

Getting What We Pay For:

Myths and Realities about Financing Canada's Health Care System

A background paper

by

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Table of Contents

Executive Summary	I
Introduction	1
Defining Our Terms: Elements of Health Care Systems and the Public-private Mix	1
Public and Private	2
Basic Economics and the Concept of Medical Necessity	4
Funding Flows	6
The Nature of Insurance	8
The Canadian System	10
What Is Covered: The Comprehensiveness Dilemma	12
Health Spending in Canada	15
The Role of the Federal Government: The “Shares” Debate	22
The Public Share of Health Care Spending	27
The Myth of Health as an Ordinary Market Good	31
The Myth of Canada as “Socialized Medicine”	33
The Myth of Canada as the Most Publicly-funded System	34
The Myth of Medical Savings Accounts	35
The Myth of User Fees	37
The Myth of Strengthening the Public System by “Freeing up Resources”	39
The Myth of the Federal Government	40
The Myth of “Affordability” Requiring More Private Money	41
What Does Need Fixing?	43

List of Figures

Figure 1: The Two-way Flow	6
Figure 2: The Three- Way Flow	7
Figure 3: The Four-way Flow	8
Figure 4: Canadian Health Spending in Million \$, 1975 to 1999	16
Figure 5: Canadian Health Spending in 1992 \$ per Capita, 1975 - 1997	17
Figure 6: Health Spending as a % of GDP in Three Countries	18
Figure 7: The Transition to <i>EPF</i>	24
Figure 8: Federal Health Transfers in 1986 \$ per Capita	25
Figure 9: Public Share of Canadian Health Spending	28
Figure 10: Provincial Health Spending, Current Dollars “Cost-shared” (Hospitals + Physicians) Vs. “Non-cost Shared”	29
Figure 11: Provincial Spending Is Quite Similar	30

List of Tables

Table 1: Total Expenditure on Health as a % of Gross Domestic Product	19
Table 2: Total Expenditure on Health per Capita, in US Dollars	21
Table 3: Public Expenditure on Health as a % of Total Expenditure on Health	27

Executive Summary

Canadian Medicare is, once again, under attack. Despite being wildly popular among Canadians, and internationally admired, our system of universal insurance for “medically necessary” hospital and physician services is being dismissed by critics as old-fashioned, unsustainable, economically unfeasible, and otherwise out of step with our new global times. The newspapers are full of announcements of “privatization” of hospital care in Alberta, accusations that “we already have two tier medicine” and might as well finish the job, and seemingly erudite pronouncements that we must choose between “maintaining equity” and economic good sense. Too often, however, these criticisms result from some fundamental confusions about both concepts and evidence. In consequence, they often misinterpret the actual problems with Medicare. Just as physicians cannot treat without an accurate diagnosis, healing Medicare requires that we be clear in defining our terms.

This paper provides some background information about public and private places within our health care system. It begins with some concepts and definitions, including:

- the distinction between how we *finance* a health care system and how we choose to *deliver* care;
- the various levels within “public” and “private,” and, more specifically, the difference between *for-profit* and *not-for-profit* delivery;
- the ways by which funding can flow between those who finance care, and those who deliver it;
- the nature of insurance, and the concept of “risk selection.”

It then moves to a consideration of the Canadian system, and an analysis of data about health spending. It uses the definitions and data from the Canadian Institute for Health Information (CIHI) for within-Canada comparisons, and data from the Organisation for Economic Cooperation and Development (OECD) to compare Canada with 21 other developed economies. Scrutiny of this data reveals the need for more careful interpretation of Canadian health spending. In particular, several commonly voiced beliefs are not supported by the data. Contrary to current rhetoric, we found:

- Canadian health spending is not particularly high in international terms.
 - The commonly-employed measure, health expenditures as a proportion of Gross Domestic Product (GDP), reflects both health spending, and the strength of the economy. The well-publicized fact that Canadian health spending as a % of GDP had risen to 10.1% by 1993, ranking 2nd in the OECD, reflected the stagnation of the economy (a “denominator effect”) rather than excessive spending for health care services. As that interpretation would predict, improved economic times has dropped Canada’s spending to 9.1% by 1997, and a 5th place ranking.
 - Measured in terms of actual spending in US dollars per capita, Canada would have ranked in 9th place in 1993 (rather than 2nd) and fallen to 14th place by 1997.
- Private-sector spending is increasing more rapidly than is public-sector spending, with almost all recent cost increases arising from the privately funded sector.

- Canadian health spending is not out of control
 - At first glance, Canadian health care spending, measured in current dollars, has indeed increased steadily between 1975 and 1999. However, this is not true once we adjust for inflation and population growth. Even without taking account of increased needs resulting from such factors as the aging of the population, the increased scope (and costs) of new technology, or any excess inflation within the health care sector, Canadian health spending per capita, as measured in 1992 dollars, has been *decreasing* between 1992 and 1997, the last year for which inflation adjusted data is available.
- The federal government's share of provincial health care spending is far higher than has been argued by provincial governments. It is commonly argued that federal contributions have dropped from 50% to somewhere between 9% and 13% of provincial health expenditures. This is seriously misleading. Creative accounting has adjusted both the numerator and denominator of this ratio:
 - As far as the numerator (federal share), in 1977, the old cost-sharing arrangements for hospital insurance, medical care insurance, and post-secondary education had been combined into a single transfer, *EPF*, which was made up of both cash and tax points, meaning that the baseline for federal cash transfers should be considered 25% of matched spending, not 50%. In 1996, this was transformed to the Canada Health and Social Transfer (CHST), which also added in the health and welfare programs formerly funded under the Canada Assistance Plan. Since 1977, these transfers have all been part of provincial general revenues, and provincial governments are free to determine how to spend them, further complicating the task of determining what was contributed for health. However, creative accounting has cut the imputed transfer at least in half by ignoring the yield from tax points.
 - As far as the denominator (provincial health expenditures), under the old cost-sharing arrangements, the federal government matched spending only for hospitals and physicians. These amounted to about 65% of provincial health expenditures in 1997. Creative accounting assumes that all such expenditures would have been matched. Taken together, the federal share is at least three times what popular rhetoric has claimed.

Several myths are then addressed:

- the Myth of Health as an Ordinary Market Good
- the Myth of Canada as "Socialized Medicine"
- the Myth of Canada as the Most Publicly-funded System
- the Myth of Medical Savings Accounts
- the Myth of User Fees
- the Myth of Strengthening the Public System by "Freeing up Resources"
- the Myth of the Federal Government
- the Myth of "Affordability" Requiring More Private Money

We conclude by arguing that several elements of the Canadian system indeed need fixing, but that private financing of medically necessary care would severely damage the system, without fixing the real problems.

Introduction

Canadian Medicare is, once again, under attack. Despite being wildly popular among Canadians, and internationally admired, our system of universal insurance for “medically necessary” hospital and physician services is being dismissed by critics as old-fashioned, unsustainable, economically unfeasible, and otherwise out of step with our new global times. The newspapers are full of announcements of “privatization” of hospital care in Alberta, accusations that “we already have two tier medicine” and might as well finish the job, and seemingly erudite pronouncements that we must choose between “maintaining equity” and economic good sense. Too often, however, these criticisms result from some fundamental confusions about both concepts and evidence. In consequence, they often misinterpret the actual problems with Medicare. Just as physicians cannot treat without an accurate diagnosis, healing Medicare requires that we be clear in defining our terms.

This paper will accordingly begin with a discussion of, in effect, the anatomy and physiology of some key elements of any health care system, before turning to the Canadian context. It will then turn to an analysis of some common complaints, and examine some commonly-suggested folk remedies, to see which are likely to help, and which would be likely to make things worse. Because the critique is usually posed in economic terms, we will obligingly follow suit. For Canadian Medicare is a triumph not only because it has helped to ensure that people who need care have access, regardless of their financial means. It also makes economic good sense. And the very real problems, in some sense, have arisen less from within Medicare, than on its boundaries.

Defining Our Terms: Elements of Health Care Systems and the Public-private Mix

Although we commonly speak of a “health care system,” it is important to recognize that we are usually focused more narrowly upon care for people who are (or are at risk of becoming) ill¹. Clearly, medical care is only one small part of what makes us healthy. As individuals, we are faced with an endless stream of admonitions to watch our diet, stop smoking, exercise more, practice safe sex, avoid recreational drug use, and, by the way, avoid stress, even when thinking about all of our unhealthy habits. As a society, we are well aware of the importance of clean air, clean water, safe foods, and being immunized against infectious diseases. We know that poverty is strongly correlated to ill health, and that an individual who must sleep on the street is unlikely to be healthy. Although we recognize the critical importance of public health or other policies outside the “health care system” toward maintaining and improving the health of the general population, and note that present-day Canadians appear to be among the healthiest and longest-lived populations in human history, this paper will deal more narrowly with medical care. There is still a need for health care services when we are sick or injured. The question this paper will focus on is how best to pay for these services.

Similarly, this paper will address only in passing the frequent complaint that the series of medical care services we have do not form a coherent system. Here, we will use the term “system” to refer to the many encounters between people seeking care, and people providing it, with no

imputation that these encounters are either organized or systematic. These issues, as well, are beyond the scope of our analysis.

What we will concentrate upon are the payment questions involved when an individual seeks care from hospitals, doctors, nurses, rehabilitation specialists, pharmacists, and other health care workers. We will begin by speaking of these in the language of economics. In effect, economists often view obtaining such care as a series of transactions, in which a “consumer” (often known as a “patient”) “demands” services from a “provider” who in turn is paid (by someone) for the services which they provide. As we will note below, there are some conceptual differences between being a “patient” and being a “consumer,” but for the time being, let us stick with the language of economics.

Using this sort of language, we can separate health care systems into three dimensions²:

We will use the term *financing* to refer to the methods by which money is collected from all of those consumers, and potential consumers, of health care. Financing thus includes an array of taxes and premiums, collected from individuals and corporations, and collected by governments, insurers, and providers. Financing also includes consideration of who will be covered, and for what services.

We will use the term *delivery* to refer to all the ways in which those health care services are actually organized and delivered.

Finally, we will use the term *allocation* to refer to the variety of ways in which financing is linked to delivery. In other words, allocation refers to the way in which we choose to pay providers, and includes such topics as what incentives are inherent in the ways providers of care are paid for delivering services.

As we will see, many of the problems we have had in diagnosing the problems in our health care system have arisen from the failure to distinguish between financing and delivery. Other confusions have arisen when pathologies are diagnosed in allocation, but the suggested therapies instead deal with financing or delivery, which are working relatively well. To shift metaphors, one doesn't fix a malfunctioning appliance by breaking the parts which are already working!

Public and Private

Another set of confusions has arisen over the meaning of the terms *public* and *private*. Here, we are using the term “public” to denote “government.” As we recognize, Canada has many levels of government. By “public,” we can accordingly be speaking of the *federal* government in Ottawa, of the various *provincial* governments, of the series of *regional* governments and authorities within most provinces, or of *local* governments. Indeed, there has been a series of noisy battles occurring within the public sector, as provinces battle with Ottawa for more funds, and as provincial governments download some responsibilities to regions and local governments.

The term “private” is even more confusing. When we hear “private,” we usually think about large *for-profit corporations*, responsible for providing a good return on investment to their shareholders. But private also encompasses *small businessmen* / entrepreneurs who do not issue stock; indeed, most Canadian physicians are private providers, running their own small businesses and making their living from the “profit.” (Physicians are understandably annoyed to have their billings misrepresented as “salary” - the billings are instead their revenues, from which they must run their practices and pay their staff.) Private also includes a large *not-for-profit* sector. Some of these not-for-profit organizations, such as the Canadian Cancer Society or a local agency which delivers Meals on Wheels, rely heavily upon volunteer labour. But other not-for-profits are sizeable organizations, with paid employees. Finally, private includes *individuals* and their families. As any parent knows, most care for minor conditions is delivered privately, and never even comes in contact with the formal care delivery system.

Within the Canadian health care system, it is important to realize that almost all delivery of care is already private. Canada is not England. Under the system of “socialized medicine” found in such countries as the UK or Scandinavia, providers of health care work for some level of government and are therefore categorized as public employees. In contrast, most Canadian providers work in the private sector. This fact is often obscured because Canada has long used the rather confusing term “public hospital” to refer to private, not-for-profit institutions. To clarify the distinction, employees of “public hospitals” do not work for government, and are not civil servants. Ontario’s provincial psychiatric hospitals would accordingly be classified as public delivery, because their employees are indeed part of the Ontario public service, and their management must follow civil service guidelines. In contrast, employees of the North York General Hospital report to an independent hospital board and management, and would therefore be classified as working for a private sector, not-for-profit organization. Even in the provinces which have moved toward regional authorities, the employees of these regional boards are not civil servants, and the regional management is not bound by civil service requirements.

One reason for the confusion is that our “public hospitals” do receive most of their funding from government; in 1997, just over 90% of the spending for hospital care came from public sources³. However, this reliance upon public financing does not eliminate their formal organizational independence. Indeed, in that same year, physicians received 99% of their funding from the public sector, but are certainly not government employees (much as they may feel so if the paper work gets sufficiently aggravating). Political scientists are fond of attaching labels to this sort of private organization which nonetheless often acts on behalf of the public interest, and may be regulated by and funded from government. Some refer to them as “mediating structures;” others refer to them as the “third sector.” Under any label, they are a critical component of Canada’s health care system.

As we will see, this distinction between types of private is important in clarifying whether Ralph Klein’s initiative in Alberta really represents “privatizing” hospitals. Premier Klein has introduced legislation which would permit for-profit clinics to be paid by the government for delivering insured health care services, as an alternative to giving the money to existing not-for-profit hospitals. This initiative does not represent a shift from public delivery to private delivery; instead, it is a shift from not-for-profit private to for-profit private delivery. The distinction also

clarifies that privatization of funding has little to do with the need “to allow innovation in a stultified public delivery system,” since, as we have just noted, most Canadian providers are already private. Instead, these debates are really about three things. First, we are often arguing about the total amount of money allocated - whether it is sufficient, and whether it is being used appropriately. Second, we may concentrate upon the nature of the incentives built into the funding allocation approach, and whether these are effective in ensuring that the services we want are being provided. Third, and critical to the debate about the Alberta initiative, we are debating the role of for-profit corporations, as opposed to not-for-profit organizations, in delivering health care in Canada.

Although Canada does not have much public delivery, over two-thirds of spending for health care services does come from public sources. As we will see below, the extent of public financing differs considerably, according to what sorts of services we are talking about. We accordingly next turn to the rationale for public financing for certain types of services. We begin with an introduction to basic economics and how this relates to the concept of medical necessity. We then turn to the arguments for insurance, and then examine the reasons against allowing insurers to compete against each other. (Health researchers often refer to this using the jargon of “single payer” - that is, ensuring that one, and only one, organization is involved in financing certain types of health care services.)

Basic Economics and the Concept of Medical Necessity

Consider the following two scenarios:

1) You hail a taxi and ask the driver to take you to a destination across the city. You do not have enough money for the trip. Should you be taken there anyhow?

2) You have won a free all-expenses-paid week for two in a vacation spot of your choice, with the only catch being that the trip had to be taken sometime within the next twelve months. Do you accept?

In its simplest form, microeconomics deals with three components: supply, demand, and price. Price acts as the signalling factor that links supply and demand. Any self-respecting economist can plot supply and demand curves and look for their intersection. For example, if the price drops, the quantity demanded should increase; there should be a near infinite demand for free goods. Conversely, if supply is fixed and demand increases, price should rise until enough people get priced out of the market to balance the quantity supplied and this new (lower) quantity demanded at the new equilibrium price. Most people agree with the predictions which economic theory would make. For scenario 1, most would agree that the taxi driver is under no obligation to take you. If you cannot pay the cost the taxi driver wishes for the trip, you are priced out of the market for taxicabs. In turn, if you are priced out of the taxicab market, you can walk. If taxi fares get so high that there are insufficient customers, either some providers will leave the market, or prices will fall to a level with a more satisfactory balance of quantity supplied and quantity demanded. For scenario 2, most people would be delighted to accept the free vacation.

Now consider two similar scenarios relating to health matters:

1) You come into a hospital emergency room with a ruptured appendix. You do not have enough money for the surgery. Should you be treated anyhow?

2) You have won free open heart surgery in the hospital of your choice, with the only catch being that the surgery must be performed within the next twelve months. Do you accept?

Suddenly, economic theory does not seem to apply. Most people would agree that your appendix should be treated, and would be horrified were you turned away for financial reasons. In economic terms, however, this means that we will not allow you to be priced out of the market for appendix care, or other sorts of services which you “need.” Under those circumstances, we have set up a rather peculiar economic model, in which there is a “floor price” (whatever charity or the public system agrees to pay for that service) but no ceiling price. The private tier is thus free to jack up their prices as high as they wish, because anyone priced out of their market has the option of falling back into the publicly-funded tier. Indeed, providers working simultaneously within both tiers are assured that they will get at least the price which would be paid by the public tier, with the ability to collect whatever additional private charges they can as a bonus. Two disquieting consequences follow. First, under these circumstances, market forces can no longer achieve cost control; the refusal to allow people to be priced out of the market means that markets can’t set a ceiling price. Second, unless the publicly-funded tier is inadequate (or at least, perceived to be inadequate), there would be no reason for “consumers” to pay extra for care. As we will note below, the myth that a privately-funded tier could strengthen the public system by “freeing up” time and resources accordingly makes no economic sense, precisely because a viable private tier depends upon eroding the publicly funded system to create a market for privately funded care.

But need has a flip side, as can be seen in considering our likely responses to scenario 2. Most people would be eager to take that free trip. However, whenever I have tested this hypothetical offer of free surgery, the main response is laughter, and then the statement, “only if I needed it.” Microeconomics speaks of “demand.” However, much of health care instead speaks the language of “need.”

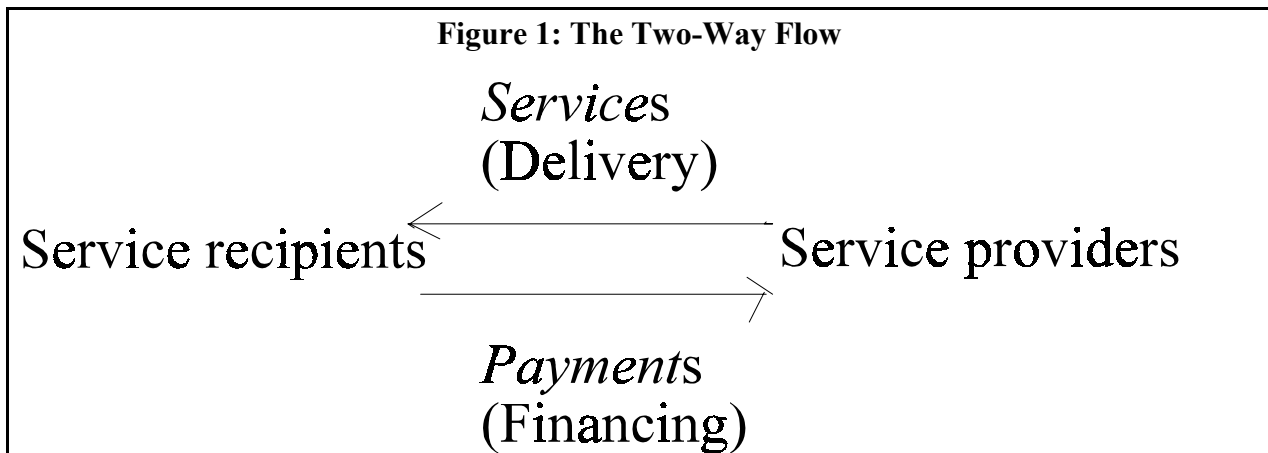
There is a category of good, often referred to as “merit goods,” which most societies believe should not operate according to the laws of the market. Instead, these goods are allocated on some basis of need and merit. Need is a complex concept, and notoriously difficult to define. However, we tend to know it when we see it, at least in extreme situations. Market models are not designed to assist us in allocating resources on the basis of need. Indeed, the concept is inherently paternalistic, since “need” must be validated by some outside authority. I can tell you what I want, but we allow health professionals (or “society”) to determine what I need. The term “consumer” is accordingly inappropriate when we are talking about these sorts of services. Consumers purchase what they want and can afford. Patients receive what they need. And, just as we are unwilling to deny people with a ruptured appendix care they “need,” we consider it inappropriate, or even unethical, to provide most medical services if they are not needed. If a shoe store has an excess supply, they may hold a sale, and no one worries if I already have twelve pairs of similar shoes, if

the shoes are unattractive, or even whether or not they fit. However, if my local hospital had surplus operating room time, it could not advertise **Half-price Surgery, Today Only**. We can speak of unnecessary surgery, in a way we cannot speak about unnecessary shoes. And in turn, this implies that the issue of finding the resources to pay for things that we “need” is fundamentally different from paying for things which we merely “want” or “demand.”

Funding Flows

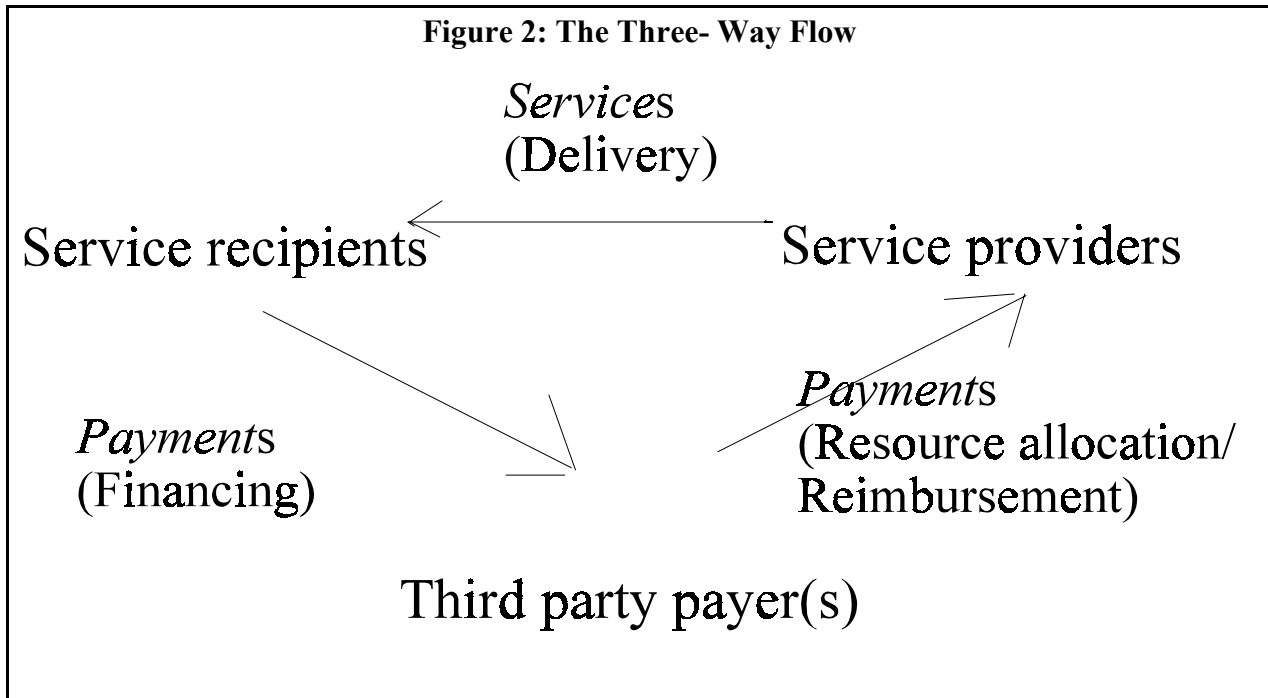
One way of looking at how we should pay for these services is in terms of the array of ways by which one can “flow” funds from consumers to providers⁴. The factor we will consider here is how many parties are involved in the transactions.

The simplest approach can be termed a “two way flow.” The two-way flow, illustrated in Figure 1, avoids the middlemen; consumers pay providers directly for the services they receive. For example, an individual purchasing an over-the-counter drug pays the drug store and receives the product. As with any other retail transaction, there is a direct link between using services and paying for them.



In almost every country, however, individuals seek to minimize the extent to which they rely on these sorts of direct payments for most health care services. Instead, the logic of insurance often drives people to pool their risks by introducing a third-party payer. In these “three way flow” models, illustrated in Figure 2, potential consumers pool their resources and pay taxes or premiums to a third-party payer, who in turn agrees to reimburse providers should services be required. As we will note below, these third party payers can be public (government) or private (*e.g.*, employers, private insurers), and the payments can be established in a number of ways. The common element is that three way flows are intended to break the direct link between using services and paying for them. If there is only one such third-party payer, it can enjoy what economists call “monopsony” power. This term is analogous to a monopoly, except it refers to the situation when there is only one buyer of services, rather than being only one seller. Monopsony power means that this buyer can drive tougher deals with providers, reducing the price of their

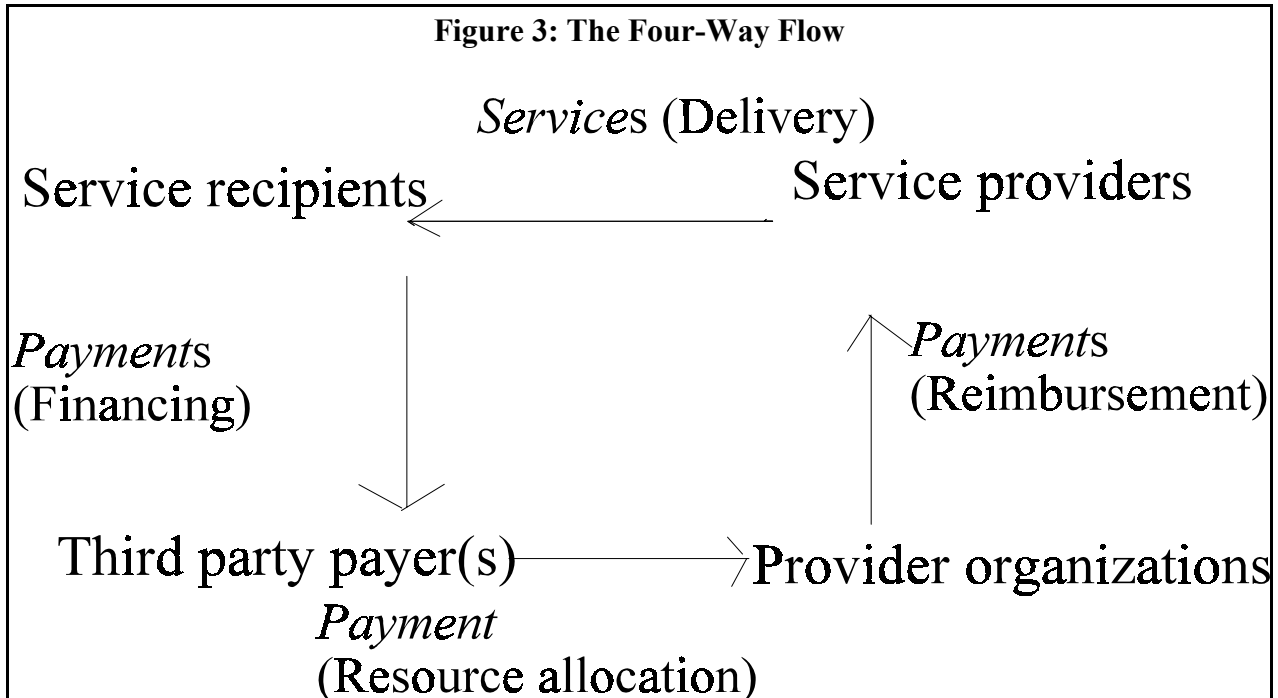
services. (This, of course, is likely to be unpopular with providers and popular with those who must pay for their services.)



One can also establish more complex funding flows. For example, four-way flow models, illustrated in Figure 3, add a series of “provider organizations” (ranging from hospitals through to US-style managed care organization or Canadian or British regional authorities) which in turn employ and pay health providers. To clarify these “flows,” consider the example of a hospitalized patient who needs nursing services. In a two-way flow, the patient would directly hire and pay the nurse (as is currently the situation for private duty nurses). In a three-way flow, the patient would have paid for insurance (from either a government-run or private plan) and that insurer would now directly pay the nurse (much as they would currently pay the physician). In a four-way flow, the insurer would instead pay the hospital or other provider organization, and that provider organization would take responsibility for hiring and paying nurses.

Clearly, health care services are a complex mix of these types of funding flows. The precise nature of these arrangements critically affects delivery systems and allocation models, influencing how third party payers flow funds to providers and precisely how health care systems are arranged. One commonly suggested set of reforms can be viewed as moving toward provider organizations, which would then take responsibility for ensuring the delivery of a pre-set basket of services to a predefined roster of patients. Depending upon the scope of services included and the way in which the patients become associated with the organizations, these models can be known as “primary care reform,” “integrated systems,” “health maintenance organizations,” or “regional models”⁴. These models thus have a major impact on delivery; there is no place for an individual physician running a solo practice. They also may have significant implications for allocation, including shifting the flow from third-party payers to provider organizations onto a capitation

basis. However, in general, they will not have a major impact upon financing, which is the focus of this paper, except as they affect how resources are pooled by what we have termed the third party payers in the above diagrams. To understand how these third party payers must operate, we must examine the logic of insurance.



The Nature of Insurance

We noted when we were talking about “flows” that one major reason why most countries involve third-party payers in financing health care relates to the need for insurance. Insurance is a way to distribute risks by pooling expected costs both across time, and across a wider population. To take an arbitrary example, imagine 10,000 homes, distributed across many communities and each valued at \$300,000. Now assume that, on average, one will be destroyed every year by lightning. Without insurance, most people would not be struck by lightning, and therefore would not have to replace their house, but one unlucky individual would incur a bill of \$300,000. Most people would find that cost prohibitive. However, if each household paid a \$40 premium, we could create a pool of \$400,000. That should be enough to reimburse the unlucky individual, cover the costs of collecting the premiums, and still allow a profit for the group willing to act as the insurer. Each individual would be trading a sure loss of \$40 to avoid a potential loss of \$300,000. However, “on average” is not the same as “exactly.” Some years, no houses would be struck. In other years, lightning might hit two or even three. If only \$400,000 were collected, the pool would not be large enough to cover the losses in such years. Precisely because the number of unlucky individuals is unpredictable, the logic of insurance encourages large risk pools, so that peaks and valleys are more likely to average out to a predictable value.

However, not all houses are at equal risk. In insurance markets, this difference in risk links to two important concepts - “moral hazard,” which pertains to the behaviour of those insured, and “risk selection,” which pertains to the behaviour of those who are doing the insuring.

Economists use the term “moral hazard” to refer to the fact that rational individuals are more likely to buy insurance if they think they are more likely to use services. Indeed, people may even engage in risky behaviour precisely because they are insured (*e.g.*, building on a flood plain if they have flood insurance). Moral hazard in turn suggests that rational insurers are not willing to extend unlimited coverage to a population which can voluntarily decide whether they wish to purchase insurance. Some obvious examples suggest themselves. Those people wishing cosmetic surgery would be far more likely to purchase insurance which would cover such services than would the general population. Women in their 70s would not purchase additional coverage for childbirth. Similarly, those who are young and healthy may be more willing to forego health insurance than those who already know they have a chronic disease. However, moral hazard in health care does not work in quite the same way that it does for other insurance markets. People are unlikely to abuse their health solely because they will not have to pay for the resulting care, because poor health has too many other unpleasant consequences.

The flip side of “moral hazard” is referred to as “risk selection.” In this case, the rational insurer seeks to avoid those customers most likely to cost them money. Sometimes, they refuse a policy outright. Other times, they charge higher premiums. If they can, they will also seek to limit their “exposure” to claims. Just as the insurer can cap the amount payable for the destroyed house at \$300,000, sellers of health insurance also try to limit the amount they must pay for claims. As one example, most dental policies sold limit the total amount that they will pay for dental work.

As Deborah Stone has noted⁵, there are two basic ways to determine insurance premiums. One approach is to charge everyone the same rate; she refers to this as employing solidarity principles. Under this type of system, often known as “community rating,” those at high risk are subsidized by those at lower risk. The alternative is to employ actuarial principles, also known as risk-rating or medical underwriting. Under this model, premiums are based on expected claims. Automobile insurance works on this principle; the teenager with the sports car will pay far higher premiums than the proverbial little old lady who only drives to church on Sundays.

In general, we consider this fair. If the teenager finds insurance too expensive, she can walk or find a part-time job. Neither are we concerned if the person with a history of traffic accidents finds he cannot afford to keep driving. However, when we are talking about health care, things become a bit trickier. We are no longer as comfortable to find people priced out of the market. We are not sure whether the person with a history of cancer should pay higher premiums for health insurance. Unfortunately, any altruistic insurer who agrees to give lower rates to these high risk individuals is likely to lose their lower risk customers to less magnanimous competitors who can often bargain rates to the healthy. As Fein has noted, the resulting spiral means that those companies willing to cover such high- risk cases usually become less and less competitive, precisely because they find themselves left with the costliest cases⁶. Solidarity-based markets are inherently unstable if competition among insurers is allowed; therefore, because competitors have

an incentive to woo those at lower risk by offering them lower premiums and/or enhanced benefits (e.g., wellness programs). Without government regulation, competing insurers will employ actuarial rating, which means that high risks will eventually be priced out of the market. For example, a General Accounting Office (GAO) study of the US private insurance market found that they "virtually always denied coverage" to individuals with AIDS or heart disease; for individuals with other serious conditions, such as chronic back pain, anemia, knee injury, glaucoma, and asthma, the coverage excluded costs arising from these "pre-existing conditions."⁷ Similarly, almost all travel health insurance policies will tend to exclude pre-existing conditions and carefully examine the medical history of their prospective clients. Very few travel health insurers are willing to cover your 85-year-old mother with a cardiac condition, even though she really wants to visit Florida. In the US, insurers are increasingly seeking to avoid having to cover individuals at high risk of needing health care services; paradoxically, of course, these are precisely those who need such insurance the most. You can easily buy health insurance, as long as you are healthy and seen as likely to remain that way.

In theory, one could compute a fair, risk-adjusted premium for each individual in the population on an actuarial basis, aggregating private and public pools. In practice, however, attempts to introduce such "risk-adjusted capitation rates" have proven extremely costly and complex.⁸⁻¹² A US attempt to allow seniors to join HMOs was found to lead to risk selection; those enrolled tended to be healthier, and the resulting "overpayment" of approximately 7% led to windfall profits for the HMOs, and cost escalation for the Medicare program¹².

In summary, competitive insurance principles give economic incentives for insurers to limit their risk, both through defining whom they will cover, and through ensuring that liability will not be open ended. Any company not abiding by these incentives will be uncompetitive. In a competitive model, those most in need of insurance coverage are least likely to find anyone willing to insure them; if coverage is available, it is likely to be at a very high (often unaffordable) cost. Overall costs also tend to be higher, in part because fragmented payers have a diminished ability to control the costs they must pay to providers, and in part because of the additional administrative overhead introduced. (As one of many examples, providers have to deal with a myriad of insurance companies, each with different forms, rules, and regulations.) Many of these added costs fall upon employers, decreasing their economic competitiveness. For these reasons, health economists are virtually unanimous in agreeing that introducing competition in financing medically necessary care - as opposed to competition in how this care is delivered - is a bad idea. Indeed, the international evidence is clear that, when dealing with this sort of necessary care, single payer systems tend to be more economically efficient than more pluralistic approaches to financing medically necessary services¹⁴⁻¹⁷. Canadian insurers and employers agree.¹⁸⁻¹⁹

We will return to these concepts when considering the recent suggestions for Medical Savings Accounts.

The Canadian System

Canada may be proud of its "national health care system," but it is neither national, nor a system. When Canada was formed, the *British North America Act 1867* (subsequently renamed

the *Constitution Act 1867*) distributed powers between the federal (national) government in Ottawa, and the provinces. Among the exclusive provincial powers were “hospitals;” in consequence, health care has been viewed as being under provincial jurisdiction. Provincial governments guard their powers carefully, but provinces also vary considerably in their economic strength. Left to their own resources, some provinces could afford far more extensive programming than others. In order to equalize the availability of services to Canadians regardless of their province of residence, the federal government accordingly became involved in assisting provincial governments with the costs of Medicare. There are two key elements to this federal involvement. First, Ottawa has provided money to help the provinces pay some of the bills. Second, Ottawa has set a series of terms and conditions which the provinces must meet in order to receive the federal money.

Since 1977, these two components have been embodied in separate legislation. In that year, the *Established Programs Financing Arrangement (EPF)* pooled the money which the federal government had been giving for three formerly cost-shared programs - hospital insurance, medical insurance, and post-secondary education. In 1996, *EPF* was replaced by the *Canada Health and Social Transfer*, which enlarged the pool to sweep in the welfare programs which had been included under the *Canada Assistance Plan*. It is important to note that these transfers - made up of a combination of “tax points” and cash payments - are not tied to specific spending. Since 1977, they have been part of provincial general revenue, and provinces are free to determine their own spending priorities, as long as they do not contravene the national terms and conditions.

The national terms and conditions with which provincial governments must comply to receive cash transfers from the federal government are contained in the 1984 *Canada Health Act*. However, this legislation is based upon, and incorporates much language, from the two earlier pieces of legislation which set up Medicare - the 1957 *Hospital Insurance and Diagnostic Services Act* and the 1966 *Medical Care Act*. (There are no conditions on spending for post-secondary education, and only very minimal conditions for spending on those programs which had been part of the *Canada Assistance Plan*.)

The *Canada Health Act* contains five specific conditions. To receive federal transfers, the provincial insurance plans must ensure:

- public administration: a requirement that the provincial health care insurance plan be “administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province” although contracting out would still be permitted. This requirement is designed to ensure accountability for public funds spent, as well as to eliminate the overhead of private insurers. Contrary to statements that this requires “socialized” medicine, this condition says nothing about who can actually deliver the health care services.

- comprehensiveness: “the health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners.” As we will note below, this condition is perhaps the most problematic at present.

- universality: “the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions.” This provision eliminates the possibility for risk selection by ensuring that all eligible residents of the province be included within the insurance plan.

- portability: requiring that some provision be made for covering Canadians insured by one province when they traveled within and outside of Canada. The requirements are fairly minimal ones, meaning that there is still a market for travel health insurance.

- accessibility: requiring two things. First, that the provincial plan “must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons” - in short, that insured people cannot be charged user fees for insured services. Second, that the province “must provide for reasonable compensation for all insured health services rendered by medical practitioners or dentists” and pay hospitals for “the cost of insured health services.”

In addition, the *Canada Health Act* included provisions for ensuring that the federal contributions were visible, and that data about the operation of provincial plans be provided. However, regulations enforcing these conditions were never really implemented. The Act also made mention of “extended health care services,” defined as including: “(a) nursing home intermediate care service, (b) adult residential care service, (c) home care service, and (d) ambulatory health care service.” Although some federal funds were provided for extended health care services, no real strings were attached to this money, and extended health care services did not have to meet the above five national conditions.

As pointed out by Hollander *et al* in recent as yet unpublished briefing notes for the Canadian Nurses’ Association, most of these principles are still appropriate²⁰. However, the letter of the act (as opposed to its spirit) has been bypassed by technological change. The dilemma is particularly acute around defining what services should be insured by each provincial health insurance plan.

What Is Covered: the Comprehensiveness Dilemma

As Hollander *et al* note:

Any health care system must draw boundaries; some things will be covered, while others will not. An overly narrow definition can be counterproductive. For example, if preventive care is not insured, individuals may be sicker by the time they seek out medical attention. This is not only undesirable from the viewpoint of the health of the population, but also may cost more money in the longer run. For example, the fact that a number of insurance plans in the US did not cover immunizations has been considered a classic example of “penny wise, pound foolish” and led to public policy to ensure that such services would be insured.”²⁰

The definition of comprehensiveness in the *Canada Health Act* is a rather broad one, and extends far beyond sickness care. The definition explicitly includes all services “medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability.” The enumerated elements of hospital services are also quite extensive, including not only ward accommodation and nursing, but also inpatient drugs, rehabilitation services, and even other services delivered by hospital employees (which, for example, would presumably include nutritional services). Indeed, the *Canada Health Act* also allowed provinces to designate other health providers (e.g., midwives) as “health care practitioners,” whose services would then be considered equivalent to those offered by physicians.

Although still valid in principle, the operational definition of comprehensiveness in the *Canada Health Act* has now been outpaced by technology. For historical reasons, the earlier legislation defined insured services in terms of where these services were delivered, and by whom. In one sense, this definition gave necessary flexibility; rather than attempt to micro-manage which hospital services were considered insured, the *Canada Health Act* left that decision up to the presiding doctor. Similarly, as long as services were included within a fee schedule, they were insured, and the fee schedules intentionally included enough vague codes (e.g., “assessments”) to give doctors discretion to do what they thought necessary. As one example, one would not have to indicate that taking vital signs was an insured service; as long as a patient was within a hospital, the medical staff was free to use their judgement about how best to use available resources. Since it was assumed that sick people would be in hospitals and/or under the care of doctors, this definition sufficed for several decades.

It is noteworthy that earlier proposals for health insurance in Canada, such as the 1945 health insurance proposals, had envisioned a broad spectrum of benefits. As Malcolm Taylor reports, this earlier model would have included general practitioner services, hospital care, and visiting nursing service in the first stage, and phased in more specialized services (including specialist and surgical medical services, other nursing services including private duty nurses, dental care, pharmaceuticals, surgical appliances, and laboratory services) later²¹. Had this model been adopted, some home care would have been included from the outset. Instead, after the earlier proposals crashed on the rocks of federal-provincial disputes, a series of political compromises was made, which began with the most expensive parts of the system. The 1957 *Hospital Insurance and Diagnostic Services Act (HIDS)* cost-shared provincial insurance for hospital care, but did not encompass most mental health services, on the grounds that these were being delivered within provincial psychiatric hospitals. Similarly, the 1966 *Medical Care Act* added physician services, but did not cost-share services delivered in the community by providers other than physicians. Home care, like dental care and outpatient pharmaceuticals, was seen as the next step. However, given fiscal constraints, this next step never happened. Some limited services were made available through the 1966 *Canada Assistance Plan (CAP)*. *CAP* provided federal cost-sharing for welfare programs, and grew to include many services for the elderly and disabled. However, because *CAP* was not a universal program, the availability of such services varied by locality, and required cost-sharing.

In 1977, the cost-sharing formulae for *HIDS* and the *Medical Care Act* (but not the acts themselves) were replaced by a new funding arrangement, the *Established Programs Financing*

Act (EPF). This new arrangement gave provinces more flexibility; instead of cost sharing only the in-hospital and physician services, the provinces were given lump sums (made up of cash plus tax points) and were free to rearrange their health care systems, as long as they continued to meet national conditions. As we will see, this arrangement has led to considerable scope for confusion in determining “who pays what” for health care.

It was not until 1984 that *HIDS* and the *Medical Care Act* were replaced by the *Canada Health Act*. At that time, there was considerable debate about whether the passage of new legislation should be used as an opportunity to extend the scope of coverage beyond the earlier programs. However, the provinces successfully argued that the federal government should not expand the scope of mandatory services without also increasing federal funding, and the terms were accordingly not changed.

It is important to recognize that the comprehensiveness condition is a floor, rather than a ceiling. Provincial plans are able to insure services beyond the scope of this definition; they are merely not required to do so. Indeed, one principal rationale for the 1977 shift from cost-shared funding to block funding (under *EPF*) was precisely to allow provincial governments to offer services in the most cost-effective manner possible. Indeed, the *EPF* funding formula included a small ‘thrust fund’ for ‘extended health care,’ although this was never tied to specific program requirements.

In 1957, when the comprehensiveness language originated, it was expected that people who were really sick would be treated in hospitals. It is now possible for individuals to be treated at home. However, services that must be paid for inside hospitals need not be paid for if the patient is being cared for at home or in the community. In consequence, government has an incentive to send people home and shift their costs elsewhere. Similarly, hospitals, faced with global budgets, may wish to offload some of their expenses. If someone is sent home, then the hospital need no longer pay for their nursing, drugs, rehabilitation, etc. In contrast, sick people soon recognize that the hospital is one of the few places which must treat them “for free.” The resulting pressure can be seen across Canada, as hospital emergency rooms attempt to cope with patients who might indeed be treated more appropriately (and more economically) elsewhere, if those alternatives existed. The *Canada Health Act* does not prohibit provinces from extending coverage into the community. However, under fiscal pressure, many provinces have instead chosen to allow “passive privatization” of Medicare²². The consequence has been to undermine health reform across Canada, since “closer to home” can mean “out of pocket.”

One obvious example is the treatment of “surgical dental services.” Although the *Canada Health Act* frequently mentions “dentists” along with “physicians” as providers of insured services, the language of the Act requires coverage only when these services must be delivered within hospitals. Improved technology has in turn meant that it is almost never necessary to perform dental procedures on an inpatient basis, and accordingly this provision is basically moot.

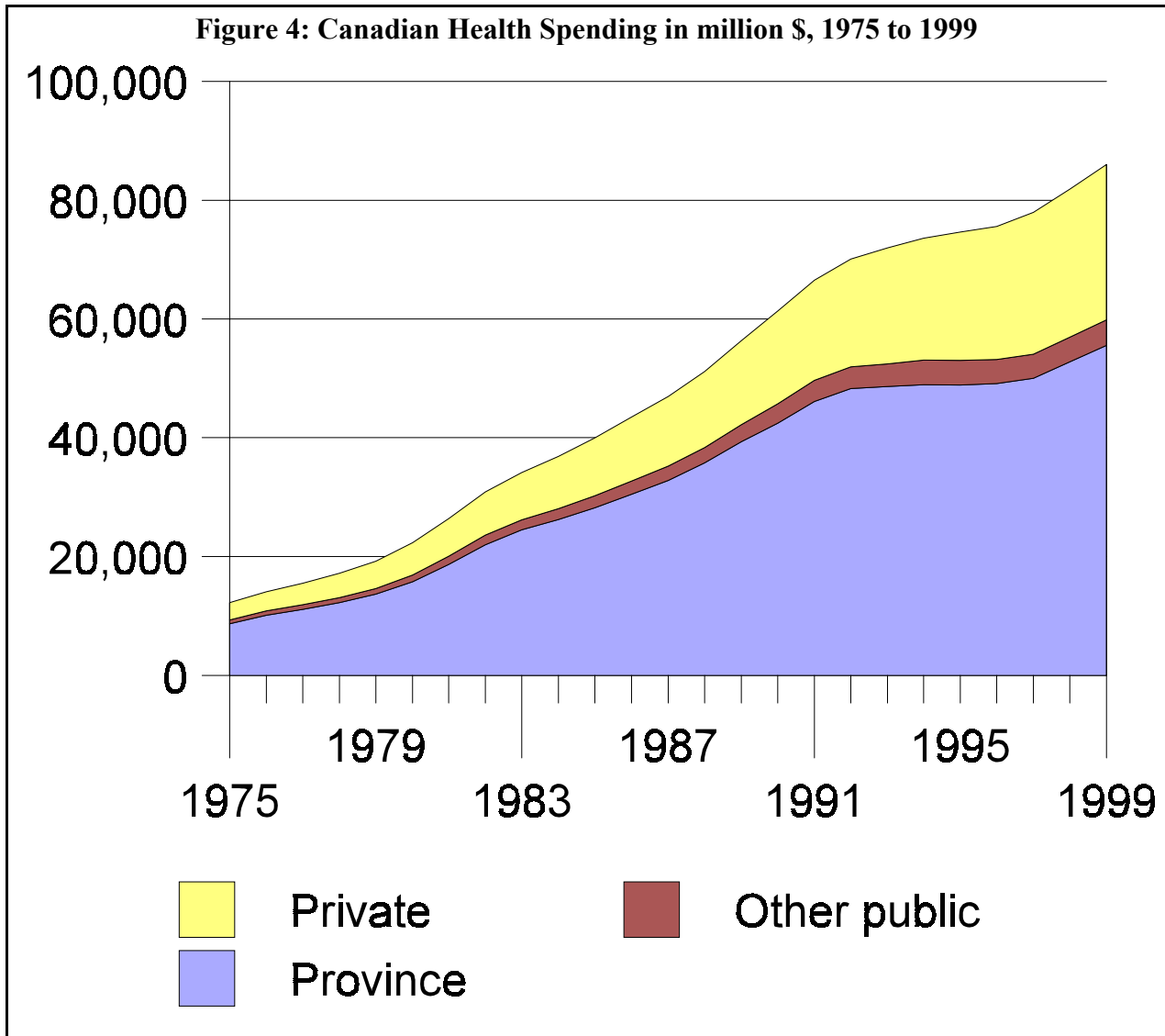
Health Spending in Canada

What have been the trends in public and private financing of health care in Canada? This seemingly simple question can give rise to astoundingly complex answers. In this document, we will rely upon the data collected by the Canadian Institute for Health Information (CIHI) for Canada-wide information, and that collected by the international Organisation for Economic Cooperation and Development (OECD) for international comparisons. The OECD currently has 29 member countries, and has been in the forefront of efforts to develop homogeneous, standardised health statistics about its member countries.²³ The most recent published CIHI data is for the period 1975 to 1999, with cautions that the numbers for 1998 and 1999 are still provisional estimates. Many of the tables here will accordingly use 1997 data, since that is the most recent year for which the numbers are considered reliable. We would like to express our appreciation to Geoff Ballinger of CIHI for providing this data; he is not responsible for its interpretation.

As we have pointed out elsewhere, there are a number of different ways to look at health spending²⁴. Each contains its own assumptions.

One obvious way to look at health expenditures is to tally up how many dollars are spent. CIHI divides up this spending in two ways. First, they look at the “source of finance” and distinguish “public” from “private” sector payments. Second, they look at the “use of funds,” which will be discussed later. Under “source of finance,” Public can be further decomposed into the following four categories: payments from the provincial government, direct payments from the federal government, payments from municipal governments, and payments from workers’ compensation. However, most of the “public” money is counted as provincial spending, although as we will see, some of this comes from transfer payments from the federal government.

Figure 4 shows Canadian spending for health care between 1975 and 1999 in million dollars. This “area” chart decomposes total spending into the share paid by provincial governments (at the bottom), the remainder of public sector spending (in the middle), and private sector spending (at the top). This figure shows the familiar story of rising health expenditures which has been used to justify the familiar claims that “we can’t afford health care” without massive changes to the system. Although careful scrutiny reveals that private expenditures are growing more quickly than public spending, total costs do appear to be rising.



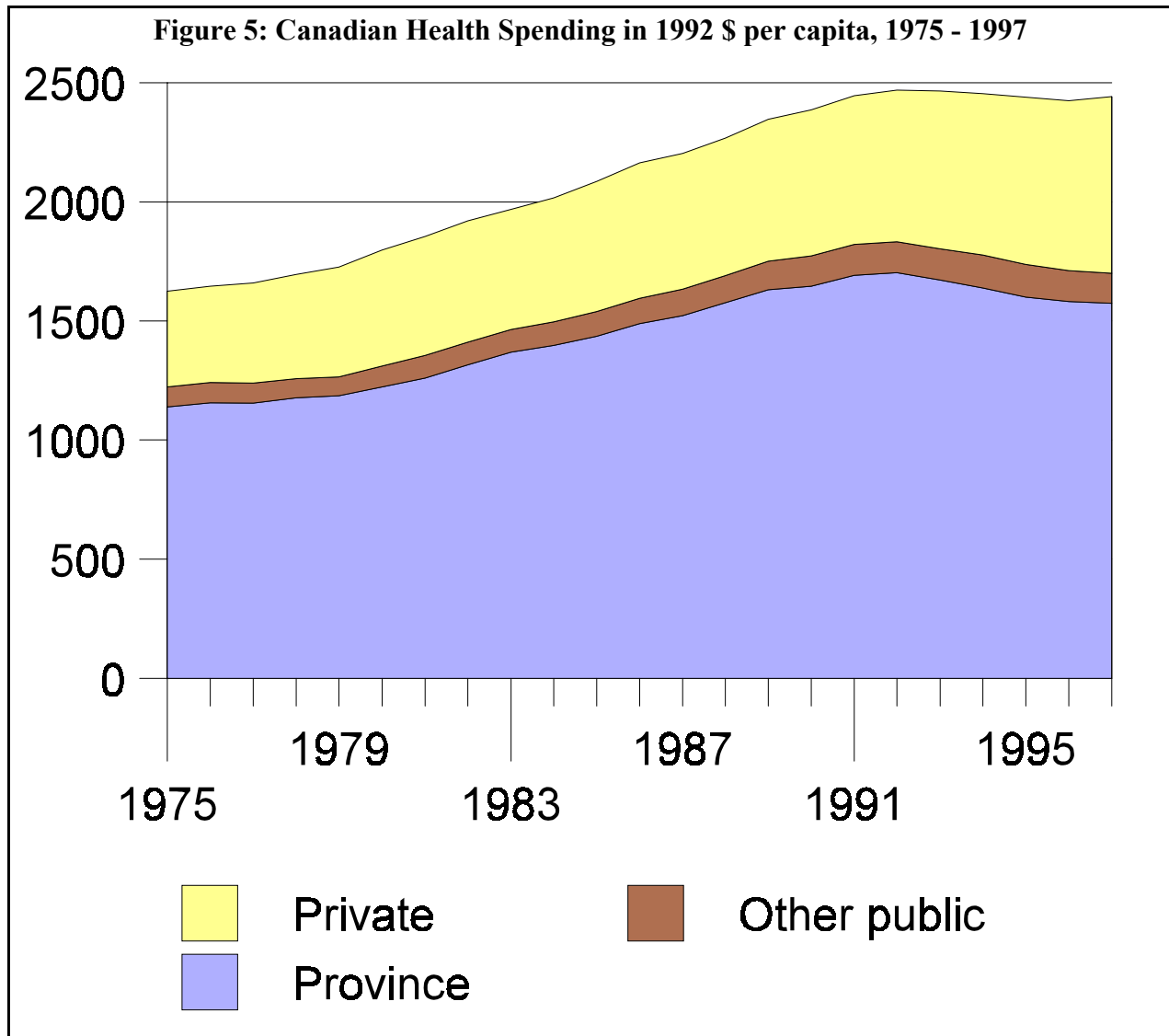
By themselves, however, these spending numbers are not particularly useful. As one example, few would be impressed by a table showing that Ontario spent far more than did Prince Edward Island, without taking account of the obvious fact that Ontario has far more people. The most basic correction we must make is to look at these expenditures “per capita” - that is, divide them by the population being served. This correction is a very simple one, and does not account for differences in need arising from other demographic changes. For example, as our population ages, we will find an increased need for health services. As technology changes, we may be able to do more. We have merely adjusted for growth in the number of Canadians.

The second correction we will make is to control for inflation. Clearly, a dollar today is not the same as a dollar in 1975. We will not attempt to control for “health care inflation” - that is,

changes in the costs of health care services (including purchasing equipment and supplies, and paying increased salaries to those delivering services) over and above the inflation rate.

Fortunately, CIHI has provided a series of tables which uses a standardized “price deflator” and population adjustment, to allow us to look at the same data, but now in 1992 Canadian dollars, and divide it by population. We have used them to construct figure 5, another area graph which shows spending by provincial, other public sources, and private spending, per capita in 1992 dollars. Again, the provincial share is on the bottom, other public spending is in the middle, and private sector spending is on the top.

Figure 5 leaves us with a rather different impression than did Figure 4. We now see more clearly the reason for stress within our publicly funded system; per capita, public expenditures for health care have been dropping steadily since 1992. Private spending increased over that period, but evidently not enough to make up the difference. It appears that government took the rhetoric that “we are spending enough for health care” rather seriously. Expenditure did not even keep pace with population growth, let alone allow for new technologies or the aging of the population.



This decline in spending came well before the infamous cuts to the Canada Health and Social Transfer we will note when we discuss the role of federal transfer payments. Far from spending ever more money on health care, at least as of 1997, provincial governments had clearly constrained the resources they were dedicating to health care.

The other frequent way to look at health expenditures is to look at spending as a proportion of Gross Domestic Product - that is, to indicate what proportion of national wealth is being spent for health care. This comparison can be a bit tricky, particularly if different countries define health care in different ways. However, the OECD has done an excellent job in attempting to standardize these numbers, and we will use their data for the next comparisons.

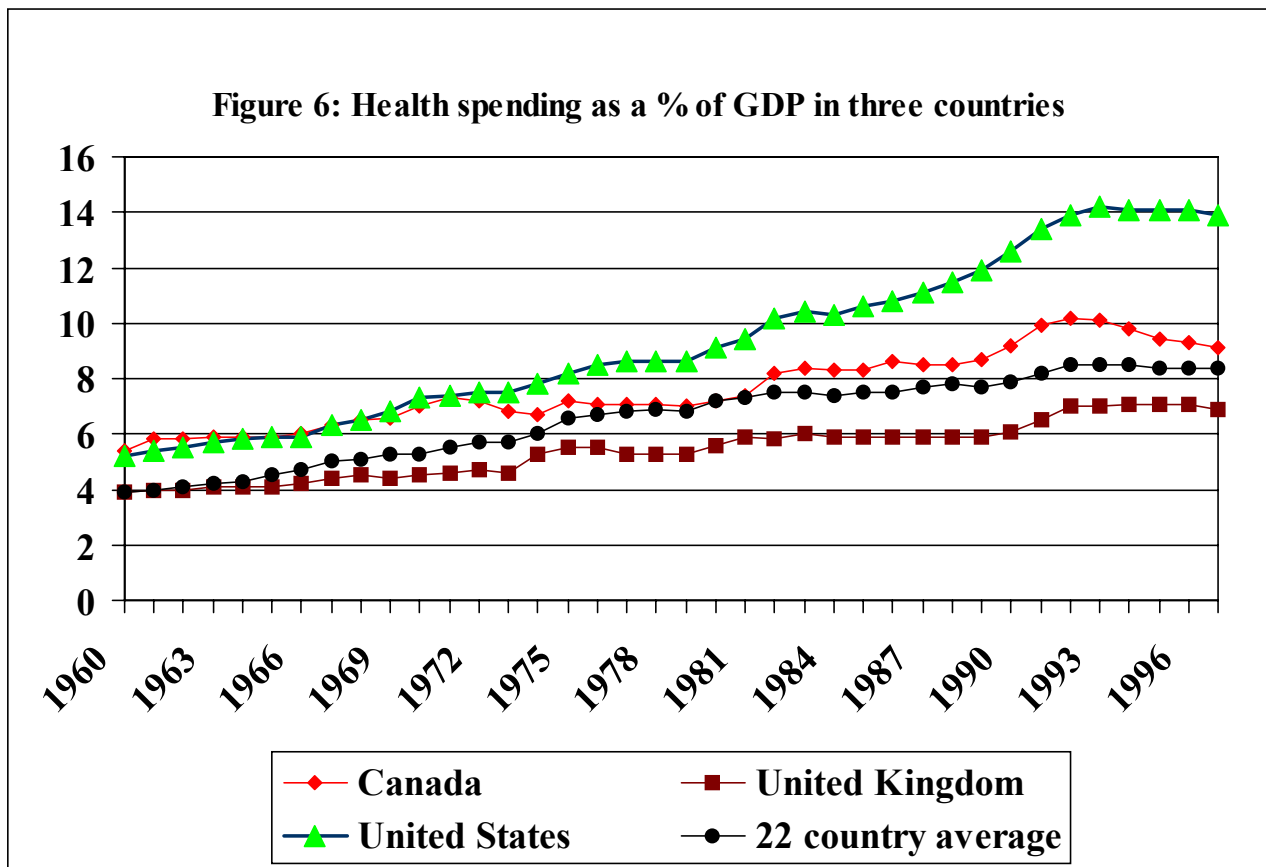


Figure 6 shows the data for Canada, the US, and the UK, and a “22 country average” of the values for: Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Iceland, Ireland, Italy, Japan, Luxembourg, Netherlands, New Zealand, Norway, Portugal, Spain, Sweden, Switzerland, UK, and US. (We have omitted Czech Republic, Hungary, Poland, Greece, Turkey, Korea, and Mexico, which are at a different stage of economic development.)

Although there is no easy answer to the question of the “right” proportion of national wealth that should be devoted to medical care, international studies have found that the best predictor of what proportion of GDP a country will spend for health care services is the strength of its economy.^{17,25} This is not surprising; richer countries can afford more than can poorer countries. Thus, it is not useful to compare Canada to such countries as Ukraine, which have more difficulty

in affording to provide much personal health care to all of their population. From Figure 6, it is evident that the British National Health Service has consistently spent far less of its national wealth for health care than did either Canada or the US. The often-mentioned deficiencies of “socialized medicine” might be interpreted as saying that England got excellent “value for money” for the relatively small amount of money it was spending. Canada and the US looked virtually identical until about 1971 - the date at which Canada instituted universal insurance, and the US did not. As our earlier discussion might suggest, the move to universal coverage for merit goods acted to contain costs rather than escalate them; the Canadian ratio remained relatively stable throughout the 1970s, ranking 8th among the 22 countries in 1975.

What happened next? We can see a rather rapid escalation of the Canadian ratio, although less pronounced than the cost growth south of the border. By 1993, the Canadian ratio had risen to 10.1% of GDP, second only to the US (at 14.2%) highest in the world. This result was widely discussed and interpreted as meaning that the Canadian model was inherently inflationary. The facts, however, were slightly more complex. As Evans has shown, discussion tended to forget that ratios have both numerators and denominators²⁶. Policy arguments within Canada have concentrated on the numerator - spending for health care services - and assumed that Canada must be spending too much. Less attention was paid to the denominator - Canada’s national wealth, as measured by its GDP. Closer analysis, however, revealed that most of the reason for the growth in the ratio came from the deep recession which had hit Canada in the early 1980s. This economic situation meant that health care spending was consuming a higher proportion of a stagnant economy. Had these economic hard times continued, Canada might indeed have had to reduce its standard of living in many areas to fit new realities. However, when economic growth improved, spending as a proportion of GDP rapidly fell to more tolerable levels.

Table 1 shows data about spending as a proportion of GDP for the 22 OECD countries for three selected dates - 1975 (the first year in current CIHI publications), 1993 (the year in which Canada appeared in 2nd place in its spending as a proportion of GDP), and 1997 (the most recent year for which validated data is available). The countries are arranged in descending order of their 1997 spending. We have highlighted the US, Canada, and UK. As can be seen, by 1997, Canada’s ratio had dropped to 9.2%, and it now ranked 5th.

Table 1: Total Expenditure on Health as a % of Gross Domestic Project

	1975	1993	1997
United States	8.2	14.2	13.9
Germany	8.8	9.9	10.7
Switzerland	6.6	9.4	10.3
France	7	9.8	9.6
Canada	7.2	10.1	9.1

	1975	1993	1997
Sweden	7.9	8.9	8.6
Netherlands	7.5	9	8.5
Australia	7.5	8.4	8.4
Austria	7.2	8.1	8.3
Denmark	6.3	8.5	8
Iceland	5.8	8.3	7.9
Portugal	5.6	7.5	7.9
Belgium	5.9	8.1	7.6
New Zealand	6.7	7.2	7.6
Italy	6.2	8.6	7.6
Norway	6	8.1	7.5
Spain	4.9	7.6	7.4
Finland	6.4	8.5	7.4
Japan	5.6	6.6	7.2
Luxembourg	5.1	6.7	7
United Kingdom	5.5	7	6.9
Ireland	7.7	7.4	6.3
Average of the column:	6.6	8.5	8.4

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This inference that the problem resulted from weaknesses in the denominator - the Canadian economy - rather than out-of-control health care spending is strengthened if one looks at spending in adjusted dollars per capita. In Table 2, we have used the OECD data which translates health spending for the same 22 countries into a common unit, per capita spending in US dollars. We examine the same three years - 1975 (the first year in the current CIHI data series), 1993 (when Canada looked like the second most expensive system in the world), and 1997 (the most recent year in the OECD 1999 data set). Because the inflation rates in different countries vary, the OECD data set accordingly inflation-adjusts only within each “national currency unit,” that is, it does not choose to present its time series data in inflation-adjusted US dollars per capita. However, as long as we are comparing across countries within the same year, the inflation adjustment is not as important, although we should accordingly use extreme caution in comparing

across years. We have again sorted Table 2 in descending order, this time using the 1997 spending per capita.

Table 2: Total Expenditure on Health per Capita, in Us Dollars

	1975	1993	1997
United States	605	3481	4095
Switzerland	594	3186	3698
Germany	592	2340	2733
Norway	475	2172	2624
Luxembourg	371	2165	2597
Denmark	480	2280	2574
Japan	253	2262	2378
France	451	2129	2286
Sweden	706	1900	2219
Iceland	375	1906	2177
Austria	364	1841	2109
Netherlands	483	1831	2032
Australia	542	1408	1839
Canada	518	1926	1828
Belgium	372	1725	1812
Finland	382	1421	1736
Italy	237	1477	1511
United Kingdom	229	1136	1508
Ireland	213	1019	1333
New Zealand	290	910	1312
Spain	145	928	1001
Portugal	104	636	803
Average of the column:	399.1	1821.8	2100.2

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Table 2 reveals that Canadian spending in 1993 was \$1,926 US dollars per capita; using this measure rather than the % of GDP used in Table 1 would have placed us in 9th place rather than 2nd. This discrepancy is what we would expect if “high” Canadian health expenditures were a “denominator effect” of a stagnant economy rather than a “numerator effect” of out-of-control health care spending. By 1997, we had fallen to \$1828 US dollars per capita, for 14th place. Interestingly, Japan has shown the flip side of the same phenomenon. It has relatively high per capita spending (\$2262 in 1993, and \$2378 in 1997), but this has represented a relatively small proportion of a healthy economy (6.6% in 1993, 7.2% in 1997). Since the most frequent comparisons are to our immediate neighbour, it is worth noting that US spending was high in both absolute and relative terms. It spent \$3481 per capita in 1993, and \$4095 in 1997, at the same time as it left more than 40 million Americans without health insurance coverage at all.

The second way in which CIHI divides up spending is by the “use of funds.” CIHI uses the following categories: Hospitals, other institutions (such as nursing homes), physicians, other professionals other than those employed by institutions (in turn broken down to show dentists separately from all other health professionals), capital costs, drugs (in turn broken down to separate prescribed drugs from over-the-counter pharmaceuticals which are not covered by either public or private insurance), and other health expenditures (including administration, public health, and research). We will next turn to this data as we look at the roles of the federal and provincial governments.

The Role of the Federal Government: the “Shares” Debate

We noted above that health care is a provincial responsibility; the federal role was to send money. However, there are several ways in which money can be sent. To somewhat oversimplify, let us divide federal transfers to the provinces into three categories:

1. “Targeted” funding - that is, money that can only be spent for a particular purpose. For example, if a student wins a scholarship, but that money is paid directly to the college or university, it is not available for other purposes.
2. “General revenues” - that is, money that is given directly to a provincial government. It can come accompanied by strong suggestions, but in the final analysis, the priority decisions are left to the province. An analogy would be if the scholarship money were paid directly to the student. Under those circumstances, the only way to ensure that the money was not “squandered” on rent, food, or beer is to hope that tuition is of high enough priority to the student. Ultimately, if the student is sufficiently feckless, the only alternative is to cut off the payments altogether.
3. “Tax points” - this form of transfer recognizes that there is only one taxpayer. The federal government agrees to reduce its own tax rate, leaving provincial governments free to increase their own rates without affecting the “bottom line” which a taxpayer must pay. This approach gives up total control. The “tax take” goes into provincial general revenues, in much the same way as the untied transfers of category two. However, the transfers cannot be revoked even if misused. If the federal government subsequently wishes to increase its own taxes, it cannot force the provinces to decrease theirs.

One of the reasons it is so difficult to sort out the role of the federal government in financing health care relates to the change in 1977 from the first model of transfers (targeted funding) to a combination of approaches two and three. This in turn has left considerable scope to play around with the numbers in order to support various agendas.

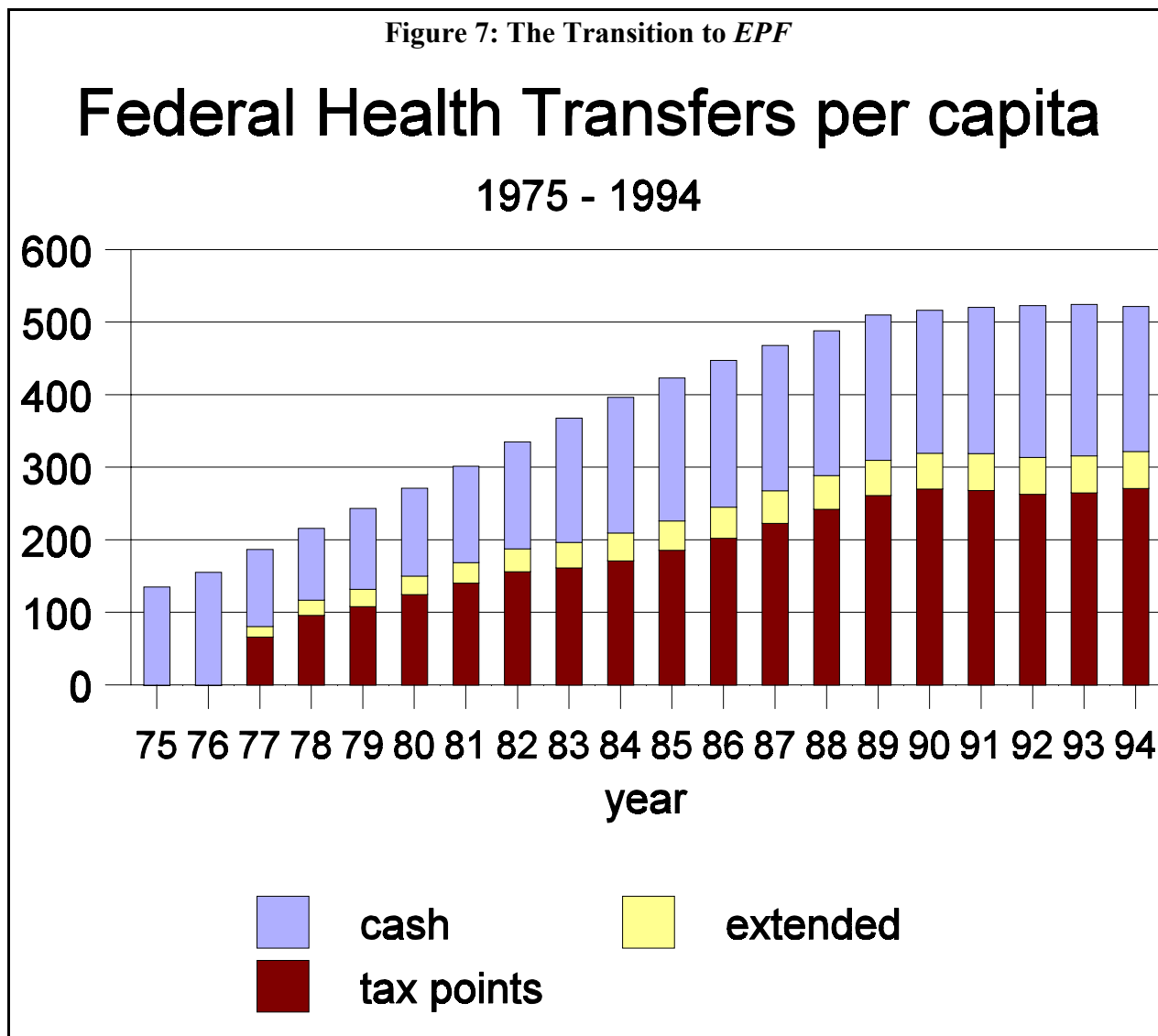
As we noted above, Canadian Medicare came about gradually, with the federal government sharing the costs of hospital insurance, and subsequently insurance for physician services. The transfers were targeted, with federal cost sharing for hospitals and physicians, but not explicitly for spending falling into the other CIHI categories - other institutions, other professionals other than those employed by hospitals, capital costs, drugs, or other health expenditures. (This picture is somewhat oversimplified, since the federal government did pay some of these costs through other programs.)

In 1977, this all changed. The cost-shared programs for hospital insurance, medical care insurance, plus the cost-shared program for post-secondary education, were all replaced by *EPF*. *EPF* which combined approach two (untargeted “cash” which became part of provincial general revenues) with approach three (tax points). Although the federal government continued to report a transfer for health, it is important to recognize that this was “notional” only. As of 1977, federal transfers for health and post-secondary education were no longer targeted. Provincial governments were free to make their own decisions about how to spend their own revenues. Federal transfers were important only as they contributed to provincial fiscal ability - that is, to how much money a provincial government had available to spend on all of its priorities. For example, provincial governments were now free to reduce the money they spent for colleges and universities, without having to return the “savings” to the federal government. In terms of health programs, the provinces had to comply with the national terms and conditions (reinforced in 1984 by passage of the *Canada Health Act*), but had total flexibility in how they spent this money.

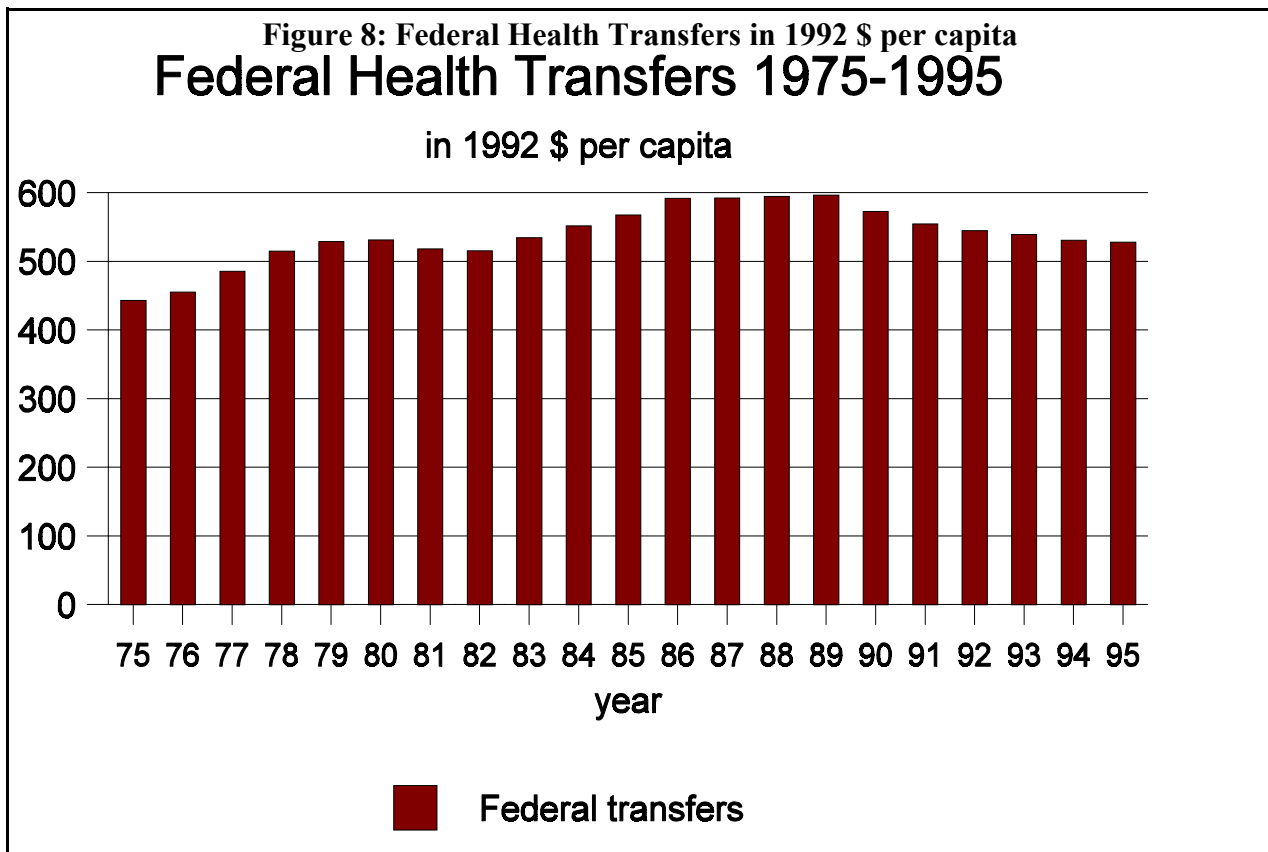
The 1977 *EPF* formula was a complex one, but consisted of about half cash, and about half tax points. (The frequent comparisons between current federal transfers and the old days of “50% federal cash contributions” are therefore seriously misleading, since the cash was intended to make up about half of the transfer, placing the new baseline at about 25%.) There was also a small per capita grant which was entitled “extended health care services” but not tied to any specific program requirements. *EPF* computed a provincial “entitlement,” on a per capita basis. The entitlement was to increase each year with inflation. This meant that the provinces would receive payments which reflected population growth and inflation, but took no account of other inflationary pressures. In effect, the federal spending per capita in inflation-adjusted dollars was intended to remain stable.

For several years, this was what happened. However, the federal efforts to bring the deficit under control also affected federal transfer payments. Under then Finance Minister Wilson, the federal government unilaterally changed the escalator to be less than inflation. Since the entitlement did not change, the cash portion began to shrink. Figure 7 shows the data as reported by the federal government for per capita transfers in Table 8B of the *National Health Expenditure Trends, 1975-1997*, which are not adjusted for inflation²⁷. For 1975 and 1976, all of the payment was in cash. For subsequent years, the bottom part of each bar shows the yield from tax points, the middle portion the yield from extended health care benefits, and the top part the residual cash.

Figure 7: The Transition to *EPF*



Clearly, the total amount continued to increase, but a smaller proportion came in the form of cash, particularly in Quebec, which had negotiated a formula which gave them more tax points and less cash. The shift is evident. For example, in 1976 (before the change to *EPF*), the average per capita payment was \$155.05. The next year, the average per capita cash payment was reduced to \$106.05, plus another \$14.66 for extended health care, but tax points were estimated to yield an additional \$66.08. By 1994, the total (not inflation-adjusted) cash had risen to \$199.51, extended health care payment to \$50.85, with the tax point yield amounting to \$271.²⁷ CIHI's publication, *National Health Expenditure Trends, 1975-1997*,²⁸ translates these federal health transfers per capita into 1986 dollars; CIHI has kindly provided me with the same data in 1992 dollars. By including the mixture of cash under *EPF*, *CAP* and other programs (e.g., the Health Resources Fund, and the Payments to Territories), plus the tax points, they found that total payments had indeed decreased from their high point of \$596.20 per capita in 1989, but that even at their 1995 value (\$528.00), they were still higher than the pre-*EPF* cost shared numbers. This data is shown in Figure 8.



From a policy point of view, there was obvious room for dispute. Did a failure to award increases sufficient to keep up with inflation constitute a cut, or merely the absence of a raise? Could a transfer which went into provincial general revenues be considered as earmarked? For example, if less were spent for post-secondary education (which was also part of the *EPF* transfer), should the “savings” be attributed to health? Although the federal government continued to publish data attributing a portion of *EPF* to health and a portion to post-secondary education, these numbers were notional only; they were not tied to specific spending.

From a political point of view, however, simple extrapolation made it clear that eventually the cash portion of the *EPF* payment would disappear, and with it the ability to enforce the terms and conditions of the *Canada Health Act*. A momentary reprieve was gained by passing federal legislation to allow withholding from any federal transfer payment. In the longer term, the answer was to move to the *Canada Health and Social Transfer (CHST)* in 1996. In effect, the *CHST* took another cost-shared program, the 1966 *Canada Assistance Plan (CAP)* and swept it into the *EPF* transfer. At the same time, the federal government cut the total transfer, by an amount approximately equal to the transfers under *CAP*. The federal government committed itself to a “cash floor” below which it would not allow its transfers to fall. Interpretation of the transfer data, however, became even more dubious. If provincial governments cut spending which had formerly been included under *CAP* (as occurred, for example, when Ontario reduced its welfare rates), should this be seen as a diversion of federal money? Interpretation of transfer data became even more complex once Ottawa stopped giving even the “notional” allocations by program area. There

is now no agreed upon method for computing federal “health” transfers, which has made a rational discussion even more difficult. (On their web page, the government of Alberta currently argues that 48% of the CHST is for Health, 16% for “Advanced Education,” and 36% for “family and Social Services.” [<http://222.health.gov.ab.ca/funding/funtrans.htm>]).

As far as health care policy is concerned, however, it is important to recognize that nothing has changed since 1977. In that year, provincial governments were given the ability to make priority decisions about how, and what, to spend for health care. The only issue for provincial governments is whether they have sufficient provincial revenues to meet their spending priorities. In contrast, after 1996, all of those programs which had formerly fallen under *CAP* were no longer “protected.” Under *CAP*, they had been paid for with “50 cent dollars”; after, they were forced to compete with all other spending priorities, from roads to tax cuts. After 1996, provincial governments became as free to slash welfare programs as they had become able to reduce funding to post-secondary education after 1977.

It has been widely repeated that the share of federal funding for provincial health care spending has fallen from 50% to 9%. This number results from some creative accounting on both sides of the ratio. The first step is to deflate the numerator. This is accomplished by arguing - as many commentators on “fiscal federalism” do - that the federal tax points should not count as a federal transfer. The *EPF* formula, however, as is shown in Figure 7, had converted approximately half of federal transfers for the three programs into tax points. If one chooses to ignore the tax points, this immediately means that the baseline for “full federal funding” should be seen as 25% rather than 50%.

As we shall see, the second part of the creative accounting game is to artificially increase the denominator - what is being spent for health care. Recall that federal cost sharing had applied only to physicians and hospitals. As care shifted to the community, care could accordingly shift out from the protection of the *Canada Health Act* to private financing, whether it was medically necessary or not. Similarly, the trend toward understanding the importance of non-medical factors as “determinants of health” could justify reclassifying many social programs into a “health” budget, further inflating purported health care spending.

The Public Share of Health Care Spending

In international terms, Canada has ranked relatively low in terms of the public share of health care spending. Table 3 gives OECD data for public expenditure on health as a proportion of total spending on health, for the same 22 countries included above, again sorted in descending order for the 1997 data. Canada’s share started below the 22 country average, ranking 14th in 1975, 18th in 1993, and 19th in 1997. At this stage, rather than being among the most publicly funded, Canada ranks above only Australia, Portugal, and the United States.

Table 3: Public Expenditure on Health as a % of Total Expenditure on Health

	1975	1993	1997
Luxembourg	91.8	92.9	91.8
Belgium	79.6	88.9	87.6
Denmark	91.9	84.2	83.8
Iceland	87.2	83.7	83.8
United Kingdom	91.1	85.9	83.4
Sweden	90.2	85.7	83.3
Norway	96.2	83.3	82.2
Japan	72	79.2	79.9
New Zealand	73.7	76.6	77.3
Germany	79	77.5	77.1
Ireland	79	74.1	76.7
Spain	77.4	79.7	76.1
Finland	78.6	76.1	76
France	77.2	74.4	74.2
Switzerland	68.9	71.8	74
Austria	69.6	74.2	73
Netherlands	73.4	78.3	72.6
Italy	84.5	73.1	69.9
Canada	76.4	72.8	69.7
Australia	72.8	67	66.7
Portugal	58.9	63	60
United States	42.1	42.9	46.4
Average of the column:	77.8	76.6	75.7

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As is evident in Figure 9, the public share of Canadian health expenditures varies considerably by sector. Not surprisingly, given the history of Canadian health care, we see that virtually all of the costs for physicians and hospitals come from public sources, whereas funds for pharmaceuticals and other providers come primarily from private-sector sources²⁹. For those services which nonetheless qualify as “merit goods,” (*i.e.*, that we would not be willing to allow people to be denied on financial grounds), one would predict that a reliance on financing them from a mixture of public and private sources would lead to access problems and higher total costs than would result from retaining a single-payer approach.

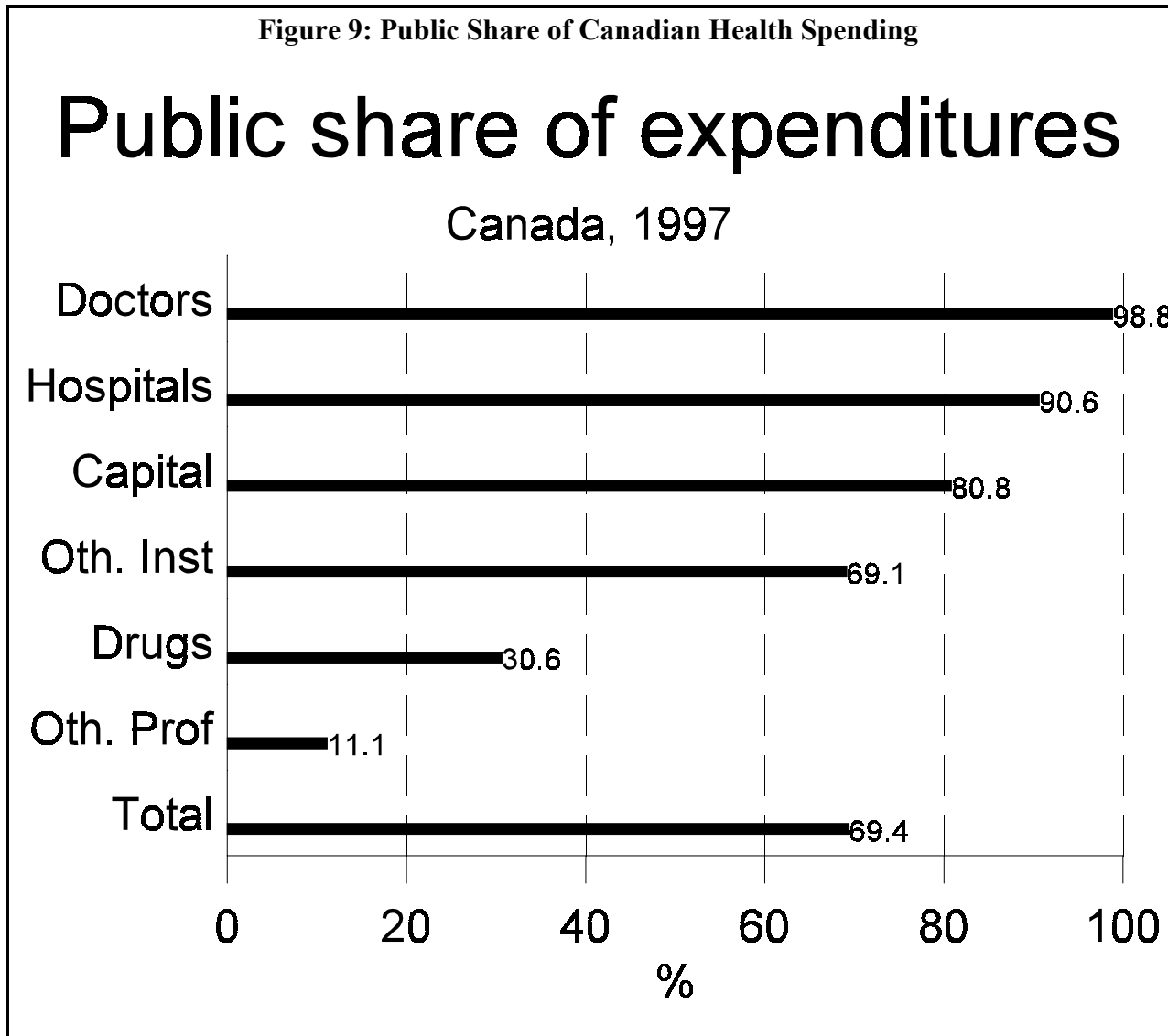
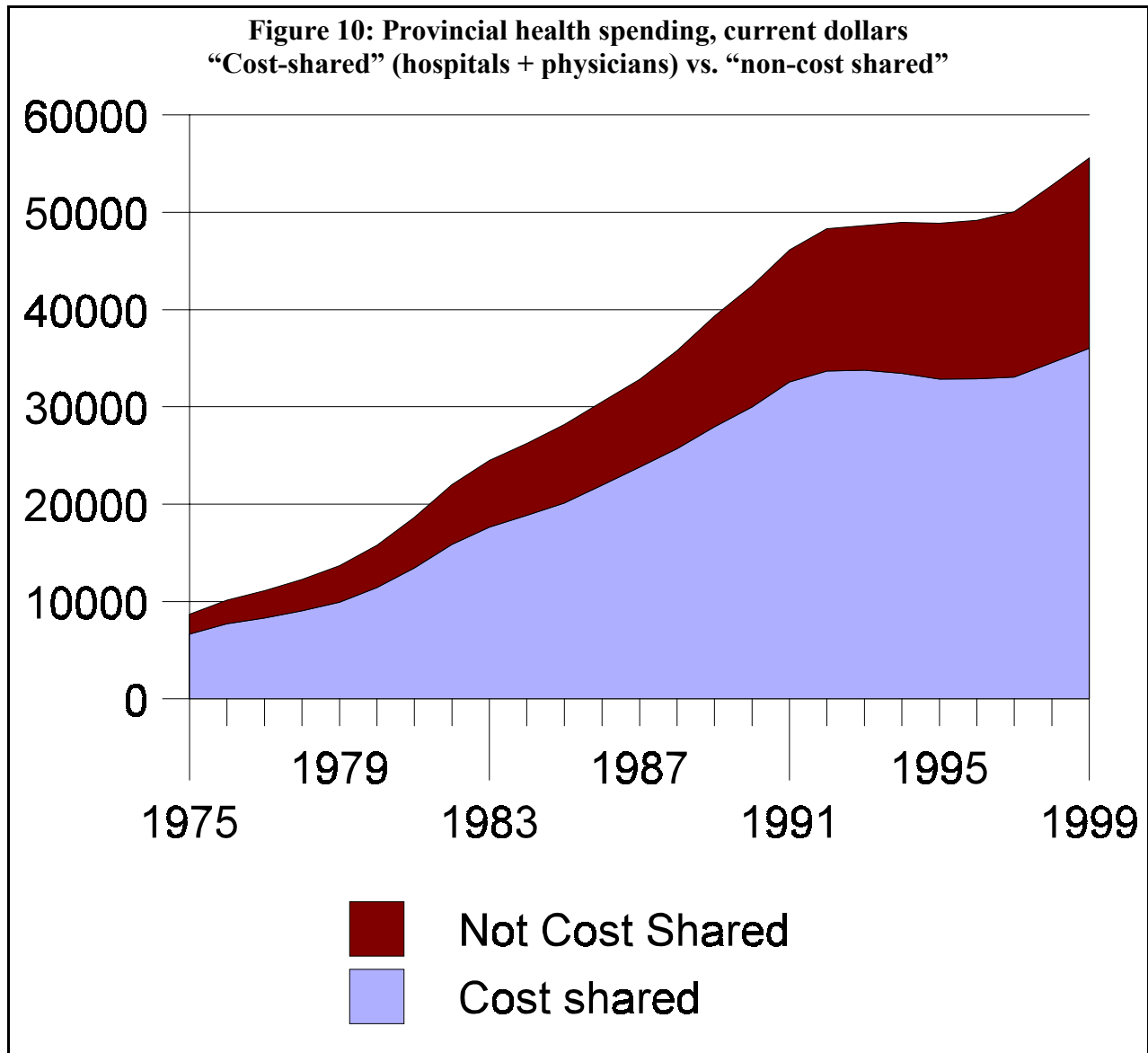


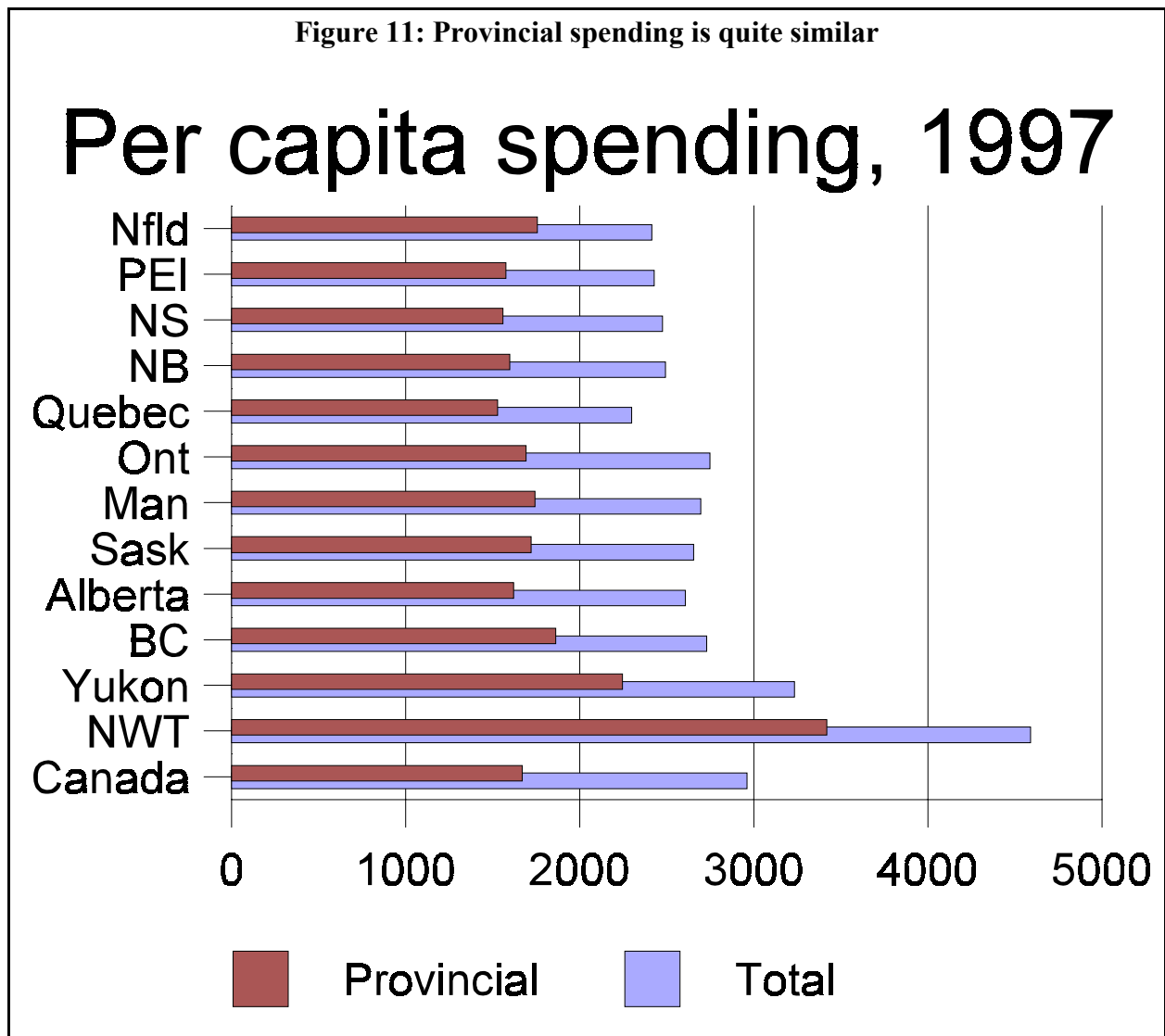
Figure 10 divides provincial health care spending into the amount dedicated to doctors and hospitals (“cost shared”) and that spent for all other health expenditures (“not cost shared”). This figure does not give inflation-adjusted data, but does show the changing proportions. As can be seen, this proportion has fallen from 76.7% of provincial spending in 1975 to an estimated 64.7% of provincial spending in 1997. Some of the arguments claiming low federal payments instead use total provincial health expenditures as the denominator, thus inflating the purported federal contribution.



What is the impact of these alterations in numerator and denominator? They act to make federal contributions appear to be less than one-third of their actual total (divide the numerator by 2, inflate denominator from 64.7 to 100). Although they have decreased, federal constraint has not been as dramatic as rhetoric claims. Indeed, CIHI data shows federal health transfers as 38.9% of

provincial government health expenditures in 1975, rising to a high of 44.6% in 1979 (the early years of *EPF*), and falling to 33% in 1995. These claims also ignore the impact of provincial cuts to the other programs (particularly welfare and post-secondary education) which were also intended to be financed through the CHST. It is unfortunate, if unsurprising, that facts have become hostage to other agendas. Nonetheless, the continued attempt to displace responsibility for provincial priority-setting decisions onto the federal government serves only to confuse the actual issues. To reiterate, since 1977, the question of how much to spend for health care has been left up to provincial governments, subject only to their continued compliance with the terms of the *Canada Health Act*. Federal transfers are important only as they affect provincial ability to meet their spending priorities. Trade-offs among health, education, welfare, roads, justice, and tax cuts are - and remain - provincial responsibilities which cannot be hidden by continued efforts to shift blame across levels of government.

As Figure 11 shows, despite considerable disparities in provincial wealth, the provinces have managed to spend a similar amount for each member of their population. The graph shows two sets of figures, both per capita in 1997 Canadian dollars. The longer bar represents total health



expenditures, and the shorter one provincial spending for all health care services. The Canadian average for provincial spending in 1997 was \$1670.90. Excluding the northern territories, which present specific problems relating to small populations spread over large distances, we note how little variation exists in aggregate spending per capita (although differences would no doubt arise if one age-adjusted spending, or examined precisely which services were being purchased). The lowest spending province, Quebec, spent \$1526.41; the highest spending province, BC, spent \$1860.95. The role of provincial priorities is clear. For example, Alberta is among the richest provinces, but was a relatively low spender. More importantly, this rather similar spending translates into rather different burdens on provincial treasuries. It is ironic that the loudest complaints have come from the wealthiest provinces.

With this backdrop, it is now time to move to examine some of the claims which have been made about what is wrong with Canada's health care system, and how to fix it. As we will see, many of these claims would be better classified as "myths." For the most part, they are supported by neither evidence nor logic. They are what Robert Evans has termed "zombies" - common, but inaccurate ideas which do not die, but instead keep walking about and doing damage³⁰.

The Myth of Health as an Ordinary Market Good

"What is wrong with people being allowed to use their own money to buy health care services?"

"Health care is like any other marketable good that people should be free to purchase or not purchase. If we allow people to buy food and shelter, which are considered primary goods, as they will, why not health care?"

In a free country, people are of course free to spend their money as they see fit, as long as the goods they wish to purchase are legal. By definition, people should be free to buy market commodities in the marketplace. Thus, we have little problem if already fit people choose to pay for a gym membership, or if people are priced out of the market for aromatherapy. The main problem with the above statements comes when we are talking about "merit goods" rather than market goods. Recall the examples above about the difference between the taxi ride and the emergency operation. There are certain goods which we, as a society, do not feel should be denied on the basis of ability to pay. In the language of economics, we do not allow people to be priced out of the market for these goods. Furthermore, recalling the example of the "free" open heart surgery, we, as a society, also do not believe that people should receive these services if they do not need them.

As we noted with the example of the "free" open heart surgery, people do not want to consume "needed" health care services in the same way that they want to consume movies, trips, or shoes. I have rarely met an individual who would say "with this \$500, I can finally buy that CT scan I always wanted." Neither are sane individuals eager to consume cancer chemotherapy drugs

when they are cancer-free, or take advantage of that “free” open-heart surgery when their heart is fine. Assuming that we are talking about “needed” care, people wish to buy these services because they are sick (or fear becoming sick) and wish to become (or remain) healthy.

These facts therefore imply several key differences between needed health care and other goods and services. First, providers can be placed in an insidious conflict of interest when they recommend care at the same time as they make their living from it. The market for health services also differs from standard markets in that it is mediated by “gatekeepers.” I am not free to check myself into the hospital for surgery, purchase prescription drugs, or receive radiation therapy without the permission of a licensed physician. Neither, I suspect, would most of us want that sort of freedom, nor find it appropriate. Providers are not merely providers; they are professionals, charged with the protection of the best interests of their patients.

How well does this philosophy fit with the desires of a profit-maximizing business? George Bernard Shaw mistrusted doctors precisely because of this potential conflict. In the preface to *The Doctor's Dilemma*, he writes:

That any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair of political humanity. But that is precisely what we have done. And the more appalling the mutilation, the more the mutilator is paid.³¹

In general, most of our health care professionals do not succumb to these sorts of pressures. Their professional ethics prohibit it. Public trust assumes that they will act appropriately, and to a remarkable extent they do so. Under these circumstances, it hardly seems wise to build a systematic mistrust into our health care system and hope that providers will continue to act against their own economic interests. (It seems even less wise to build a system which will systematically reward the least ethical providers.)

Neither is the comparison to other obviously necessary goods such as food or shelter a compelling one, precisely because neither contains the risk elements of medical catastrophe. Food and shelter expenses are relatively predictable, and can be budgeted for. If people cannot afford them, the problem is one of inadequate income and can be managed as such (*e.g.*, provision of pensions, welfare benefits, etc.) Health care expenses, in contrast, can be enormous; few can manage them on their own. Recall our discussion of the logic of insurance. By definition, most people will have to pool their risk with others. The policy questions concern whether this pooling happens publicly or privately, and whether people of very high risk will be excluded from the pool.

The myth of “allowing people to buy what they want” therefore confuses people’s real desires. It seems unlikely that people wish to spend their own money to buy their own health care out of some ideological sense that they want to “stand on their own two feet.” They might feel compelled to spend their own money if, and only if, they cannot obtain the care that they need in a timely and high quality manner. The solution, in that case, seems obvious. Ensure that people have access to the care that they need, and that such care is available in a timely manner, and of high quality.

The Myth of Canada as “Socialized Medicine”

“Doesn’t Canada have a clumsy state-run system and wouldn’t the introduction of competitive insurance markets make it more efficient and modern?”

“Private health care will provide more choice for citizens.”

As we have noted earlier, some confusion in nomenclature has hidden the fact that virtually all of health care delivery in Canada is already private, albeit often not-for-profit. “Public hospitals” are misnamed; they may receive much of their funding from public sources, but most of them are not public. Their employees are not civil servants, and their management has considerable leeway in how they choose to deliver services, rather than being bound by civil service procedures. (Ironically, the movement toward regional boards in much of Canada is blurring this line, particularly as provincial governments move toward electing board members. However, to date, these boards and their employees do not yet qualify as part of the public sector.) In that sense, Canada’s health care system is already built on public-private partnerships. Except in rural areas, competition also exists; people can choose which physician to patronize, and even which hospital to visit. (Indeed, the international trend toward encouraging competition has floundered on the recognition that competition requires excess capacity, which in turn tends to increase rather than decrease costs. Competition thus often acts as a transitional strategy to remove excess capacity through consumer-based rather than regulatory strategies, before moving back to a more regulated approach.) The real debate in delivery is thus not about recognizing the role of the private sector, which is already well established, but instead about what roles should be played by for-profit vs. not-for-profit firms, and the allocation of public money (*e.g.*, to profits, vs. to wages and benefits to workers.)³²

This myth thus depends upon confusing financing and delivery. Canada’s system is not state-run, but publicly-financed (at least, for those services included within the provincial insurance systems). There are indeed issues which need addressing around the amount of financing and the incentive systems built into allocation methods. However, these issues do not relate to the merits of changing financing.

Introducing competitive insurance markets are perhaps the most dramatic examples of suggesting “reforms” which will not address the broken pieces, but will themselves do terrible damage. Recall our earlier discussion of risk selection; competitive markets merely introduce an incentive for insurers to avoid the people in most need of care. The great dissatisfaction with “managed care” in the United States is one reflection of the failure of this approach. Such competitive markets also introduce enormous overhead costs. Insurers must compete for business, providers must deal with an assortment of insurers (and an assortment of rules and forms), patients must cope with complex paperwork. Indeed, those European countries who have relied on private insurance companies for historical reasons have heavily regulated the benefits which can be offered, while the companies themselves work together in consortia. Only the US persists in believing that competing markets, or “pluralism,” in financing necessary care does anything other than add costs and reduce coverage.

In terms of size, it should be noted that the Canadian provinces are already smaller than most of the US insurers. For actuarial reasons, insurers wish to maximize the size of the pool they have to cover in order to smooth out peaks and valleys. Almost no Canadian jurisdictions will be large enough to support competing insurers.

The Myth of Canada as the Most Publicly-funded System

“Other countries with public health care systems allow their citizens to purchase care privately and they spend less money on health care than we do.”

As we noted above in our discussion of public and private, this statement is not an accurate one. Canada actually has a higher proportion of private financing than do most countries. What is unusual is the split by sector, with Canada funding most hospital and physician care, but far less of the costs once care moves into the community. As the argument about the economic benefit of a universal single payer for necessary care would suggest, Canada’s cost control containment has been best precisely in those areas where public payment exists - particularly hospital services. Almost all of Canada’s cost increases in the past decade have come from the privately-funded sectors. Indeed, one could argue that this cost control has been too good, and that it may now be time for some strategic reinvestment.

In Canada, we publicly finance only about 68% of health expenditures, including the vast majority of physician and hospital services; much of the rest indeed falls on private insurance, and the employers who often pick up those costs as part of benefits packages²⁸. The worst cost control is indeed in those areas with mixed financing, including drug costs and rehabilitation services, and finding ways to improve access and efficiency would indeed prove valuable.

The Myth of Medical Savings Accounts

“What about increasing consumer choice by introducing Medical Savings Accounts and letting people buy their own health care?”

A recently suggested “panacea” is the Medical Savings Account (MSA). This simple (and simple-minded) plan would replace all government spending for medical care services, and hand it over to individual Canadians. No more public money for hospitals, doctors, mental health, public health, long term care, or medical research. Instead, every Canadian would get a fixed amount of money with which to purchase medical services. Some variants would actually have the government place this money in a registered medical savings account; others would allow individuals to use their own money and take a tax deduction. The MSA proponents assume that some of that money would be used to purchase catastrophic insurance for major medical needs. The rest could be used by each individual as they saw fit, such as paying for services which are currently uninsured. Every time someone needs care, they would just get the provider to swipe their debit card. No one would lose anything, and the healthy would get more money. Leaving aside the rather hefty investment required to set up this sort of information system, who could object?

Let's leave aside for the moment the fixed cost vs. average cost debate, which would suggest that many services serving a relatively specialized population might not remain viable, given the small population of many Canadian communities. (As one example among many, if the Hospital for Sick Children had to rely for its budget on payments from those few very sick children who could not be treated elsewhere, the cost per case would be prohibitive; the ultimate result of such cost spirals might mean that these services might not survive to be available when they were needed.) Even assuming these details could be worked out, the fundamental concepts behind MSAs make little economic sense. At the very least, they are not compatible with universal comprehensive care.

The dilemma arises from the fortunate fact that most of us are healthy at any point in time. Accordingly, the small proportion of people who are sick will account for a large proportion of health spending. For example, in 1994, those over 65 (many of whom are still quite healthy) accounted for just under 12% of the population, but about 48% of public spending for health care. In effect, seniors as a category were getting about four times their “fair share,” with the sickest among them consuming far more resources than that. Simple arithmetic suggests that we cannot simultaneously allow the 88% of the population under 65 to almost double their spending (that is, move from 52% of spending to their "fair share" of 88%) without either more than doubling total expenditures, or taking away 3/4 of what seniors are now spending. Moving from larger categories (e.g., those over 65) to individuals reveals that spending for health care services is even more heavily concentrated than that. For example, data from the 1993 US National Medical Expenditure Survey (NMES) showed that 18% of health expenditures were incurred by 1% of the population,

and 64% of health expenditures by the sickest 10%. In contrast, the healthiest 50% of the population incurred only 3% of health expenditures³³. (This problem is magnified in the US, where most health insurance is provided through employers, since those with the highest needs are also least likely to be employable.) If one can induce the healthy to enrol and avoid that sickest 1%, one can afford to buy a lot of wellness services while still making a considerable profit.

As is clear from our discussion about insurance and risk selection, we cannot punt this decision over to insurance companies and pretend that they could offer comprehensive catastrophic insurance. No insurance company trying to operate in a competitive model can afford to provide full catastrophic coverage for high risk populations, particularly for the relatively small premiums envisioned in most of these models. If everyone was to pay the same premium for catastrophic coverage, we can predict that the population over age 65 would have relatively high expenditures, amounting to a greater cost than would be collected by the premiums they would pay. Companies would be at risk for extremely high payouts to a population of predictably high risk, hardly an attractive business opportunity. At the same time, their competitors could easily undercut them by offering better rates to those at low risk! Precisely these dynamics are now underway in the field of travel health insurance. As insurance logic would predict, most companies are indeed unwilling to extend unlimited coverage - increasingly, benefits are being capped. Neither are most willing to insure against pre-existing conditions. Although advocates point to Singapore, which has indeed set up publicly-run (via a government agency) medical savings accounts, their catastrophic coverage is not available to anyone over 75, anyone with a disability, or anyone with severe preexisting conditions. Neither can full coverage be purchased; when I last checked, the best of several levels of plans limits coverage to \$70,000 Singapore dollars per year, with a lifetime limit of \$200,000. Anyone with a severe problem (say, a disabled child) would find their lifetime coverage had run out within a remarkably short period of time. Under these sorts of plans, we can thus purchase catastrophic insurance only if it doesn't cover catastrophes, which seems rather to be missing the point.

How will people react to having a fixed amount of money available for health expenditures? If this can accumulate, they may try to "save" what they can for a "rainy day." This raises similar problems to those raised by user fees; necessary visits may be unduly deferred, with expensive consequences for detecting disease late rather than early. On the other hand, if the plan is set up on a "use it or lose it" basis, we have built in an incentive to use up the available resources. Much as bureaucrats have an incentive to "spend down" at the end of a fiscal year, people may have an incentive to avoid wasting their medical savings accounts. Massage benefits are a very popular part of our university benefit plan - so popular that other benefits had to be curbed to pay for them (goodbye, subsidies for eyeglasses.). If my money would otherwise vanish, why not get a massage for that nagging back and neck pain I get from hours slaving over a hot computer? MSAs therefore allow providers to bypass the efforts to ensure that care offered is appropriate, rather than just marketable.

In short, MSAs violate the entire idea of insurance. They do not represent risk sharing, as much as a method of getting tax-sheltered (or taxpayer subsidized) income with which specified services can be purchased. As such, they mean that we will no longer transfer resources from the healthy to the sick. "Fairness" becomes redefined as "actuarial fairness." Since most of the population is healthy, they'll benefit, until and unless they happen to get sick or injured.

Proposals for MSAs accordingly beg the question of what taxpayer dollars should go for. I am very nearsighted, and wear glasses. Sure, it would be lovely if someone else paid for them. Or let me have free massages. But not if that meant taking away care from your sick mother or your disabled brother. And it would. Under the guise of "empowering consumers," these sorts of models would transfer resources from the sick to the well, raise expenditures, diminish appropriateness, and leave the sickest without insurance. It hardly seems a worthy tradeoff.

The Myth of User Fees

"Why not just have people pay a 'small' fee for care? This would reduce unnecessary utilization and provide extra money for health care."

Robert Evans has written persuasively about user fees³⁴⁻³⁶. He has noted that the above argument contains an inherent contradiction. Presumably, "reducing unnecessary utilization" means that we would save money through implementing user fees. In contrast, the "provide extra money" argument assumes that we would spend more.

At first glance, user fees seem to be a good idea. Unfortunately, they are a rather blunt instrument. Considerable research has shown that they do not accomplish their purpose. Yes, they can reduce utilization, under some circumstances. However, they are not very good at distinguishing between necessary and unnecessary visits. They also do not appear to be that effective at reducing overall costs.

The reasons why become evident upon closer reflection. One reason why there can be, at best, very minimal savings is that most health expenditures are physician-initiated. An individual may indeed make the initial decision about whether to see a doctor at all. However, these sorts of physician visits are relatively inexpensive. The costly decisions involve such questions as whether you should be admitted to hospital, be prescribed drugs, obtain surgery or radiotherapy, and so on. User fees, at best, can only deter that initial visit to the physician or the emergency room, which are usually among the least expensive portions of the health care system.

Even small savings may nonetheless be worth making. Studies do show that introducing user fees can indeed deter people from making these kinds of initial visits. The effect is greatest for people to whom even a 'modest' user fee matters - primarily the poor. However, studies also suggest that people aren't that good at distinguishing necessary from unnecessary care (which is probably why they need the expertise of a doctor in the first place). User fees are accordingly known to discourage early detection, as well as health education and health promotion, especially for lower income and lower educated groups.

Since many medical visits prove to be unnecessary, eliminating a visit is not likely to have much of a measurable impact on aggregate population health statistics, which is precisely what the studies find. In terms of these overall statistics, where is the health gain of finding that you do not have cancer, or that your blood pressure is normal? In hindsight, all such visits can be classified as unnecessary, since omitting a visit which found that you were fine clearly would have no adverse impacts on your health status. However, if the test had instead found that you need treatment, it would have been an essential one. To be helpful, it would be important to know whether a visit was unnecessary *before* the test results were in. Unfortunately, in many cases, neither patients nor doctors can do this effectively. Not surprisingly, these studies therefore find that necessary visits are as likely to be deterred as unnecessary ones. More careful analysis of the studies examining user fees usually discover that avoidable complications do increase from such conditions as untreated diabetes or hypertension. In the US, many of the poor find their diseases identified only late in the game (often in an expensive hospitalization, and often after they can be easily treated). In Quebec, user fees for prescription drugs for the elderly were found to increase bad outcomes, including deaths, hospital admissions, and complications from untreated disease³⁷. Again, this would seem a false economy.

Deber and Ross have suggested that one way of defining "medically necessary" care is in terms of our willingness to allow people to be priced out of the market. Assuming that a particular treatment is likely to be effective, is appropriate for the given condition, and is wanted by the potential recipient, society must determine whether it is willing to deny such care to those who could not afford to pay for it².

In effect, there are three alternatives for people who "need" a service which they cannot afford to pay for themselves. The first is to buy the service anyhow; under this situation, people can and do spend themselves into bankruptcy, and are forced to make difficult choices (e.g., between food and medication). Under these circumstances, there is no cost control. Indeed, most health economists recognize that the reason why US health care spending is so high is not because there are too few market forces operating, but because there are too many - cost control is achieved by denying care, rather than by otherwise constraining costs.

The second possibility is that people will decide to forgo the service, either because they do not recognize it as necessary, or because they consider other things (*e.g.*, food for their family) to be of even higher priority. There is incontrovertible evidence that imposing a user fee will deter some utilization. Unfortunately, as we noted, there is equally good evidence that this reduced utilization does not distinguish well between necessary and unnecessary visits. This is not really surprising, since if people had enough medical knowledge to distinguish between necessary and unnecessary visits, they would probably be doctors themselves. The deterrence effect is also far stronger for primary care than for the really expensive portions of the system (*e.g.*, hospitalization), implying that savings are likely to be trivial. The deterrent effect of user fees is, not surprisingly, greatest for the people to whom the money matters the most - usually, the poor, the elderly, the sick, and the disabled. Indeed, utilization by those to whom the fee is trivial may increase, leaving total utilization (and costs) largely unchanged. To the extent that people seek care only when they are very sick, early detection, health education, and preventive medicine may go out the window. In addition to being lousy medicine, in many cases, this is also lousy economics.

The third possibility is that people would like to receive the care, and will seek assistance from others. An interesting ethical dilemma arises about whether society or charity will come to the rescue, or say “tough luck.” If they come to the rescue, we move back to the first possibility - buy it anyhow - and eliminate the ability to control costs. If they do not, we move back to the second possibility, and tell people that they are on their own. As we have noted above, as long as we are unwilling to price people out of a market, we cannot use market forces to achieve cost control.

A number of variations on user fees are often considered. For example, one proposal was to charge \$5.00 per “unnecessary” emergency room visit, up to a maximum per patient, but with the fees waived for the poor or chronically ill. There are few administrators who would be able to administer this sort of scheme for less than the collection cost. In general, one suspects that all of the revenue collected by a “small” user fee would be required just to set up the administrative mechanisms required to determine which visits were necessary, who should be exempt from payment, and collect the remaining fees.

The Myth of Strengthening the Public System by “Freeing up Resources”

“If people are allowed to purchase health care privately, this will free up resources in the public system, thereby strengthening the public system and providing more resources for those who cannot purchase their own services.”

Rather than “free up” resources, most studies have found a combination of higher costs and worse access (*e.g.*, longer waiting lists) whenever mixed funding models are introduced; for a review of this material, see Deber *et al.*’s background paper for the National Forum on Health².

Why these counterintuitive results? After all, it would seem logical that removing people from a queue would result in shorter waiting times for those left, benefiting all parties. However, more careful thought reveals the flaw in the economic logic. Why would individuals pay for care if they could receive timely, high quality care “for free”? As such, privately financed health care requires that the publicly-funded system be inadequate, or at least, be perceived to be inadequate. Rather than strengthening the public system, these sorts of models require that it remain weak. Particularly when the same providers offer care within both systems, they have a strong incentive to ensure that the publicly funded care remains sufficiently uncomfortable, inconvenient, or inaccessible to maintain a market for their more lucrative privately-funded services³⁸. Not surprisingly, that is precisely what recent studies of such mixed markets have found. In Alberta, a recent report by the Consumer Association of Canada concluded:

“Contrary to commonly held beliefs and claims made by suppliers, the evidence in the report reveals that the growth of private cataract surgery clinics in Alberta has:

- increased public waiting lists (the same physician services both lines)
- increased the cost of services to the plan, the price to patients and the cost of health plan coverage to the community at large
- created a number of conflicts-of-interest which jeopardize taxpayers and patients.
- decreased public accountability, public scrutiny, and public control of the Alberta provincial health care plan.”³⁹

The report found that even though privately paying patients were being charged up to \$1500 out of pocket expenses and encouraged to purchase “enhanced benefits,” waiting lists within the publicly funded system had not improved. Similar results were found in Manitoba, Australia, and New Zealand⁴⁰⁻⁴². The arguments against the private tier are also economic ones; these additional costs often fell onto business through benefits costs, decreasing their economic competitiveness.

The Myth of the Federal Government

Isn't it the fault of the federal government for cutting transfers?

Canadians are fond of blaming most things on the federal government. Federal cuts to transfer payments have indeed decreased provincial general revenues, and made it more difficult for provincial governments to pay for all programs. Since health spending accounts for about 1/3 of most provincial budgets, any decrease in fiscal capacity is clearly important. The impact is clearly most serious in those provinces under the greatest fiscal stress. However, the impact of

federal cuts has been exaggerated by modifying two sets of numbers. First, federal contributions to the provinces are minimized by ignoring the “tax points” transferred in the 1977 *EPF* agreement. Since the yield from these tax points amounted to about half of the transfers for the former programs for hospital insurance, medical care insurance, and post-secondary education, this was a considerable sum of money. Second, the numbers exaggerate provincial health spending by failing to note that cost sharing only applied for those sums devoted to hospitals and physician services. The ultimate result is to present federal contributions as about 1/3 of what is actually the case.

Another misunderstanding has arisen by suggesting that there is a one-to-one relationship between “health” transfers and provincial spending, and that increased federal transfers are necessary to “save” health care. The germ of truth in this argument is that provincial flexibility is clearly related to its revenues, and that increased federal transfers - like any other increased revenue source - would give provinces an increased capacity to spend on any programs. However, as noted above, since 1977, there has been no direct connection between “federal cuts” and provincial spending decisions about health care or post-secondary education, and, since 1996, no connection with spending decisions for welfare programs. The entire point of such programs as *EPF* and the *CHST* is that federal transfers have gone into provincial general revenues. Indeed, to the extent that provincial governments have chosen to slash spending for the other programs encompassed in the transfer (post-secondary education and welfare programs), one could even argue that health spending has been maintained, at the expense of other priorities. Rather than attempting to couple provincial spending with “restoring the CHST,” the bottom line is instead whether provincial governments have enough money to meet their responsibilities. The choice between, for example, tax cuts and health spending is a policy one made by individual provinces, which must be judged on the merits of the respective programs. Several other federal programs, including the Millennium Scholarships, have been used to substitute for provincial spending in that area, rather than meeting the presumed policy goal of augmenting that program area. Particularly in the richer provinces, the role of “federal cuts” is largely a convenient smokescreen which is being used to hide “cutback” decisions presumably being made for other reasons.

The Myth of “Affordability” Requiring More Private Money

“Won’t the aging population and the growth of technology bankrupt our system and require an injection of more private money?”

A widespread fallacy is that services which are unaffordable within the public sector can somehow be provided more cheaply within a public-private partnership. Logically, this requires one of two possibilities - either each unit of service can be purchased at a cheaper price by the private sector, or fewer units of services will be purchased. The first possibility is demonstrably false; monopsony purchasers can clearly drive tougher bargains if they wish to do so, which is one reason why international evidence is so clear about the short-run cost advantages of a single payer. The second possibility, however, implies that people will not get any services unless they can afford to purchase them. Accordingly, as long as the public agrees to pick up the costs for those

who cannot afford a private tier, market forces cannot ensure cost control - price signals can balance supply and demand only if we allow people to be priced out of the market⁴³. As we have already observed, a parallel, privately funded system would also place enormous increased costs on business (and hence on the Canadian economy), hinder access, and otherwise weaken our health care system.

Although the elderly clearly are likely to place greater demands on health care resources, the literature suggests that these demands are relatively modest, and could easily be accommodated⁴⁴. Canada is still a relatively young country, and will remain so for several decades. The costs of the baby boom generation will not be felt until they move into their 70s and 80s; in the short and medium run, population aging is likely to be less influential in setting overall health costs than such issues as determining what level of skills, and remuneration, health care workers will receive. Futurists have not been that successful in foretelling the future; by that time, it is at least plausible that revolutions in understanding human biology will have totally transformed the way in which we deliver health care. (As one example, the ability to eliminate disabling diseases may reduce the need for expensive caregiving, although the costs will depend heavily upon how much their inventors will charge for new pharmaceuticals or therapies.) At present, Canadian costs are actually well in line with those of comparable industrialized countries²⁴. For at least the next several decades, the major limitation to the ability to provide a high quality system is political.

An important factor which must be recognized is that privately-financed services usually charge more money than those funded by public money. The reason is evident; as we have noted, single payer can exert “monopsony” power over providers and control costs. This is clearly uncomfortable for providers, however great a bargain may ensue for consumers. If costs are controlled too well, there may indeed be problems with attracting enough providers and delivering the required care. However, a series of experiences with mixed markets makes the price differentials clear. Consider the difference in the price which Ontario’s government-funded insurance plan pays for a physiotherapy visit with that charged to a privately-paying patient; the private paying customer pays nearly three times as much. The costs for radiation treatment for Ontario cancer patients currently being sent to the US are as much as six times as expensive as it would have been to treat them at home. Alberta reports similar cost escalation for cataract surgery.

How can it be cheaper to provide services at two to six times the cost? Clearly, the only savings will arise if enough people do not get care. If we try to simultaneously ensure that everyone who needs care receives it, the mixed financing approach will cost far more money. *If we as a society cannot afford care within the publicly funded sector, we cannot afford it privately.* These sorts of mixed models will work if, and only if, we decide that a type of care is a market good, which will go only to those willing to pay for it.

What Does Need Fixing?

The first law of cost containment reads: *The easiest way to contain costs is to shift them to someone else.* This law is influencing every actor in the system. In particular, governments have a short-term incentive to shift costs outside the publicly-paid system and encourage what the Canadian Medical Association has called “passive privatization” and others have termed “privatization by attrition.” But long waiting lists for occupational injuries are a false economy. Similarly, slashing the number of nurses and hiring them as casual workers is not conducive to the long term health of our system of delivering health care; in the long run, too few people will be willing to enter the profession. Similarly, sending people home from hospitals while still sick, without follow up care, or having people fail to take clearly medically necessary pharmaceuticals because they cannot afford to pay for them, increases the burden of illness, while probably increasing the total costs of health care. Delaying opening a needed cancer clinic, refusing to train enough providers, or paying them so poorly that they exit the profession are false economies, as is becoming painfully evident. However, the government which takes these actions can then introduce a tax cut and ignore the fact that total costs will have increased.

In my view, the health care system which Canadians have created is already a role model for the entire world. It is critical to identify mechanisms to ensure that government and providers are accountable for ensuring that it stays that way. Two obvious pressure points are the definition of what should be included within the ambit of public financing, and addressing issues of how to best organize providers and pay them for their services. The recent suggestions by Alan Rock are accordingly a step in the right direction. They address the “passive privatization” issue by adopting the recommendations of the National Forum on Health to introduce new programs for home care and pharmaceuticals¹⁶. Far from being “boutique” programs, they are essential to prevent the distortions currently arising as governments shift medically care outside of hospitals in order to privatize its cost. Note that the home is a place of care, rather than a type of service. Clearly, not all of the services provided within home and community will qualify as merit goods, just as not all prescription drugs (or all physician services) would. There may indeed be a place for means testing and user fees for many important services (*e.g.*, home making, meals on wheels) which we would be willing to deny to those unable to pay for. Other home-based services (*e.g.*, palliative care), however, should retain the universal coverage guaranteed by the *Canada Health Act*. Other efforts to attain primary care reform and to make better use of chronic hospitals are long-overdue approaches to improving the delivery of health care, and the allocation methods used to pay its providers.

Any reform effort must be approached with humility and caution. As the late political scientist Aaron Wildavsky once pointed out, complex policy problems are rarely solved. Instead, we usually replace one set of problems with another. The mark of success is whether we like the new problems better than the old ones⁴⁵.

Note, however, that these necessary reforms do not include the private financing myths we have addressed in this paper. For the medical and economic well-being of Canadians, one trusts that we will remain wise enough to avoid introducing financing approaches which economic logic shows make little sense, and which the experience of other jurisdictions has shown to have failed. The problem is not with who pays for health care, but with how we pay for it, and who receives the payments. Financing is not broken; allocation is. We must avoid the temptation of the drunk who dropped his keys in the middle of the block, but started searching at the corner on the grounds that the light was better there. We trust that this paper has helped to shed more light on the spots where the keys to the solution may actually lie.

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