CHSPR receives core funding from the BC Ministry of Health, and ongoing support from the University of British Columbia and the UBC College of Health Disciplines. This enables the Centre to focus on research that has a direct role in informing policy and health reform, and facilitates CHSPR's continuing development of the BC Linked Health Database.

Our researchers are also funded by competitive external grants from provincial, national and international funding agencies. They include the Canadian Health Services Research Foundation, the Canadian Institutes of Health Research, the Commonwealth Fund, Health Canada, the Michael Smith Foundation for Health Research, and WorkSafeBC.

Data Services: BC Linked Health Data Base

Much of CHSPR's research is made possible through the BC Linked Health Database, a valuable resource of data relating to the encounters of BC residents with various health care and other systems in the province. These data are used in a de-identified form for applied health services and population health research deemed to be in the public interest.

CHSPR has developed strict policies and procedures to protect the confidentiality and security of these data holdings and fully complies with all legislative acts governing the protection and use of sensitive information. CHSPR has over 30 years of experience in handling data from the BC Ministry of Health and other professional bodies, and acts as the access point for researchers wishing to use these data for research in the public interest.

Ingenuity: Sustaining Ourselves in an Unfriendly World

In its simplest terms, “sustainability” refers to nothing more than a comparison of rates of change. If a resource stock—a fishery, a forest, an aquifer, a bank account—is being drawn down faster than it is being replenished, then that stock or better that pattern of rates is not indefinitely sustainable. Continuous accumulation is equally unsustainable—the trees do not grow to the sky. Human nature being what it is, however, the latter form of unsustainability typically presents as some form of pollution or accumulating “bad” while the former involves running out of “goods”.

While the simple arithmetic of trend projection is beyond dispute, its relevance in any particular situation is not. The time horizon is critical. Economists in particular tend to be congenitally suspicious of mechanical projections, for reasons well illustrated in the controversies over the “limits to growth” in the 1970s (Meadows et al., 1972). Computer models of resource use and pollutant generation used in the study commissioned by the Club of Rome showed rigorously that the world was approaching, in the relatively near future, absolute limits to economic growth. Worse, even then-current levels of output and income in rich countries were unsustainable in the long run. But critics emphasized that the very definition of a “resource” depends upon the tastes and technology of the day, and that the latter, at least, was endogenous

Natural resources do not “run out”, they simply become increasingly expensive to locate and extract. But rising prices create powerful incentives to innovate around the tightening constraint, using an increasingly costly resource more efficiently and finding substitutes. Accordingly depletion of any one resource need not constrain the whole complex economic system. Successful innovation will be reflected in stable (or falling) price for the commodity that was previously “running out”. Long-run resource price data seem to support this view; the economist Julian Simon, for example, challenged exponents of “limits” models to find *any* natural resource whose price, over the long run, has risen in real terms.

More recently, however, students of sustainability have developed a broader, “neo-Malthusian” perspective. The environments to which human societies adapt tend to become more hostile over time, sometimes from natural changes but especially from the activities of humans themselves – Malthus’ point. On the other hand human societies have always been ingenious in finding ways to advance their purposes even in the face of this deterioration. Successful societies generate a “supply of ingenuity” sufficient to meet the challenges thrown up by both the external environment and the consequences of their own (or others’) activities.¹ But an “ingenuity gap” can open up, with potentially serious consequences, if the supply fails to keep pace with the demand (Homer-Dixon, 2000).

This concept of ingenuity includes but goes far beyond advances in technical capacity, to include most importantly the institutional frameworks within which economic and social activity take place – and which also serve to mobilize ingenuity itself. Fiduciary currency, double-entry bookkeeping, and limited liability corporations were fundamental advances in ingenuity. Price systems and markets are powerful institutional mechanisms, operating automatically to create incentives for technical innovations – or behavioural changes – to relax the constraints of any particular depleting resource. Pollutants become a problem when no institutional framework motivates a corresponding supply of ingenuity to limit their accumulation. “Pollution markets,” in which rights to pollute could be traded at varying prices, have been suggested as such a possible framework.

Markets are, however, only one form of social mechanism for mobilizing ingenuity – or indeed for promoting any other social objective. Public regulation, for example, is more typically used for pollution control. The most appropriate institutional choice will depend on the context, and is ultimately an empirical question. There is no one “right” institutional response to every social challenge.² Nor, most importantly, is there any God-given guarantee that the supply of ingenuity itself will be sufficient to deal with emerging social problems. In the

¹ The idea is not entirely new. H.G. Wells referred to civilization as a race between education and disaster, and Arnold Toynbee built a theory of history around the success or failure of different civilizations’ responses to successive challenges.

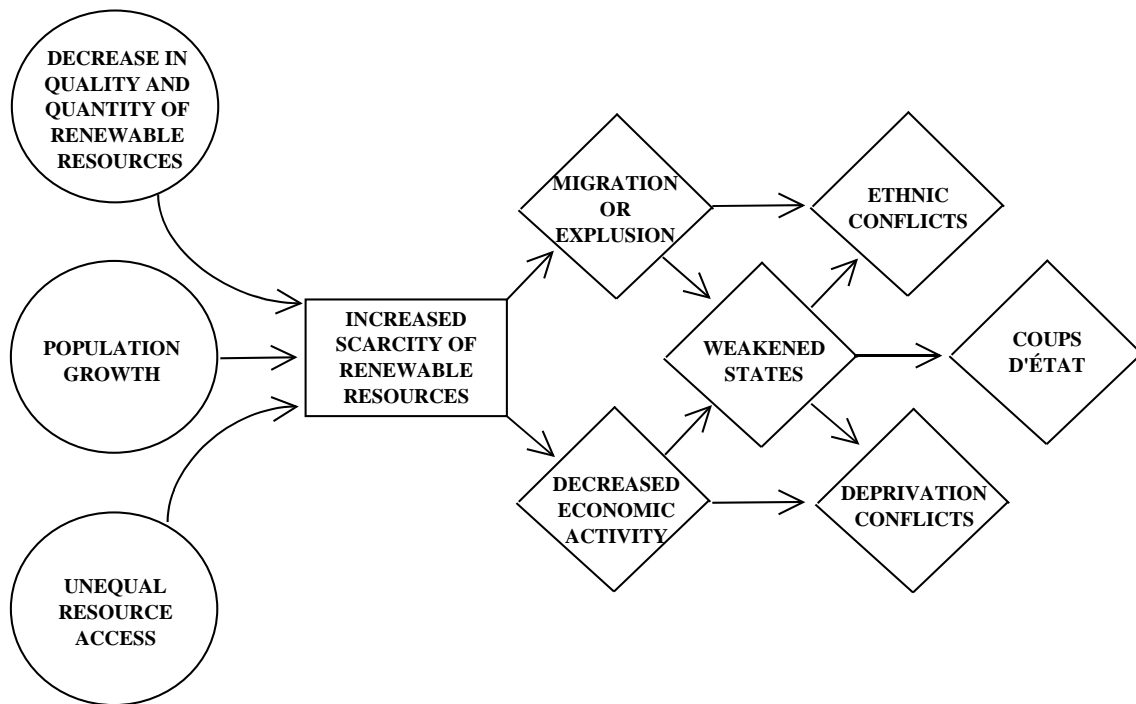
² Advocates of market mechanisms tend to presume on *a priori* grounds that private markets always generate the right or “optimal” answer. This position is typically buttressed against empirical challenge by the implicit assumption that whatever outcome is generated by such markets is by definition optimal.

idealized world of economic theory, automatic self-equilibrating mechanisms always take a society to the “best of all possible worlds” (so long as they are not perturbed by misguided government interventions). But in the real world, societies may not find a satisfactory institutional answer to their problems, becoming more or less “failed” societies with increasing suffering and misery and, in extreme cases, dissolution.³

Societies split by deep tribal, ethnic, religious or economic divisions and having weak or non-existent unifying institutions, are at particular risk. A deteriorating environment may increase internal conflict, both diverting and dissipating the supply of ingenuity. The incentive to innovate is weakened when there is little security of reward; worse, plundering one’s neighbours may become the most profitable application of ingenuity. In the most extreme cases external challenges to deeply divided societies generate a vicious circle of violent internal conflict, deepening divisions and further deterioration. Unable to hang together, the population hang each other separately.

These extreme observations underline heavily the critical importance of *political* ingenuity as an essential basis for other forms of advance, in designing and maintaining institutions for mitigating internal conflict and bridging fissures in the body politic. Absent these, and a whole society can become “unsustainable”. Figure 1 (Homer-Dixon *et al.*, 1993) provides a compact representation of the dynamics of violent conflict over renewable resources within rather than between states.

Figure 1: Sources and Consequences of Renewable Resource Scarcity



Source: Homer - Dixon et al. (1993)

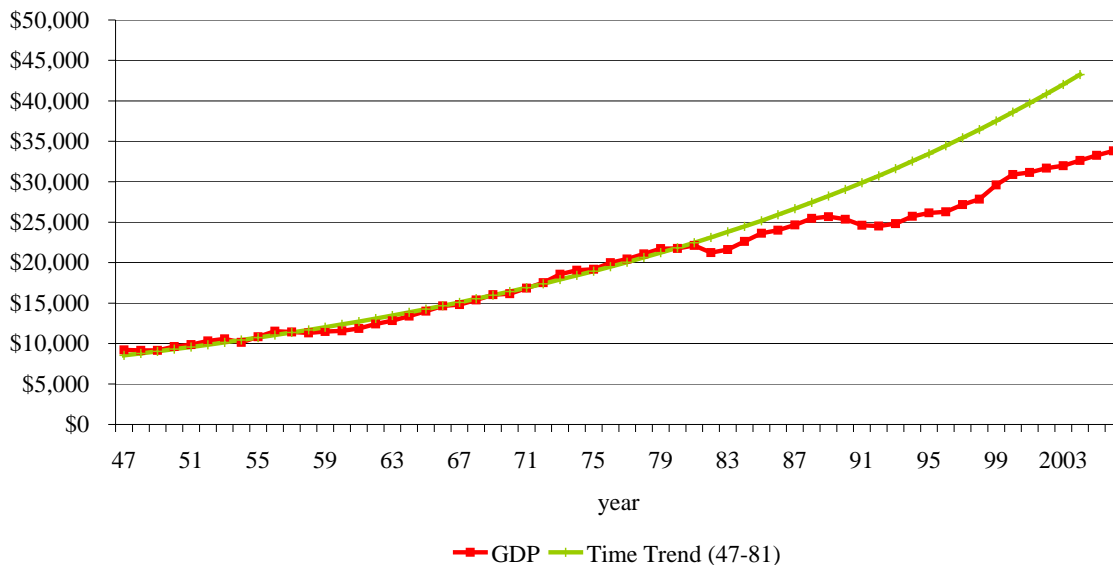
³ “...and presently word would come, that a tribe had been wiped off its icefield, or the lights had gone out in Rome.”

States do not generally collapse in high-income countries with highly developed, more or less democratic political systems and massive resources of ingenuity.⁴ Conflicts are typically political and legal rather than military; dramatic transfers of power and shifts in priorities take place not through coups d'état but by the election of a Margaret Thatcher or a George W. Bush. Nevertheless the general framework seems to have very broad applicability. Social advance in the most general sense requires a sufficient supply of appropriate ingenuity to meet the challenges of a deteriorating environment. And that supply is threatened by internal divisions that divert ingenuity from promoting collective advantage into escalating political conflicts among competing interests. In particular, this framework seems to provide an interpretation for the seemingly endless conflicts over health care policy in high-income countries (Evans, 1998). In this paper we address the recently re-ignited debate over the “sustainability” of the current system of universal public health insurance in Canada, showing that certain anomalous features of that debate can be readily understood within the neo-Malthusian framework.

Financing Canadian Health Care through Fat and Lean

To begin, the long-run economic environment in Canada *has* deteriorated significantly since the early 1980s. Figure 2A plots Canadian GDP—Gross Domestic Product—per capita (adjusted for inflation) since the Second World War, fitting a log-linear trend to 1947-1981 and projecting it to 2006.⁵ Figure 2B shows the ratio of actual to fitted or projected values over this sixty-year period.

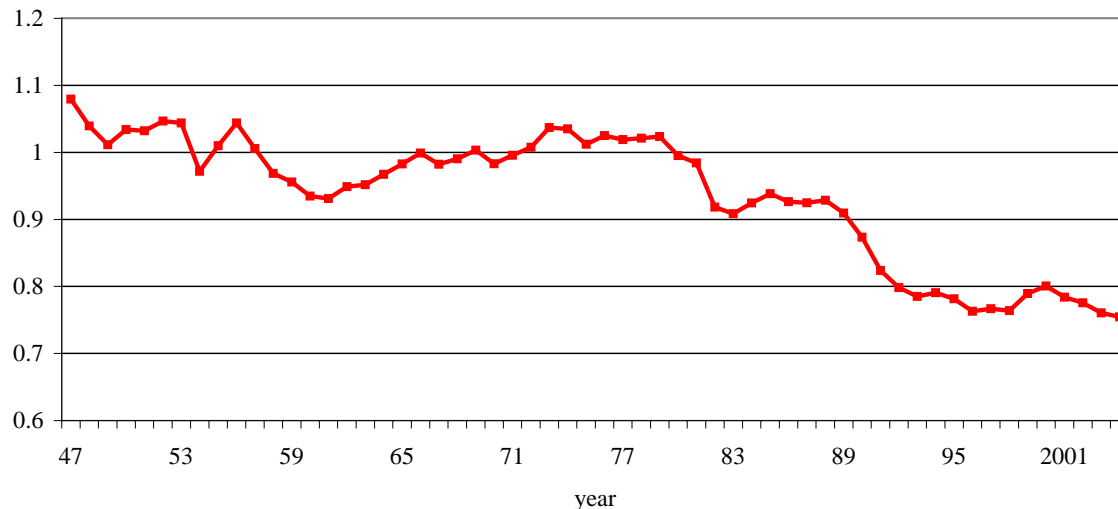
Figure 2A: Canada Real GDP per Capita
\$1992, 1947 - 2006



⁴ The ingenuity requirement to manage an increasingly complex global environment – “tightly coupled” physically, financially, and even psychologically – does appear to be increasing rapidly, and it is far from clear that our political institutions in particular have the capacity or can even recognize the need to meet that growing demand. But that, O Best Beloved....

⁵ Here and subsequently, calendar year data on GDP and health expenditure back to 1975 are from CIHI (2006). Data back to 1960 can be found in OECD (2006); sources for pre-1960 data are given in Barer and Evans (1986).

Figure 2B: Canada Real GDP per Capita over Trend
\$1992, 1947 - 2006

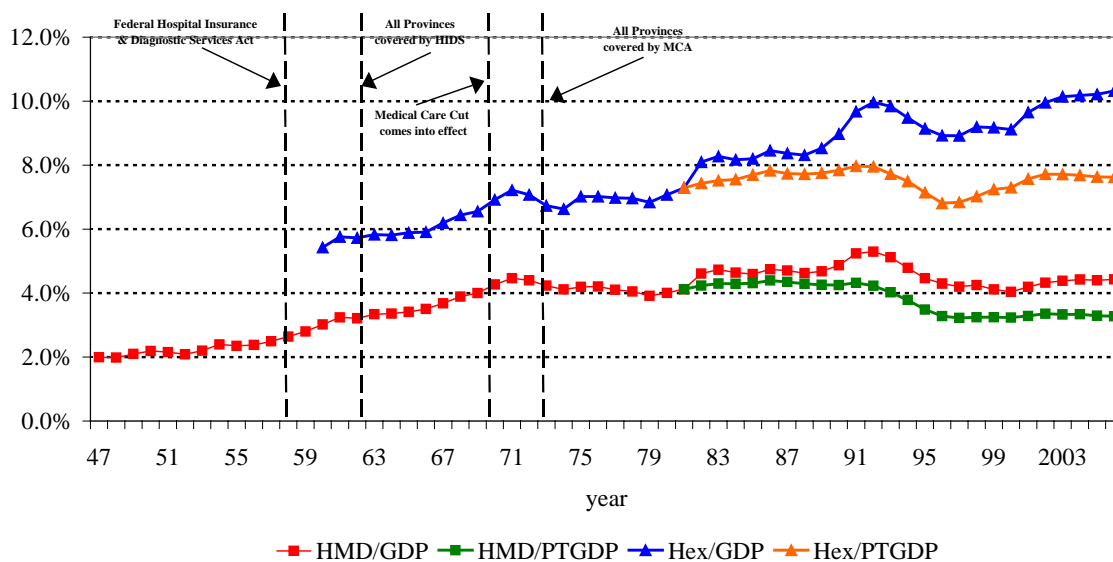


The closeness of actual experience to this trend prior to 1982 is remarkable. The discrepancy is greater than 5% in only four years out of thirty-five, and never reaches 10%. Recessions in 1954 and 1957-61 were followed not only by resumption of growth but also by recovery to the previous path—making up the lost ground.

The recession of 1982 was different. Real income per capita not only dropped sharply, but failed to recover. Growth resumed in 1983 on a trend line parallel to that of 1947-1981, but nearly 10% lower. Growth after the even more severe recession of 1989-1992 was along a still lower and slightly slower path. Canadians are not poorer now than in the past; average GDP per capita (adjusted for inflation) was higher in 2006 than ever before, and growing (between recessions) at almost the same rate as in earlier decades. But that average is now about 25% below where it would have been if the last two recessions had been followed by a real recovery. For whatever reasons, the ground lost in these recessions appears permanently lost, and the amount is huge.

This implies, among other things, a permanent reduction in the income base from which to meet the demands of an expanding health care system. Figure 3 displays the ratio to GDP of Canadian expenditure (public and private) on hospitals and physicians’ services from 1947 to 2006, and of total health care expenditure after 1960. It includes hypothetical lines showing what these ratios would have been, after 1981, if GDP had continued to grow along its pre-1982 trend while health spending had evolved as it did.

Figure 3: Canada Total Health, and Hospital and Physician, Expenditure over GDP and Trend GDP Projected, 1947 - 2006

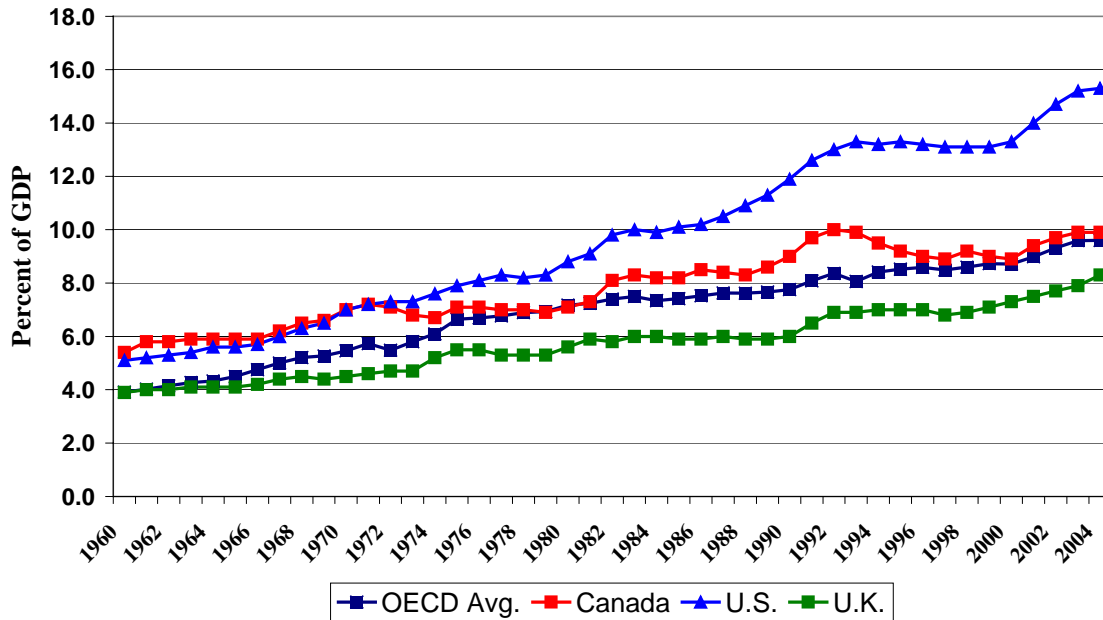


The hospital and physician data are of particular relevance because only these sectors are covered by the federal-provincial public insurance programs—Medicare—whose “sustainability” continues to be challenged. Administered by provincial governments, according to federal standards and with federal financial contributions, these provide universal comprehensive coverage without deductibles or coinsurance. Other components of health care, such as drugs, dentistry, and long-term care, are covered through various mixes of out-of-pocket payment, public and private insurance, and direct public delivery.

Perhaps the most striking feature of Figure 3 is the remarkable stability of the share of national income devoted to the public insurance programs. Provinces introduced these programs in different years, but coverage for hospital care was nation-wide by 1961 and for physicians’ services by 1971. The latter date was marked by a sharp break in the previous pattern of continuing cost escalation. Universal, comprehensive coverage was *not* more expensive than the previous fragmented mix of public and private insurance coverage and out-of-pocket payment. Consolidation of expenditures in the hands of a single payer made possible the control of rates of escalation, through a variety of different mechanisms (Evans, 1982). From 1970 until 1981, the share absorbed by the Medicare services fluctuated in a narrow band between about 4% and 4¼% of GDP.

Nor was the Canadian experience unique. By the 1970s public universal and comprehensive health service or health insurance systems were in place in all the high-income countries of the OECD (Organization for Economic Cooperation and Development). All developed, at some time during the 1970s or early 1980s, more or less effective mechanisms of cost control (Evans, 2002). Figure 4 shows the trends in health care spending relative to GDP for Canada, the United States, and the United Kingdom, and for the average of all OECD countries for which data are available back to 1960. The OECD average ratio escalates in parallel with the United States prior to the mid-1970s, rising at an average rate of 3.6% per year. From 1975 to 2004 it rises only 1.3% per year. The pattern is sufficiently consistent across countries that White (1995) referred to it as “the international standard”. The one exception, on both costs and coverage, is the United States.

Figure 4: National Health Expenditure as Percent of GDP, Selected OECD Countries, 1960-2004



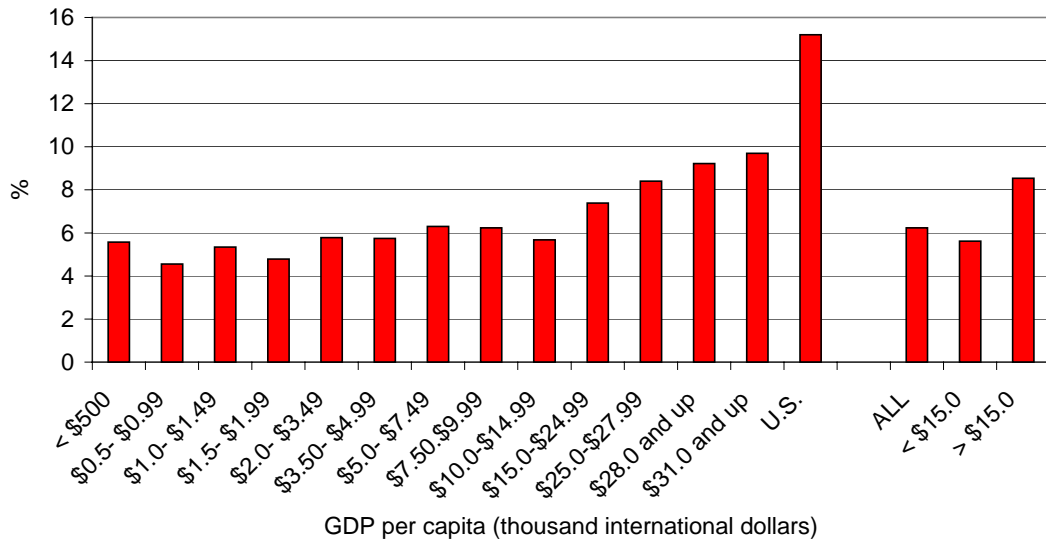
The panels of Figure 5 broaden the focus beyond the OECD to address the global picture. These data are drawn from the Statistical Appendix to the World Health Report for 2006.⁶ Countries are grouped according to their income levels in GDP per capita measured in “international” dollars (USD adjusted to national purchasing power parities). Countries are unweighted; group averages count each country equally regardless of population size or income.

Health spending is strongly linked to national income, as shown in Figure 5A. But only in high income countries does the *proportion* of income spent on health care rise with rising income. Countries with average incomes below \$15,000 (in 2003) spent on average just under 6%; those over that level spent over 8%.⁷ Canada, spending 9.9% in 2003, is just above the average (9.7%) for its top income group (excluding the United States)—just as Figure 4 shows from the OECD data.

⁶ They exclude all countries with populations of less than a million, as well as those singled out in the Report as having unreliable data.

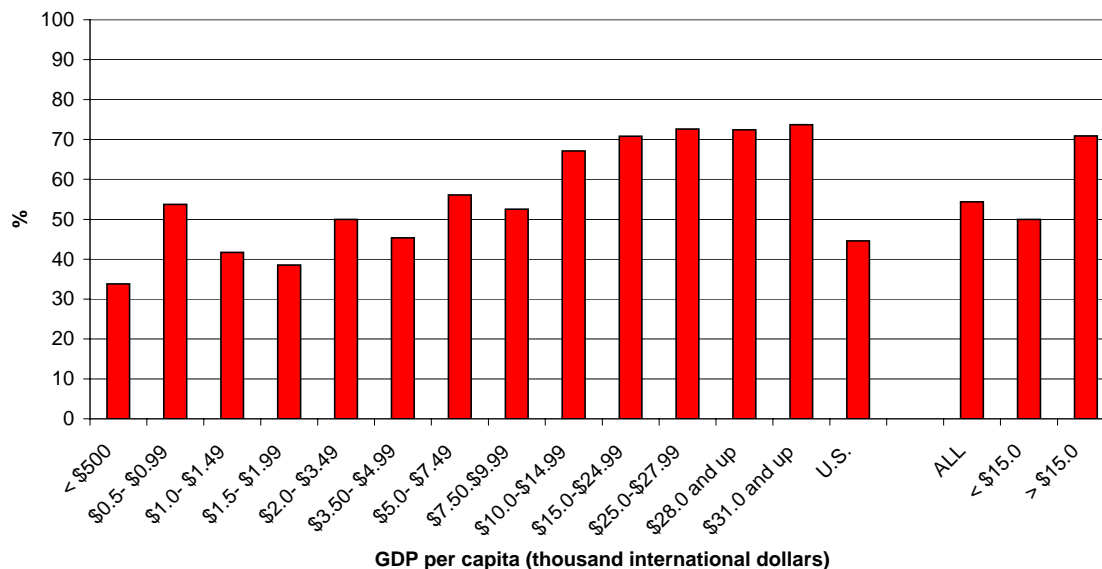
⁷ The WHR data also show that while these average percentages have increased over the last five years, they have risen more than twice as fast in the countries with incomes over \$15,000 in 2003.

Figure 5A: Total health expenditures as share of GDP (2003) averaged over countries grouped by GDP p.c. (WHR 2006)



High income countries also finance a higher proportion of their health care through the public sector (Figure 5B). Among low income countries, the public share shows an irregular upward trend with income, averaging out at about 50%, but in high income countries, other than the United States, it jumps to 70%. Canada, at 69.9% public coverage, is actually somewhat below the 73.7% average for its top income group. Allegations that Canada’s public programs to finance health care are fiscally “unsustainable” because they cover an unusually high proportion of health care costs are false.

Figure 5B: Government health expenditures as share of total health expenditure (2003) averaged over countries grouped by GDP p.c. (WHR 2006)



The distinction between high and low income countries shows up sharply again in Figure 5C, displaying the proportions of health care costs met through out-of-pocket payments. There is a strong downtrend; as national incomes rise, the proportion of health care paid out-of-pocket falls. In the United States, often viewed as a bastion of private payment, out-of-pocket payment actually covers a significantly lower share of costs than in other high-income countries—although the costs themselves are of course much higher and much more unequally distributed. Moreover the downtrend across countries begins at relatively low per capita incomes; the (group average) out-of-pocket ratio falls steadily with rising income for incomes over \$5,000 per year.⁸ Canada, with out-of-pocket payments at 14.9% of total health expenditures, is considerably below the 20.1% average for its high-income group, but—perhaps surprisingly—slightly above the United States at 13.5%.

The missing piece is provided by Figure 5D—the share of health expenditures covered by private insurance. On average, countries cover about 5% of health care costs through this mechanism, and there is no systematic difference between high and low income countries. But in the United States, 36.5% of costs are covered through this mechanism.⁹ What makes that country an extreme outlier is not the extent of direct charges to patients, but its heavy reliance on private insurance. This fragmented funding system accounts not only for the very high proportion (for a high income country) of persons with no or seriously inadequate insurance coverage, but also for the unique inability to control cost escalation.

⁸ The pattern here is significantly dependent on the fact that countries are unweighted. China and India, each with populations well over a billion, also have unusually high rates of out-of-pocket payment. Weighting countries by population would increase the rate for low-income countries, but would not change the downtrend in high income countries.

⁹ These are the official numbers. But private insurance in the United States (and in Canada) enjoys very favourable tax treatment which, when accounted as indirect public expenditure, raises the public share of total health expenditures to nearly 69% and lowers private insurance to under 25% (Woolhandler and Himmelstein, 2002).

Figure 5C: Out of pocket expenditures as share of total health expenditure (2003) averaged over countries grouped by GDP p.c. (WHR 2006)

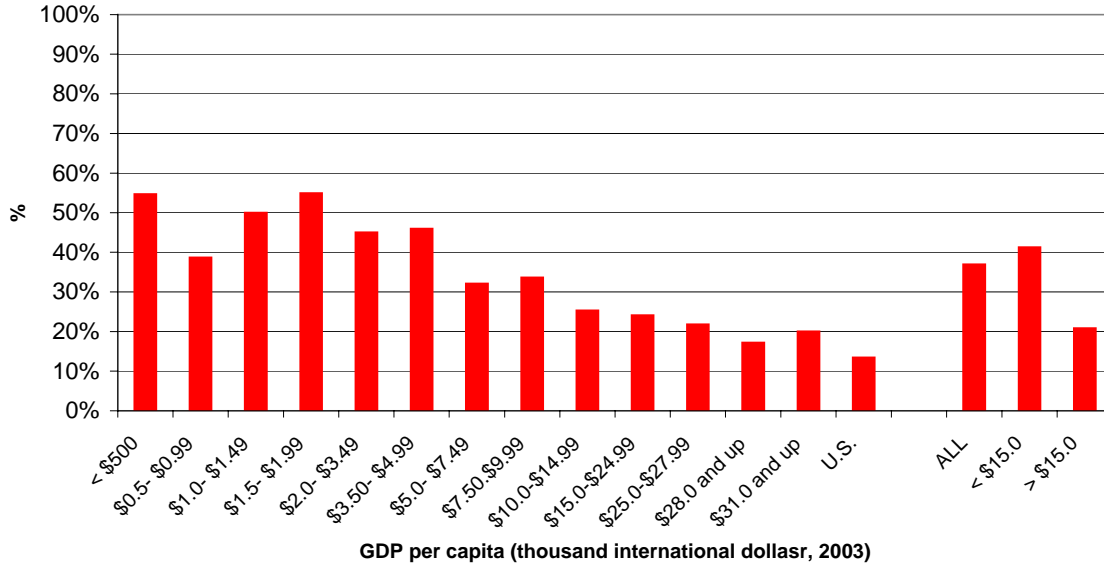
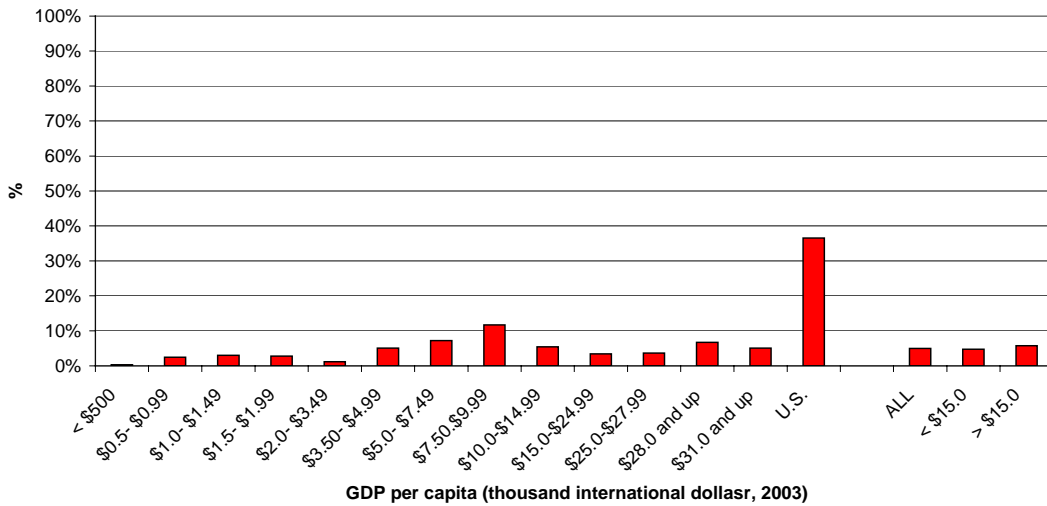


Figure 5D: Pre-paid insurance as share of total health expenditure (2003) averaged over countries grouped by GDP p.c. (WHR 2006)



And Canada? Our national Medicare system has excluded private insurance coverage (though that may be forced to change following the bizarre Supreme Court decision of 2005). Nevertheless, private insurance, primarily for prescription drugs and dentistry, accounts for 12.7% of Canadian health expenditures. This is well over twice the 5.1% average among the highest income (non-U.S.) countries. In world terms, Canadians rely unusually heavily on this financing source, ranking fourteenth out of 138 countries (right behind Zimbabwe). Any suggestion that we have a problem of fiscal sustainability because of the minimal role of private insurance simply does not meet the data.

In reality problems of sustainability, or at least of uncontrolled cost escalation, are associated not with public funding but with fragmented public and private funding, as in the United States – or Canada's fragmented payment system for prescription drugs. Single-payer public financing creates an institutional environment encouraging the supply of ingenuity to contain costs; costs are higher in multi-source funding systems where ingenuity is diverted into shifting costs onto other payers (Evans, 1990).¹⁰

Adapting to Adversity: Public Success, Private Failure

The early 1980s increase in the Canadian share of GDP spent on health care ratio was largely a denominator effect. Health spending stayed on its trend path through the recession, but national income fell. Since the previous income trend was never regained, the share of income spent on hospitals and physicians remained permanently higher. Had there been no recession, or a full recovery, the hospital and medical spending share would have remained in the neighbourhood of 4¼% to 4 1/3% for another decade.

The ratio began to follow the same pattern in the next recession, rising sharply to 1992 but again maintaining a constant share of the pre-1982 GDP trend. This time, however, the fiscal exigencies faced by both provincial and federal governments forced a quite dramatic response. Public expenditures were frozen or cut across the board after 1992, including for the first time actual cuts in hospital spending. By 1997 hospitals and physicians' services were absorbing the same share of GDP as they had in 1971; if it were not for the persistent effects of the two recessions that share would have been back to early 1960s levels.

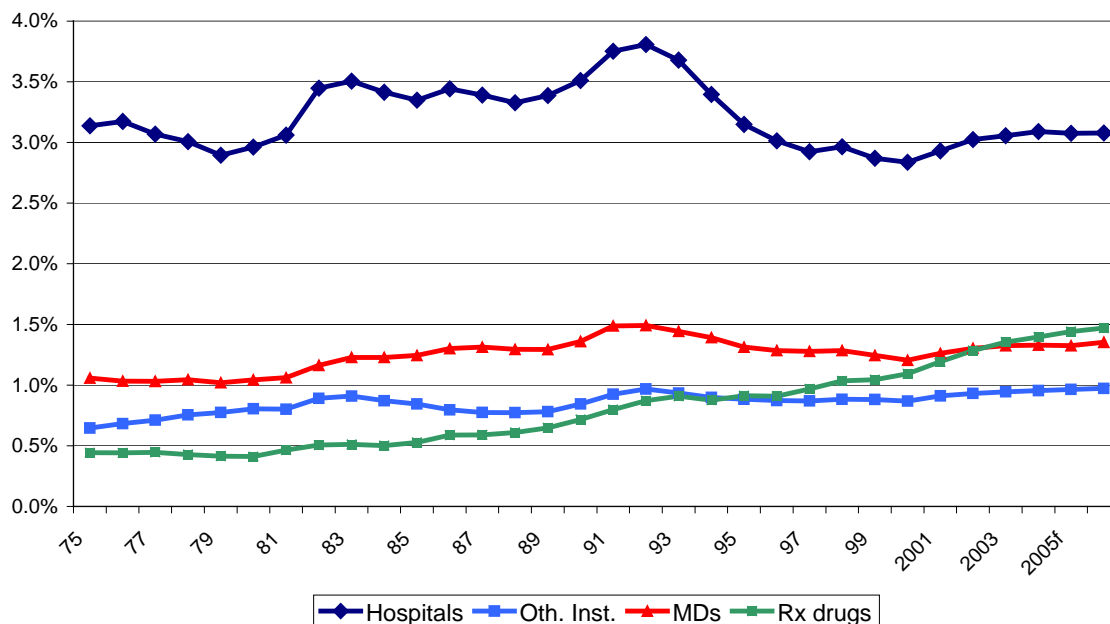
The pattern for total health care spending is roughly similar, but with a long-term upward trend. The shares of national income devoted to total health care expenditure in 1971, 1982, 1992 and 2006 were 7.2%, 8.1%, 10.0% and 10.3% respectively, while hospital and physicians' services accounted for 4.5%, 4.6%, 5.3% and 4.4%. The year-to-year movements are strongly influenced by the general business cycle, but the thirty-five year trend indicates that cost containment has been much more successful in the Medicare programs than in the other health care sectors.

Expenditures on prescription drugs, in particular, which are outside Medicare and reimbursed through a combination of public and private insurance and out-of-pocket payment, have been growing very rapidly over the past two decades, more than tripling their share of national income since 1980 (Figure 6). This pattern of rapid growth parallels the experience of the whole Canadian health care system prior to 1971 (and the American experience down to the present), again illustrating the link between fragmented funding sources and rapid cost escalation.¹¹

¹⁰ Even in the United States, the federal Medicare program for those sixty-five and older has been more successful than private insurers in controlling hospital and medical costs over the long term (Boccuti and Moon, 2003).

¹¹ The pharmaceutical industry and its advocates claim that this increase has made possible the reduction in hospital costs; the claim is spurious. It rests on little more than a correlation of trends, and cannot withstand any serious empirical scrutiny. But that again is another story.

Figure 6: Canada, Health Expenditures as Percent of GDP, 1975-2006, Selected Components



The deterioration of the Canadian economic environment after 1982 posed a serious challenge for the financing of health care. That challenge was met initially by allocating a larger share of national income to the health care system. The still larger shock of the early 1990s, however, triggered unprecedented reductions in public funding. Controversy has focused, then and subsequently, on the extent to which this mobilized ingenuity to provide care more efficiently and effectively, or simply reduced the level and standard of care provided and left real needs unmet.

We will bypass this question here, except to note that however one interprets their impact on the health of Canadians, reductions in expenditure must necessarily correspond, as a matter of elementary accounting, to a reduction in total payments to those working in or otherwise supplying resources to the health care system.¹² There is an inevitable conflict of economic interests between those who are paid for providing care and those who pay for it. Mobilizing ingenuity to improve efficiency, if it lowers total expenditure, threatens the financial interests of the former even as it benefits the latter. The deterioration of the overall economic environment since 1981 has tended to sharpen this division, intensifying the political and rhetorical conflict and clouding efforts to determine – and communicate – what actually happened.

For better or worse, however, after 1992 the Canadian public insurance programs did (have to) adapt to the general fiscal circumstances. Coincidentally, and through different mechanisms, so did American health care. The projection by the American Congressional Budget Office (United States, 1992: p. 2) that by 2000 the United States would be spending 18% of its GDP on health care was spectacularly falsified; as shown in Figure 4 the actual ratio in 2000 was little different from that in 1992.

¹² One should also note, however, that cross-national and interregional data show conclusively that higher levels of health spending are not necessarily associated with better health outcomes. Canadians are significantly healthier than Americans, and in the United States high utilization is associated with poorer quality of care and higher mortality (references in Evans, 2007).

As with the “limits to growth” modeling of the 1970s, linear projections that fail to take account of the adaptability of complex systems are likely to be misleading. The trick is to create the institutional environments that most effectively mobilize the ingenuity necessary to support that adaptation.

On the other hand, the “managed care revolution” that was widely credited with stabilizing American costs in the 1990s lost its grip after 2000. American expenditures were over 16% of GDP by 2005, and are now projected to reach 19.6% by 2016 (Poissal et al., 2007). In a similar way, the “limits to growth” arguments largely dismissed in the 1970s have now returned in the form of global warming, and are placing increasing demands upon our collective capacity to mobilize ingenuity—political and institutional as well as technological. Whether human societies can meet those demands is not at this point clear.

Canada’s experience at the beginning of the 1970s illustrates the impact of successful mobilization of ingenuity through institutional change. At the end of the 1960s there was growing concern among policy-makers (though not, apparently, the public) in both Canada and the United States about the continuing rapid escalation of health costs. The completion of universal public medical coverage in Canada coincided with the immediate flattening of the previous trend; the failure to achieve national health insurance in the United States was associated with a continuation of their previous trend. Considerable ingenuity was applied in Canada, as later in other OECD countries, to achieve this result; even more ingenuity has been expended, in the United States, in frustrating it. But the demand for further ingenuity continues to grow, exactly as Homer-Dixon’s framework would suggest.

American opponents of national health insurance have claimed for over forty years that NHI would be “unaffordable”. The counter-evidence, extending from Canada across the OECD world and now to Taiwan (Lu and Hsiao, 2003), has made no impression on these arguments. Similar concerns were urged in Canada prior to the inception of the Medicare programs, though perhaps with more excuse in the 1960s.

Their re-activation in recent years, however, presents us with an obvious anomaly. Why would those alleging the financial unsustainability of Canadian health care focus on the *public* insurance programs, on Medicare? Why would any rational person, concerned about cost escalation, advocate transferring costs from government budgets back onto patients, either directly or through increased private insurance contributions? On all the available evidence, accumulated across nations and decades, such a shift would almost certainly lead to *more* rapid escalation.

As the Yale political scientist Ted Marmor reminds us, “Nothing that is regular is stupid.” If apparently intelligent and well-informed people (in Canada and the United States) continue, in the teeth of all the evidence, to revive the argument that universal public health insurance is economically “unsustainable” and to advocate diversifying funding sources by increasing private payments, then presumably they have objectives other than cost control.

The Public Fisc—Still Afloat after Heavy Weather

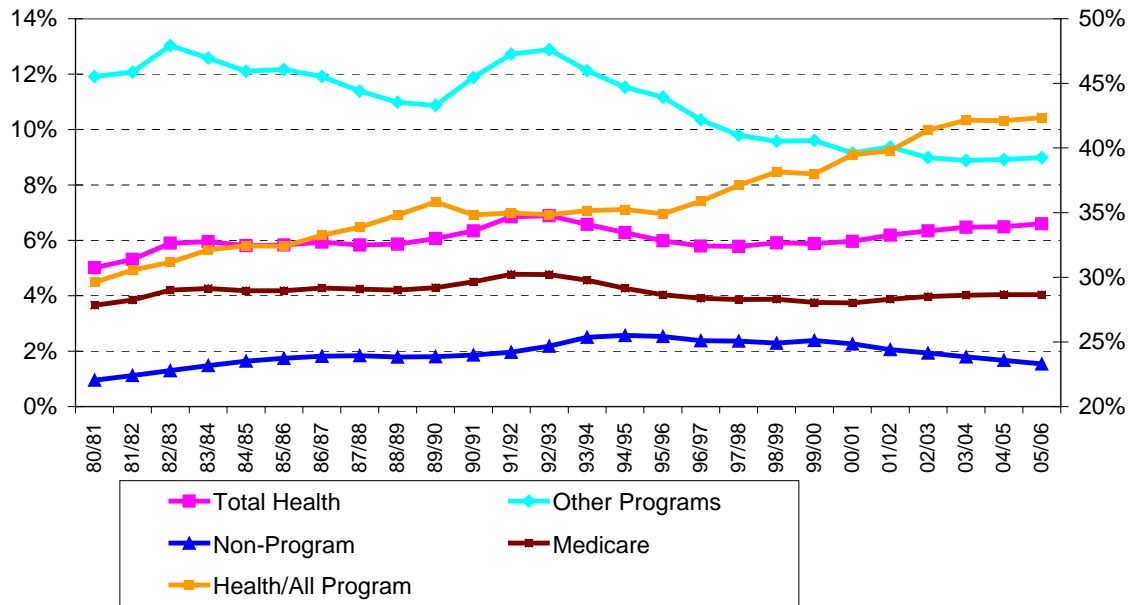
One line of explanation might be that for governments, and especially their treasurers, the GDP or its provincial equivalent is something of an abstraction. What is “real” (subject to the creativity of the public accountants) is the government’s own fiscal situation.

GDP patterns strongly affect that situation insofar as they translate into public sector revenues and expenditures. The 1982 recession ushered in a decade of continuing public sector deficits and growing debt and debt charges; the 1989-91 recession accelerated this fiscal deterioration and raised the spectre of actual bankruptcy for some provincial governments. The harsh public expenditure cuts of the 1992-1997 period, combined with subsequent more rapid economic growth, reversed this situation, generating substantial surpluses at the federal level and a falling aggregate public debt.¹³ But important as national income trends may be for the fiscal situation of governments, it is the public accounts for which they are accountable.

¹³ Canada’s ratio of national debt to GDP was in 2005 the lowest among the major industrial countries of the G7—26.3%. This ratio had fallen from its peak of 69.3% ten years earlier, and was on a steady downtrend.

In those accounts, provincial government expenditures on health care programs have over the last decade taken up a substantially increased share of total expenditures (Figure 7A, right scale).¹⁴ Between FY1995/96 and FY2005/06, health spending by all provincial (and territorial) governments in Canada rose from 34.9% of total program spending (i.e. net of debt service charges) to 42.4%. This trend appears to provide strong evidence that escalating health care costs in the public sector are increasingly crowding out other and important forms of public expenditure – clearly an unsustainable situation. Allegedly this problem can be addressed only by transferring costs from public to private budgets.

Figure 7A: Canada Provincial Government Expenditures as percent of GDP, 1980/81 to 2005/06



The story is more complicated, however, and the appearance is deceiving. A closer look at Figure 7A shows that there is something unusual about the eight-year period from FY 1995/96 to FY 2003/04, during which the health share climbed to 42.2%. During the seven-year period from FY1988/89 to FY1995/96, by contrast, there was no change at all in the ratio of aggregate provincial health spending to other program spending. Of particular importance, there has been effectively no change in the two years since 2003/04.

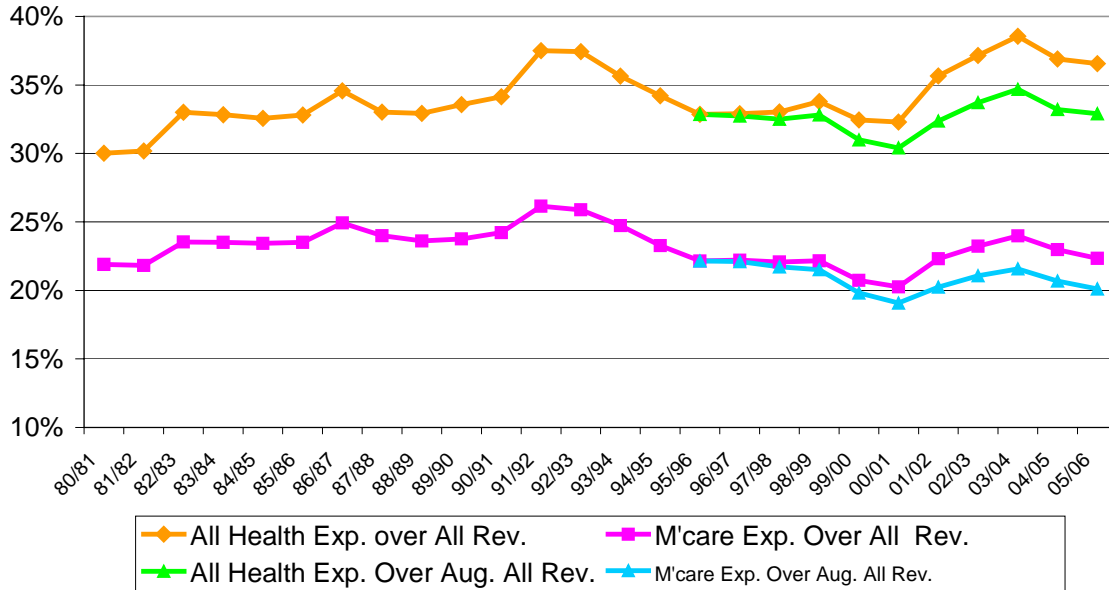
Moreover, if we look at total provincial government health spending relative to national GDP since 1995/96 (also in 7A) we see a much weaker upward trend. Provincial spending on the Medicare programs is in fact flat, taking up the same four per cent share of national income in 2005/06 as in 1995/96. Claims that public Medicare is “unsustainable” find no support in these data. [Provincial health spending on programs other than Medicare has been growing – we referred above to the escalation of prescription drug costs.]

It follows that provinces must have been cutting back on their non-health program spending, and as Figure 7A shows, they were. Provincial government spending on other programs took up a roughly constant share of national income from 1980/81 to 1995/96, between 11% and 12%. It has since fallen steadily, to 8.9% in 2003/04, and appears to have stabilized there. Yet this quite significant reduction was not driven by an “unsustainable” surge in health spending, because no such surge occurred.

¹⁴ Here and subsequently, FY data on provincial and federal public accounts are from the federal Department of Finance, Fiscal Reference Tables (Sept. 2006). FY health expenditures are from CIHI (2006).

A claim that health care is “crowding out” other programs could still be salvaged, if cuts to aggregate spending were being forced by a declining revenue base while political considerations made it difficult or impossible to impose parallel cuts on health. Other programs would then have had to bear more severe cuts because of the inflexibility of the health care programs as presently structured. But this would imply that health spending was rising as a share of provincial revenues as well as of program expenditures. In fact such an increase did take place, but had little or nothing to do with trends in health spending (Figure 7B).

Figure 7B: Canada, Provincial Government Expenditure on Medicare and on All Health Programs, as a Share of Total Revenue, with and without Tax Cuts, 1980/81 to 2005/06



Starting in 1996/97, several provincial governments introduced a variety of fiscal measures, including in particular reductions in their rates of personal and corporate income taxation. By 2005/06 the resulting net revenue foregone amounts to about \$28 billion, or nearly 15% of aggregate provincial government own-source revenues (excluding federal transfers). Had provincial governments not chosen to use the reviving economy as an opportunity to cut tax rates, the share of aggregate provincial revenues devoted to health care would in 2005/06 have been very slightly below its level in 1982/83, over twenty years previously. The proportion taken up by Medicare programs would have been below its level in any previous year reported in the Finance Canada Fiscal Reference Tables.

There is thus no basis whatever for a claim that health care is “crowding out” other provincial programs by taking up a growing share of provincial revenue. That impression can be sustained only by ignoring the fact that provincial governments, in aggregate, have deliberately lowered their revenue base through tax cuts.

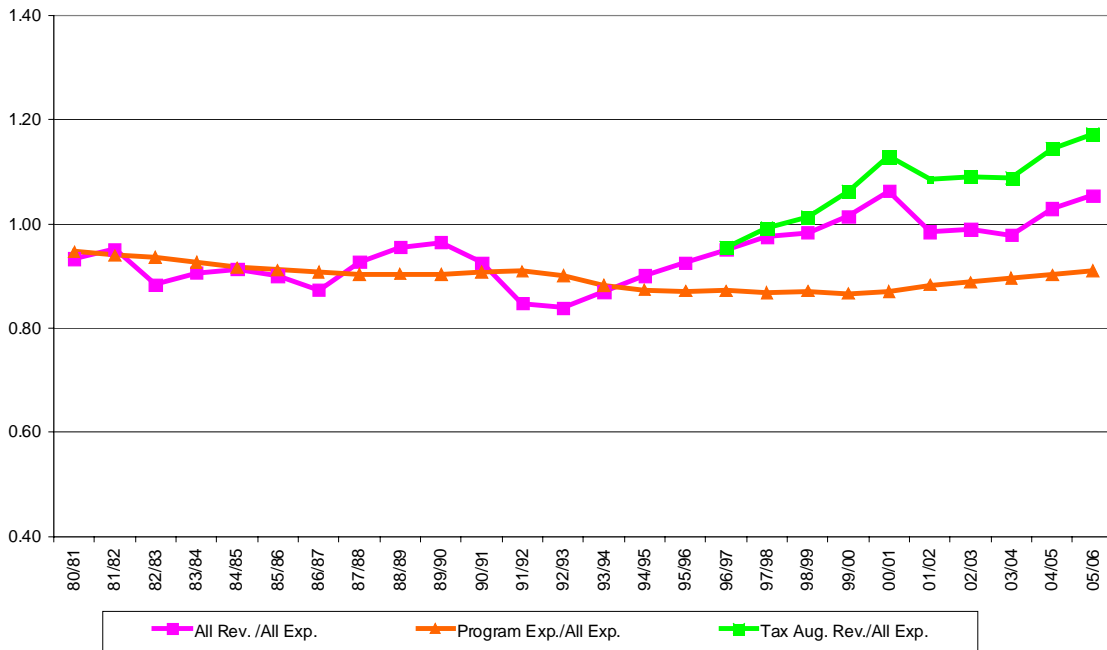
Despite these tax cuts, however, provincial spending on the Medicare programs is still a smaller share of provincial revenues that it was in 1982/83. Total health spending, which includes the costs of public pharmaceutical insurance programs, has risen, but the increase from 30.0% to 36.6% is not dramatic over twenty-five years, just over a quarter of a percentage point per year. And in any case most of that increase is accounted for by the tax cuts; abstracting from those the up-trend over twenty-five years in the share of provincial revenue devoted to health care is just over one-tenth of a percentage point per year.

Health spending does not appear to be placing an increasing strain, over the long term, on the provincial revenue base. The recessions at the beginning and end of the 1980s certainly reduced that base, and each resulted in, among other things, a jump in the proportion of total revenues going to health care. Since the

economic ground lost in those recessions was never really recovered, that ratio stayed up through the 1980s. In the 1990s, (politically difficult) cuts and rationalizations in the Medicare sector brought the ratio back to its long-term level, consistent with the now lower path of economic growth.

But if health spending has been taking a relatively stable share of revenue while increasing its share of program spending, then the ratio of revenue to expenditure must have been rising. And it was, for nearly a decade (Figure 8A). Provinces reacted to the recession of the early 1980s by running persistent deficits; the 1989-91 recession exacerbated their weak fiscal positions.¹⁵ By 1992/93 aggregate revenues were nearly 20% below expenditures (including debt service). This *was* unsustainable, and serious expenditure cutting began in both the health and non-health sectors. Figure 7A shows the corresponding downturn in both spending components, relative to GDP.

Figure 8A: Canada, Provincial Governments, Total Revenues over Total Expenditures, 1980/81 to 2005/06

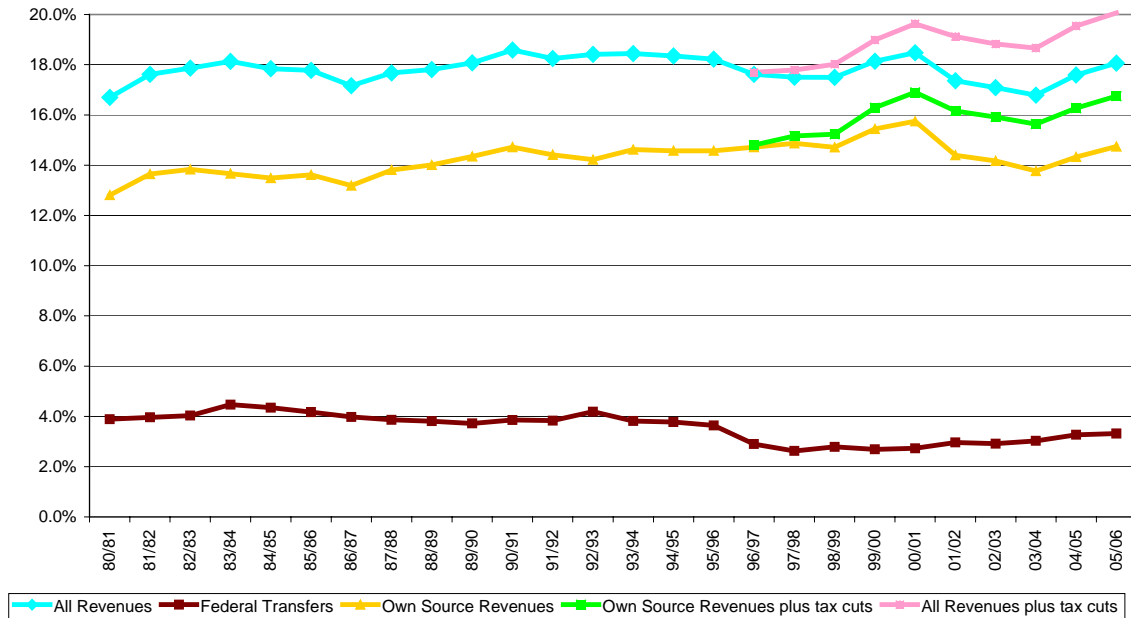


But the persistent deficits that were a hangover from the 1980s are long gone. The Canadian provinces, in total, moved into surplus seven years ago, in 1999/2000. In the absence of the income tax cuts and other fiscal changes that began in 1996/97, provincial governments budgetary revenues would now be nearly 20% above their expenditures. As it is, they are about 5% above. Correspondingly, the relative cost of debt servicing has been falling and, as shown in Figure 8A, program expenditures are rising as a share of total expenditures.

As Figure 8B shows, however, the tax cuts have in fact served to stabilize, not to depress, provincial own-source revenues relative to national GDP. The “income elasticity” of provincial revenue sources is apparently greater than unity, so that in the absence of the rate cuts provincial governments would be taking an increasing share of national incomes, and a share well above the long-run trend.

¹⁵ They may quite reasonably have anticipated a recovery to the long-run growth path, as in previous recessions. That did not happen.

Figure 8B: Canada, Provincial Government Revenue, Total and Components, as percent of GDP, 1980/81 to 2005/06



These aggregate surpluses, however, are not spread evenly. The unequal distribution of economic development and particularly of resource revenues results in very large disparities between so-called “have” and “have-not” provinces. While wealthier provinces have been cutting their tax rates, and driving the aggregate data, fiscally weaker provinces are still struggling to keep their heads above water. They are also under political pressure to compete in the “tax cut” game. The much-publicized “fiscal imbalance” in Canada is among the provinces, not between the provinces and the federal government.

Federal-Provincial Fiscal Relations—Of Course

There is another dimension to the story. The federal government transfers money to the provinces, both as “tax room”—tax rate reductions to permit provinces to raise their rates—and as block grants of cash, to help provinces support health, education and social welfare programs. These transfers are a source of continuing friction. Without delving into the fascinating arcana of federal-provincial fiscal relations, the critical point is that after a number of years of chipping away at the cash grants, the federal government introduced a major restructuring effective 1996/97 that consolidated several of them into one item—the Canadian Health and Social Transfer (CHST)—but significantly reduced the overall amount (Figure 8B).

Between 1995/96 and 1997/98, federal cash transfers fell by about \$5 billion, or nearly 20%, leaving a substantial hole in provincial budgets. Critics argued, with some justification, that the federal government was fighting its own deficit “on the backs of the provinces”. That federal fight was outstandingly successful: the Government of Canada has been recording surpluses ever since 1997/98 and, barring major recession (or major federal tax cuts), seems likely to do so for the indefinite future.

It is hardly surprising, therefore, that provincial governments have for a decade demanded restoration of the cash amounts unilaterally reduced through the introduction of the CHST.¹⁶ Rather than restoring the cash grants to their pre-CHST rate, however, the federal government began in 1998/99 to cut its own income tax rates. A substantial amount of new federal money has since begun to flow to the provinces, but as Figure 8B shows, this has not restored the previous relationship of federal transfers to GDP.

On the other hand the federal government seems to have taken the (also understandable) view that there was no benefit to either the health care system or its own political fortunes from transferring more revenues to provincial governments whose principal priority was cutting their own income tax rates. The government of Ontario, in particular, (ideologically at odds with the federal government during much of this period) had by 2003/04 cut a cumulative total of \$61.9 bn. out of its own revenue base.

The decline in federal transfers – relative to GDP – has meant that total provincial revenues have been a bit below their long-run trend. But by 2005/06 increases in these transfers, though not quite restoring the 1995/96 ratio to GDP, had brought total provincial revenues back to baseline.

Amid the continuing inter-governmental wrangling, one fact stands out. Between 1996/97 and 2003/04 the federal and provincial governments between them cut personal and corporate income tax rates so as to remove an estimated \$170.8 bn. from public sector revenues. By 2003/04 the annual public revenue foregone amounted to an estimated \$48.9 billion—over 60% of public sector expenditure on health care.

In summary, the Canadian federal and provincial governments have over the decade of the 1990s succeeded in restoring fiscal positions undermined by earlier unfavourable developments in the general economy. This process had two distinct phases. Prior to 1996/97, provincial health and non-health expenditures were both being reduced, relative to GDP. Since then there has been a resumption of the flow of public funds into health care, more or less in proportion to the rise in GDP, while the shrinkage of non-health programs continued into the early 2000s. Hence the rise, after 1996/97, in the share of health in provincial program spending, a rise that ended in 2003/04.

But the cuts to non-health programs after the end of the 1990s were no longer being driven by the need to balance provincial budgets. That job, difficult and important, had been done. The tax cuts after 1996/97 were a fiscal choice by right-wing governments in several of the larger provinces, a choice that then necessitated continuing expenditure cuts to maintain the fiscal balance previously achieved. Presumably finding it politically more difficult to make further cuts in the health care sector, these governments made deeper cuts to non-health programs. One could argue that in this way health care was in fact now “crowding out” other programs. But the source of the pressure was no longer fiscal exigency generated by poor overall economic performance, rather it was the political decision to take advantage of an improved fiscal situation to cut tax rates rather than to maintain spending on public programs.¹⁷

Governments are elected to make choices, fiscal and otherwise, and the provincial governments making these choices were duly and democratically elected. But it would be erroneous, and misleading, to claim that an unsustainably expensive public health care system has been the source of the pressure on other public programs. The argument that the health programs are economically “unsustainable” has no more basis in the public accounts than it has in the national accounts.

¹⁶ It is difficult to know how much of the rhetoric of “unsustainability” is simply part of the never-ending provincial campaign for larger federal transfers.

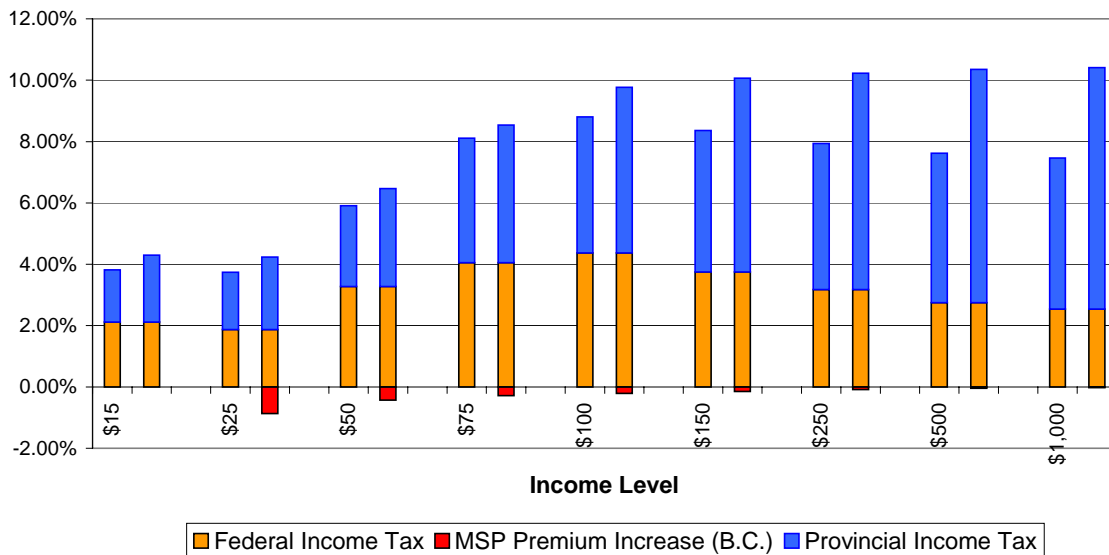
¹⁷ British Columbia initiated this process somewhat later than other provinces. Tax rates were slashed in 2001, creating a large budget deficit that was then eliminated over the next few years by essentially freezing total public spending. Since health spending continued to grow – slowly – other programs had to be cut back.

What’s the Real Issue? The Inegalitarian Agenda

So the anomaly remains. These data are perfectly well known in provincial and federal finance ministries; indeed these ministries are their source. They are not known to most of the public; that raises a whole other set of issues as to the role of the media during this period. (What politicians are aware of is always an open question.) So what *are* the real motives behind the claims of unsustainability?

An important clue lies in the pattern of some of the provincial tax changes. Figure 9 is calculated directly from the federal and provincial income tax schedules for single residents of Ontario and British Columbia. Between 1997 and 2002, individuals in both provinces with annual taxable incomes of \$15,000 and \$25,000 (and no other complications) had their tax liabilities reduced by about 4%, with roughly equal reductions in federal and provincial taxes. But the percentage reductions increase steadily with annual income, reaching nearly 9% (Ontario) and 10% (B.C.) at \$100,000. Beyond this point the federal reductions decline as a share of income, but the provincial reductions continue to increase. In Ontario these increases are quite small, and do not offset the federal decline. But in B.C. they do, reaching nearly 8% for a taxable income of \$1,000,000. At that level, after-tax income would be larger in 2002 by \$104,097 (\$78,754 from the province, and \$25,342 from the federal government). After-tax income at the \$15,000 level in British Columbia would rise by \$645 (\$327 provincial, \$317 federal). The comparable provincial amounts for Ontario are \$49,293 and \$255.

Figure 9: Income Tax Reductions in Ontario and British Columbia, 1997-2002, as percent of Taxable Income, by Income Level



Rate changes immediately introduced by the British Columbia government newly elected in mid-2001 account for most of the increased inequality of after-tax incomes. Later changes in other taxes reinforced this effect.¹⁸ British Columbia, like the neighbouring province of Alberta, also levies compulsory health insurance “premiums” (unrelated to risk status). Public coverage is not, however, conditional upon payment; the “premiums” are actually a form of poll tax. In May 2002 they were raised by 50%, or \$216 for a single individual.¹⁹ Figure 9 shows this premium increase as a proportion of taxable income; it offsets over one third of the income tax cut at \$25,000 per year, four per cent at \$100,000, and a quarter of a per cent at one million.

¹⁸ The provincial budget went from a \$1.4 bn. surplus in 2000/01 to a \$1.2 bn. deficit in 2001/02. A number of other fiscal changes were made, generally regressive in effect but not so directly linkable to income level.

¹⁹ The premium is discounted for those with incomes under \$25,000, falling to zero at \$15,000.

The Government of Alberta also increased its health care premiums in 2001, by about one third, but its approach to income taxation was even simpler. On January 1, 2001 Alberta introduced a provincial “flat tax” of 11% of taxable income above a basic exemption level, substituting for the previous percentage of the (relatively progressive) federal liability. This approach twists the whole tax schedule above the basic exemption level to decrease the relative burden on the wealthy and increase it on middle incomes.

In all three provinces, the higher the income, the greater the percentage gain from income tax reductions. In addition, the cuts to public expenditures imposed in these provinces along with a variety of additional fees for public services were significantly regressive in their impact.²⁰

One has to conclude that these provincial governments were pursuing, for whatever motive, a quite deliberate agenda of regressive income redistribution.²¹ Nor are they alone. Historically Canadian governments have significantly mitigated, through taxes and financial transfers, the degree of income inequality that is generated in the market-place (Wolfson and Murphy, 1998). Changes since the mid-1990s, however, appear to have reduced this buffering effect, and post-government income inequality is now on the rise (Sharpe, 2003; Statistics Canada, 2003).

Taxes and transfers are, however, only part of the process by which governments influence the distribution of economic well-being. Expenditure programs, such as public education and health care, also play a major role in detaching benefits from ability to pay. In all public health insurance systems (at least in the high income, industrialized countries) people in the upper income brackets subsidize (on average) the care of those lower down, while at the same time the relatively healthy subsidize the care of the comparatively unhealthy. There is no other way to maintain a modern health care system – at least none is known.

There is, however, considerable variation among national systems in the nature and extent of this subsidization. The Canadian Medicare programs, covering hospital and physicians’ services, are almost entirely financed from general taxation and provide care “on equal terms and conditions” to the whole resident population. In the United States, in sharp contrast, people of different incomes receive care on very different “terms and conditions” depending upon their employment status, age, and ability to pay. Most European systems make care available on more or less equal terms and conditions to the whole population, but several (unlike Canada) permit providers within the public system to sell, to those willing and able to pay, more timely access to a perceived higher standard of care. Purchasing these advantages for themselves, the better-off are not required to contribute to a similar standard for the rest of the population. The payments go into providers’ pockets. These two features underpin all arguments for “two tier” care.

The distribution of the cost of public health care across the population varies considerably among these national systems (Wagstaff et al., 1999; van Doorslaer et al., 1999). Financing raised through direct taxation tends to distribute the burden more or less proportionate to income, indirect taxation is more regressive, and social insurance programs can be either more or less proportional to income (France) or quite steeply regressive (Germany, the Netherlands) depending upon their structure. But private payment, whether through private insurance or directly out of pocket, is by far the most regressive. Low-, middle-, high-, and very high-income people pay the same amounts for the same services, but these payments represent very different shares of their respective incomes.

Since health is correlated with wealth, on average lower-income people would pay an even larger share of their incomes for health care through private payment – if they were to get equal service for equal need. But of course they do not. Higher-income people spend more on health care through private payments, and get more

²⁰ A *regressive* tax takes a larger share of the incomes of people lower down the income distribution, and rests more lightly on those with higher incomes. A *progressive* tax, by contrast, takes a larger share of the incomes of those with higher incomes.

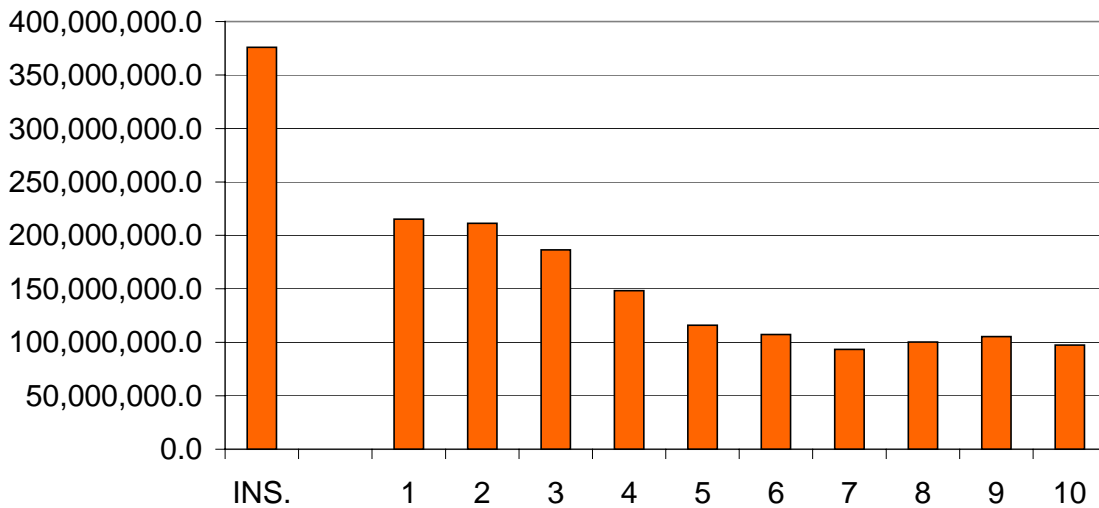
²¹ This agenda was spelled out explicitly by Conrad Black (2001) in an editorial bitterly critical of Canadian governments for “... taking money from people who have earned it and redistributing it to people who haven’t.” As owner at that time of most of the major newspapers in Canada he had taken the opportunity energetically to promote his personal political views. At time of writing Lord Black is on trial in Chicago, charged with fraud and racketeering; his concept of “earning” may therefore be somewhat idiosyncratic.

services, but spend a much smaller share of their incomes in this way. This pattern is similar for both private insurance and self-payment, because private insurers in a competitive market must set their premiums in proportion to the estimated risk of the insured. For equivalent coverage, healthier people will pay less, regardless of their incomes, and sicker people will pay more.

The distributional impact of public, tax-based financing of Medicare in Canada is dramatically illustrated in Figure 10 drawn from a unique study in Manitoba (Mustard *et al.*, 1998). For a sample of about 40,000 Manitobans, individual-level data on the costs of hospital and physicians services paid by the public programs were linked with corresponding individual (actually family) level income data from the Canadian Census. These records were then anonymized, expanded to represent the entire population of Manitoba, and grouped into income deciles of roughly 105,000 persons each.

Figure 10A shows that total provincial expenditures for the care of persons in the lowest income decile were just over \$200 million in 1994. These costs fell, for successively higher income deciles, until the middle of the income distribution. From the fifth decile upwards, public expenditures were roughly \$100 million in each decile or in round figures \$950 per person – on average. There would of course be a great deal of variation in individual costs among the members of each decile, some generating very high costs and others none. But above the middle of the income spectrum there appears to be no systematic relation between expenditures and income. In the lower half of the income distribution, by contrast, health care needs – or at least use, rise as income falls.

Figure 10A: Expenditures on Publicly Financed Health Care, by Income Decile, Manitoba, 1994



The INS category are persons who are permanently institutionalized. This group – about 18,000 people – accounted for about \$375 million in public outlays or roughly eleven times the per capita costs of people in the lowest income decile of the non-institutionalized population.

Figure 10B shows the estimated tax contributions – income and sales, of persons in each decile. These are much more skewed than the utilization of care, with people in the top decile contributing about \$470 million to the maintenance of the public health care system while those in the bottom decile contributed less than \$50 million. Contributions rise steadily by income decile, as one would expect; the large jump at the top decile, almost doubling from the next highest income band, reflects the extent of concentration of income at the top

end.²² (Since 1994 before-tax incomes in Canada have become considerably more unequal and concentrated among the highest earners.)

Figure 10B: Tax Contribution to Health Care, by Income Decile, Manitoba, 1994

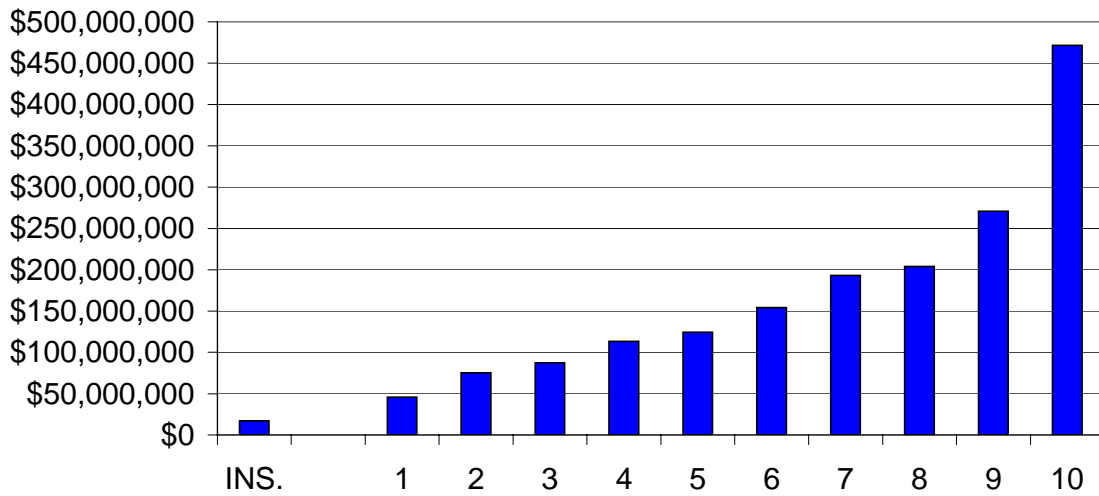


Figure 10C shows the obvious calculation, subtracting decile-specific tax contributions from the value – or at least cost – of care received. Figure 10D then converts this net dollar benefit or cost into the proportion of consumable income (net of income and sales taxes) received in each decile. (The INS population are excluded because their incomes are so low that they would blow up the scale.)

²² The share of market income paid in taxes is about 10% higher in the top decile than in the next highest, so the overall progressivity of the tax system accounts for part of the jump—but not much.

Figure 10C: Net Transfer to/from Income Decile, Public Financing of Health Care, Manitoba, 1994

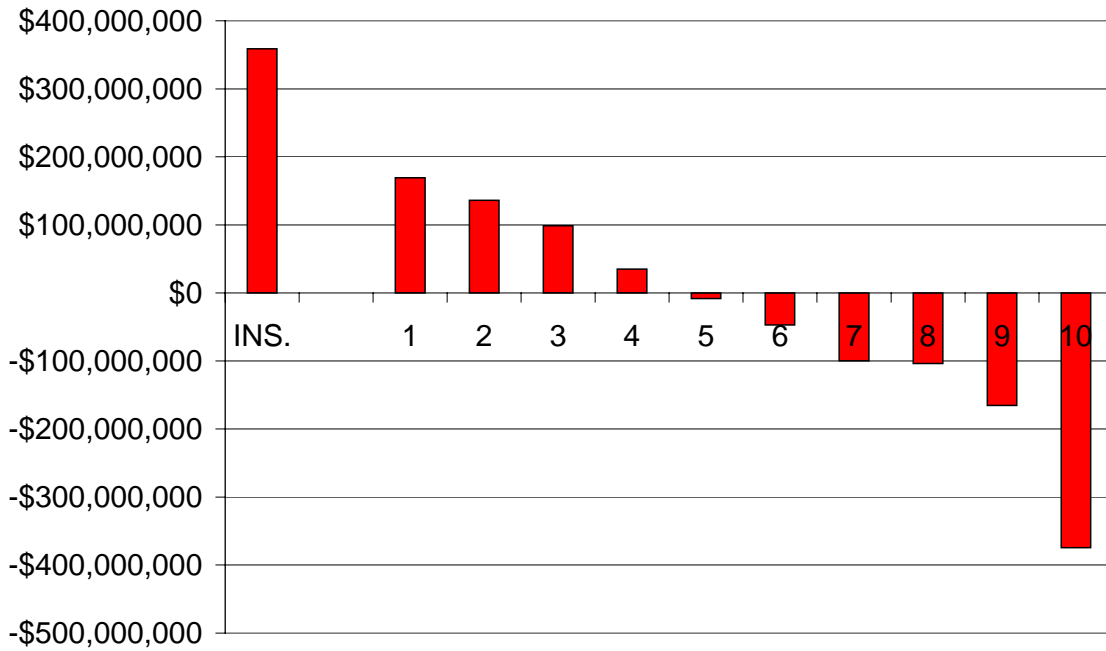
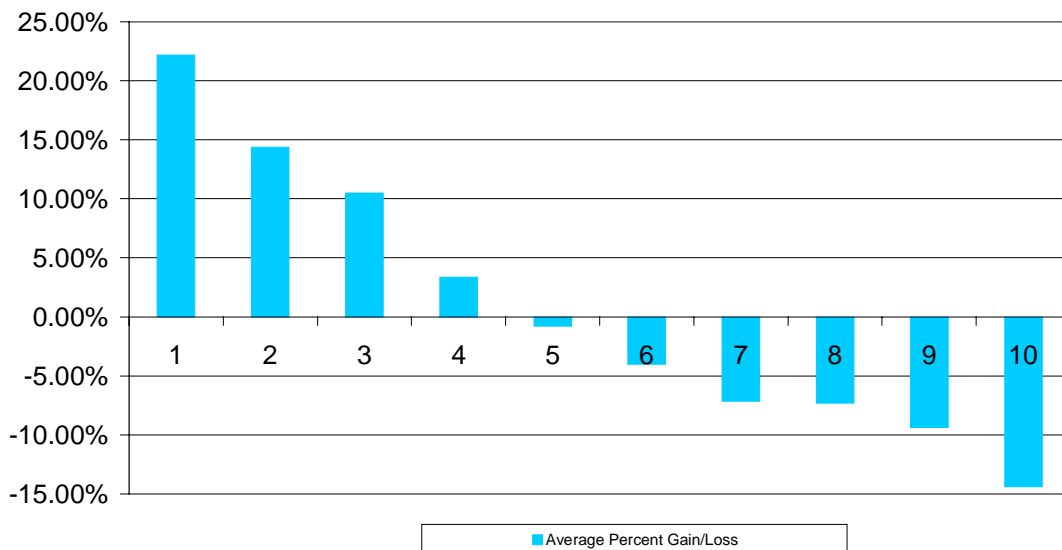


Figure 10D: Net Transfer by Income Decile, as Share of Consumable Income, Manitoba, 1994



In 1994 the roughly 105,000 Manitobans in the top decile contributed about \$380 million to the financing of the health care system, or about \$3,600 each, over and above the cost of the services they used. Coincidentally, this almost exactly equaled the cost of caring for the permanently institutionalized population. The second-highest decile contributed half as much net, about \$1,670 each, and the fifth decile broke even. These net contributions cost those in the top decile just under 15% of their consumable incomes, while augmenting the incomes of those at the bottom by about 22%.

Whether these financial transfers across the income distribution are fair or unfair is a matter for political or ethical judgement. What should be obvious, however, is that they exist, are large, and are a potent source of political debate. In particular, as a matter of simple arithmetic, any shift away from tax finance toward more private insurance or user charges would shrink each of the bars in each of these charts toward the horizontal axis. People in higher income deciles would contribute less, those in lower income deciles will contribute more. (As well, of course, the healthy will gain at the expense of the users of care.)

Thus the “private/public” debate about financing sources is, in all modern health care systems, fundamentally a debate about Who Pays? and Who Gets? The Canadian universal tax-financed system requires higher-income people to contribute more to supporting the health care system, without offering them preferred access or a higher standard of care. Any shift toward proportionately more private financing would reduce the relative burden on people with higher incomes and raise it farther down the spectrum. Insofar as private payments may also limit access by people with lower incomes, private finance also opens better access for those willing and able to pay. Relative to universal, fully tax financed public insurance, an expansion of private payment would thus enable the wealthy to pay less (in charges, private premiums and taxes) and get more (in volume, quality, and/or timeliness). And conversely for those with lower incomes. This conflict of economic interest is real, unavoidable, and permanent in all systems, which is why the “public/private” debate is never resolved (and why it is typically so occluded with “econofog” about how more private financing can make everyone better off).

Cutting across the income spectrum there is a third equally deeply entrenched conflict feeding the endless “public/private” financing debate – “Who Gets Paid?” and how much.

Private insurance systems, for example, incur heavy administrative costs to identify relative risks and set corresponding premiums, to market policies, and to adjudicate and pay individual claims, as well as to reward investors and (sometimes spectacularly) senior executives. These overhead costs absorb between 15 and 20% of the revenues of Canadian private insurers. In addition there are substantial costs imposed on providers of care and beneficiaries or their representatives, in negotiating with insurers and trying to ensure that claims are in fact paid.

In the United States, these overheads were recently estimated (Woolhandler et al., 2003) at 31.0% of total health care expenditure in 1999. In a universal public system most of these costs vanish; the comparable estimate for Canada was 16.7% and that includes extensive private insurance for dentistry and drugs. The *excess* administrative costs in the United States were estimated at \$209.0 bn. or 17.1% of total American health expenditures. But all these billions represent income for insurers, benefits managers, and administrative and financial staff in hospitals and clinics. In a universal public insurance system, most of these jobs would not exist.

Payments to care providers raise exactly the same issue. Insofar as public single-payer systems have been relatively more effective in controlling overall costs (particularly prices) of health care, they have to the same extent controlled the incomes of providers. Hence the intense opposition to such coverage in North America from economically motivated providers, most notably the for-profit pharmaceutical industry. Again the conflict of interest is real and fundamental. For a firm whose products have high fixed costs of development and are sold at prices far above variable cost, any reduction in prices comes straight off the bottom line.

Not all providers thrive in a private funding system. Health and wealth are correlated; a high proportion of costs are generated by a relatively small proportion of people with above-average morbidity and below-average incomes. The income base of the provider community as a whole depends on a high proportion of public funding. Even in the “private” United States, about 60% of health care expenditure comes directly or indirectly

from public funds (Woolhandler and Himmelstein, 2002). But a multi-source financing system, with supplementary private financing and public sources that are indirect and difficult to control, provides the best income opportunities for providers – i.e. higher health care expenditures.

Political Wolves Masquerading as Economic Sheep

These embedded conflicts of economic interest over “Who Pays?, Who Gets? and Who Gets Paid?” play roles in the framework of Figure 1 analogous to tribal, ethnic or religious divisions. They are always present, but tend to flare up into more intense and self-reinforcing political conflict under economic stress. Such conflicts may pose a real threat to the sustainability of Canada’s Medicare. But it is a threat from private interests pursuing a redistributive agenda, rather than from expenditures outrunning public resources.

The relative deterioration of the economic environment in Canada since 1981, with its particularly powerful impact on the public fiscal situation, has resulted (among many other things) in a number of relatively successful efforts to “do more with less”.²³ On the other hand a number of policy proposals for structural “reform” represent in reality the application of ingenuity to redistribute burdens and benefits – to eat the other fellow’s lunch. Efforts to promote – and to expose and combat – such “re-forms” distract from the very real needs for improved system management and adaptation to a less favourable environment.²⁴

The wealthy in the modern world may be increasingly reluctant to accept a single standard of care for the whole population, with no preference for themselves, while contributing a relatively larger share of the cost. Private financing quite genuinely offers them “more, for less”, while offering the rest of the population “less, for more”. It may lead to a less efficient and more expensive system overall, through increased overhead costs, weaker control over prices, and reduced potential for managing care patterns. Diversion of care from those with greatest needs to those with greatest resources will result in a less effective distribution of services. But the wealthy still come out ahead.

It also appears that in several countries, including Canada, political systems have become increasingly sensitive to the priorities of the wealthy, for reasons well beyond the scope of this paper. Claims that Canada’s Medicare is economically or fiscally unsustainable represent part of a broader propaganda campaign to advance those priorities, “softening up” a generally skeptical and unsympathetic public to accept that the current form of public health insurance (which most Canadians still strongly prefer) is simply impossible to maintain. The agenda has been advanced by right-wing governments in the larger provinces, with sympathetic coverage from the country’s dominant newspaper chain. In these circumstances the political sustainability of the public system is very much an open question. But the claims of *economic* unsustainability appear from the data to be themselves wholly unsustainable.

That Was Then, This Is Now?

Or are they? Unsustainability is a claim about the future, not the past, and that claim is buttressed by current fiscal projections showing public health care spending growing much faster than provincial revenues. As noted above, the most recent data do show a resumption of more rapid rates of cost escalation. Is there now a real economic wolf at the door?

The future is an uncertain place, and all forecasts will be falsified. But why should the future be different from the quite sustainable past? A standard triad of reasons is typically offered – and has been for decades. They are classic examples of “Zombies” – ideas and arguments that are intellectually dead but will not stay buried (Evans et al., 1994; Barer et al., 1998). They are repeatedly disinterred to advance interests that are very much alive.

²³ The spread of “managed care” in the United States during the 1990s can be similarly interpreted as the application of ingenuity to deal with an increasingly unsatisfactory environment – somewhat less successfully.

²⁴ Medical Savings Accounts provide a leading example. They would serve no useful purpose in the Canadian context, merely providing a cover for increases in both user charges and health expenditures. But de-bunking the claims of their advocates has taken up a significant amount of research effort (e.g. Hurley, 2000; Forget et al., 2002), and diverted public attention from more constructive topics.

The triad consists of interlinked claims about trends in demography, technology, and public attitudes, each asserted to be generating increasing needs or demands (the distinction is typically fuzzy) for increasingly expensive health care. Aging populations have greater needs; advancing technology creates ever more expensive possibilities for intervention; and “public expectations” of the health care system are ever increasing. People just want more, and want it now. But (it is further asserted) no government can afford to meet these ever-expanding needs/demands. So we should, indeed must, limit the public liability, and let those who can, buy more for themselves if they wish. There is really no alternative. QED.

When one unpackages these broad generalities, however, and looks at the actual data, a very different picture emerges.

The zombie of the aging population, a.k.a. “apocalyptic demography,” has been studied in particular detail. The average age of modern populations *is* rising. And, on average, elderly people *do* have greater health needs and generate greater costs. But it is *not* true that these patterns will place an unsustainable burden on public health care systems. Holding age-specific per capita use and cost rates constant, Canadian population forecasts indicate a rise in per capita costs of about one per cent per year – well within the range of prevailing rates of economic growth.

And well below observed rates of growth of expenditures. Use and cost are primarily driven not by changing age structure, but by changing patterns of care use – what is done to and for patients. These patterns obviously respond to the evolution of scientific knowledge and technical capacity, but the link is neither simple nor direct (Bassett, 1996). New technologies may be inherently either cost-enhancing or cost-reducing – there are many examples of each – but it is the way in which they are taken up and applied that determines their impact on costs. That process of up-take and application is primarily controlled by clinicians (subject to available capacity), and the cost-enhancing bias of technology arises *inter alia* from the economic incentives that they face.

There is extensive evidence of the provision of questionable or simply inappropriate services, old and new, at unnecessarily high cost. But efforts to evaluate outcomes, eliminate ineffective or questionable practices, and restrain the exuberant proliferation of interventions have typically met indifference from clinicians, if not active resistance. Apart from issues of professional autonomy and pride (and the urge to “do something”), this reaction has roots in the ineluctable reality that cost containment must always threaten someone’s income.²⁵

The potential for transferring a large proportion of inpatient care to ambulatory or day care facilities, for example, has been well documented in Canada since the early 1970s. But large-scale uptake was slow until the rigorous budgetary restraints of the 1990s. The transfer eliminated jobs; widespread claims of “underfunding” and threats to patient health have not been substantiated.²⁶ If substantial additional funds flow into the health care system, the incentives for improved efficiency are relaxed.

The clearest examples of inappropriate and excessively costly choice of intervention can be found in the pharmaceutical sector. The principal driver in Canada of rapid cost escalation is the replacement of older, off-patent drugs with new patented ones at prices that may be ten times higher. These are marketed as superior, but the regulatory process does not require new drugs to be tested against those they will replace, only against placebo. In some major trials high-profile (and high cost) new drugs have shown no additional benefits (e.g. Furberg et al., 2002; Rosssouw et al., 2002). Large additional expenditures, stimulated by intense marketing, are in effect buying nothing.

But what about public demand for the newest and the best, at any cost? Again the pharmaceutical experience is instructive. Manufacturers have always engaged in intense and highly sophisticated marketing, primarily targeting physicians. American pharmaceutical manufacturers – for whom data are available – now spend twice as much on marketing as on research (Families USA, 2001).

²⁵ Accordingly, when technologies emerge that are both therapeutically superior and less costly per patient treated, they are often associated with rapid proliferation – and increased total cost.

²⁶ A similar pattern was observed in the United States when the Prospective Payment System was introduced in 1983. Patterns of care respond to economic incentives.

More recently the industry lobbied successfully to eliminate American regulatory restrictions on advertising directly to the public, and is now spending over \$4 bn. annually to manipulate public expectations. Such advertising does change physician prescribing behaviour (Mintzes et al., 2003) – why else would a for-profit industry spend the money? Canada’s ban on advertising prescription drugs directly to patients is now facing a constitutional challenge mounted by the communications conglomerate CanWest Global, with an obvious interest in, and only in, the potential advertising revenues. (There is no evidence of a groundswell of supportive public opinion!) In this environment, to speak of “public expectations” as if they represented independent consumer choices is at best dangerously naïve, and at worst deliberately deceptive.

Managing patient expectations has always been a significant part of the professional role. The difference between a physician and a for-profit firm is that the former is responsible for the health of patients, the latter for the earnings of shareholders. In both cases expectations management has very significant effects on trends in health expenditures, but those effects depend on the incentives created by the institutional environment in which the process takes place. That environment is determined by public and private policies and is always politically contested – as the pharmaceutical example makes clear.

Such matters as technology assessment, medical practice guidelines, and efforts to promote the practice of “evidence-based medicine” are highly political, interacting with the economic incentives embodied in the different structures for reimbursing physicians and hospitals. Medical and other professional associations and unions take a very active interest in these matters; advancing the economic interests of their members is one of their principal responsibilities. The recent growth in Canadian health care costs includes some very successful physician fee bargaining. To pretend that trends in health care use and costs are determined by impersonal forces external to the industry itself is just that, a pretense.²⁷

Whether or not the recent rise in Canadian Medicare expenditures presages a period of more rapid longer-term escalation is thus a critical question, but the answer does not depend upon external forces. Rather it will, as in the past, depend on the outcome of political and administrative contests between those who pay and those who are paid for delivering or financing care. Projecting cost trends is akin to predicting the outcome of the Stanley Cup; there is certainly relevant information, but it is not a scientific exercise.

Private Morality, Public Choices—and Consequences

And in the end, though it looms large in the public debate, the question of “sustainability” may not be about expenditure trends at all. Reinhardt (2001) argues that it is actually a moral issue, a debate about what the members of a society owe to each other.

To illustrate, suppose the argument above is incorrect, and we *are* in fact entering a new era in which advancing medical technology really does offer dramatic improvements in health – at dramatically increased expense. Citizens might quite rationally accept this bargain. Health care spending would then rise as a share of GDP – why not? [That is exactly what happened in Canada when universal public hospital insurance was introduced; there was consensus (rightly or wrongly) that more spending would produce better health for everyone.] At root, the arguments for cost containment have always been about seeking value for money, containing price inflation and paring away waste, not about foregoing effective care.

But who should pay, and who should get the care? Under public insurance, the burden would fall on taxpayers and the benefits would go to patients. Government expenditure on health care would rise, as would taxation. The claim that such increases would be “unsustainable” 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

²⁷ “...the Pharmaceutical Research and Manufacturers of America, known as PhRMA, will spend at least \$150 million in the coming year.” on political lobbying activities including “... spend[ing] \$1 million for an *“intellectual echo chamber of economists — a standing network of economists and thought leaders to speak against federal price control regulations through articles and testimony, and to serve as a rapid response team.”*” and “allocates \$1 million *“to change the Canadian health care system”*” (Pear, 2003; italics are quotes from industry documents).

higher standard of care for themselves, should not have to contribute, through taxation, to support a similar standard for others.

This moral position does not appear to be widely shared by the Canadian public. Nor can its advocates credibly claim that governments “cannot afford” such increased expenditures, while simultaneously advocate and carrying through substantial cuts to income taxes. Considerable ingenuity must therefore be devoted to finding general harms from an expanded public sector.²⁸ This ingenuity might more constructively be directed toward improving the efficiency and effectiveness of the health care system. But those who allege unsustainability largely ignore the evidence on waste and inappropriate care, and implicitly or explicitly also allege “underfunding” – thus coming into alliance with provider interests.

Reinhardt’s (2001) comment on the United States Congress is worth quoting:

“That no one in the U.S. Congress shows much interest in the glaring inefficiencies that could easily be addressed within the current Medicare program [in the U.S., covering only those 65 and over] speaks volumes about the true, but hidden, agenda that actually drives the quest for privatizing ... Crisply put, the objective is to shift responsibility for health spending on older persons from the general taxpayer onto the older people themselves...” (p.201)

Canada’s universal system has done a much better job of mobilizing ingenuity to deal with these “glaring inefficiencies”, but a much better job than the U.S. still leaves much to be desired. More significant reforms continue to be stalled by the political struggles over “Who Pays?” “Who Gets?” and “Who Gets Paid?” Claims that the Canadian public system is both economically unsustainable and underfunded seem driven by the same agenda that Reinhardt identifies in the U.S. – containing public outlays while letting private expenditures go where they will. Such a mixed system would be more expensive and less efficient overall, escaping the price restraints imposed by the public single payer and bearing significantly increased administrative overheads. But it would be better for the wealthy.

Hence Reinhardt’s assertion that “sustainability” is actually a moral issue, of defining the mutual obligations of the members of a community. Public choices are private morality writ large. There *is* a wolf at the door of the Canadian Medicare system. But it is a political wolf dressed in phony economic clothing to deceive the sheep.

²⁸ Economists have been particularly helpful in this quest, being ingenious in providing rigorous demonstrations – from faulty assumptions – of the general benefit from smaller government and greater inequality. This ingenuity can be well rewarded.

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