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Misinformation and Wishful Thinking about Medicare's Sustainability

Brett J. Skinner

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Executive summary

In July 2007, the *Canadian Medical Association Journal (CMAJ)* published articles by Irfan Dhalla (2007) and François Béland (2007) denying that the growth of government health expenditures observed in Canada is unsustainable. Methodological and conceptual errors in their articles produced invalid analyses and grossly misleading conclusions about the sustainability of government health spending under the Medicare policy model. Yet the errors were elementary mistakes that should have been easily flagged by peer reviewers at the journal before publication. Even worse, the errors were avoidable because peer-reviewed research previously published by The Fraser Institute has already explained why the methods and concepts used by Dhalla and Béland are inappropriate. Appropriate metrics show that government health spending continues to grow faster than the ability to pay for it.

The *CMAJ* articles contained numerous errors. In estimating the scale of public health spending, one article did not count spending on drugs and other outpatient services funded through various provincial Medicare add-on programs. Both articles also based their conclusions on data from 1992 to 1997, a time that was affected by a temporary episode of strict government-imposed spending controls and restrictions. The use of this data produced unrealistic expectations about future health spending growth rates. One article analyzed the sustainability of public health spending by comparing its growth rate relative to total public expenditures. This metric hides the exaggerating effect of deficit spending on the actual long-term availability of revenues, creating an illusion of sustainability. Both articles recommended increased federal transfers and tax rates to solve the sustainability problem facing public health spending. Evidence shows that neither of these policies has been successful in the past.

A more appropriate metric for estimating sustainability is the ratio of total provincial health expenditures to total provincial revenue from all sources. This is the only method that explicitly compares actual expenses with actual ability to pay. Previous analyses have monitored trends using this metric on a moving-annual basis by comparing the most recent five-year average annual growth rates in each of the provinces and projecting the trend forward. When capturing the short-term trend, a five-year average metric has the effect of smoothing out aberrant years and is just long enough to isolate the effects of the most recent policy regime. Based on the most recently published five-year trends (2001/02 to 2005/06), public health spending in six of 10 provinces was on pace to consume more than half of total revenue from all sources by the year 2020.

Using an alternative approach, other estimates suggest that as of 2003, Canadian governments faced future funding obligations for health care that exceeded expected future revenues by \$555 billion or 46 percent of Canada's 2003 total economic output

(GDP) of just over \$1.2 trillion. Most worrisome is that this unfunded liability grew by 28.5 percent between 1999 and 2003, from \$432.2 billion to \$555.3 billion.

The *CMAJ* articles ignored the empirical reality that when Canadian governments have been able to slow the growth of spending on public health insurance it has been only temporary, and it has been achieved by abusing the government's monopoly power over medical insurance. Examples include ending coverage of previously insured goods and services and refusing coverage for new drugs and medical technologies; under-funding the capital deficits of hospitals; under-investing in diagnostic equipment; directly regulating the price of new medicines; reducing the effective supply of health professionals; and exploiting medical labour by suppressing wages. All of this has coincided with increasing waits for hospital services and new medicines.

Medicare promises to pay for everything for everybody without any price at the point of consumption. This is the major reason why public health insurance is financially unsustainable. Consumers (patients) face no price incentives to rationalize demands for low intensity medical care. And providers face no price or profit incentives to efficiently allocate supply, substitute treatment alternatives, or invest in new technologies.

Flat percentage co-payments, user fees, extra-billing, and flat-rated premium based financing are ways to introduce price mechanisms that would make public health insurance more sustainable while empowering consumers with greater choice. Permitting private insurance options would also allow the shifting of costs off the public system. Other countries employ such policies showing that there are better ways to achieve universal health insurance coverage than through a government-run health insurance monopoly.

Researchers who deny that the growth of government spending on health care observed in Canada is unsustainable base their analyses on three unrealistic assumptions: (1) that the disproportionate demand for publicly funded health spending can increase indefinitely relative to other spending; (2) that tax rates can increase indefinitely to fund health spending growth, or (3) that the scope of coverage for and access to medically necessary care can be reduced indefinitely while maintaining a government health insurance monopoly. They also assume that all of these things can happen without any economic, political, or medical consequences. Such assumptions are demonstrably false and analyses that are based on them mislead policy makers and the public about the actual declining value and increasing cost of current health policy in Canada.

Introduction

In July 2007, the *Canadian Medical Association Journal (CMAJ)* published articles by Irfan Dhalla (2007) and François Béland (2007) denying that the growth of government health expenditures observed in Canada is unsustainable. Methodological and conceptual errors in the articles produced invalid analyses and grossly misleading conclusions about the sustainability of government health spending under the Medicare policy model. Yet the errors were elementary mistakes that should have been easily flagged by peer reviewers at the journal before publication. Even worse, the errors were avoidable because peer-reviewed research previously published by The Fraser Institute has already explained why the methods and concepts used by Dhalla and Béland are inappropriate—research that is notably absent from the authors' citations. Appropriate metrics show that government health spending continues to grow faster than the ability to pay for it.

A detailed critical analysis of the main flaws in the Dhalla and Béland articles appears below, followed by an accurate analysis of the sustainability of government health expenditure growth in Canada.

Critical analysis of the Dhalla and Béland articles

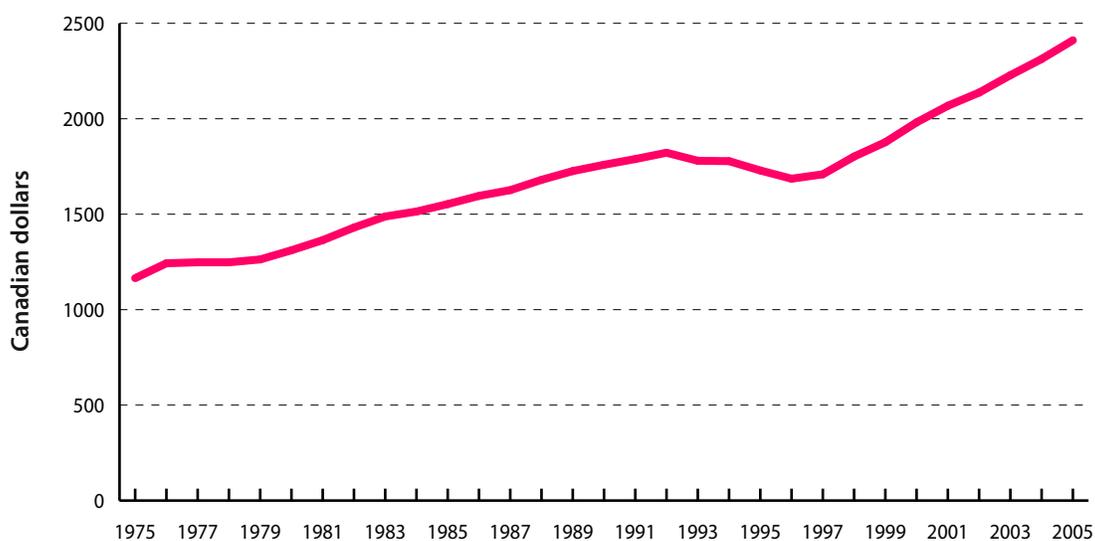
When measuring the level of public spending on health care, Béland excluded spending on drugs and other outpatient services funded through various Medicare add-on programs. This approach is grossly misleading. It significantly underestimates total public spending on health care. Government spending on drugs and other outpatient services are equally a part of the Canadian health system as we know it and are not likely to be abandoned by governments in the future. All publicly funded spending on health care must be counted in any measure of the sustainability of Canada's particular approach to health policy. The invalid logic of Béland's metric implies that we should count the public money spent on doctors, but not the public money spent on the treatments they prescribe. Furthermore, a previously published analysis has provided empirical evidence showing that, for example, even excluding drugs entirely, government health spending on all other non-pharmaceutical items continues to grow faster than revenue (Skinner and Rovere 2007). Béland fails to cite this research suggesting an inadequate familiarity with the literature in this area.

Both Dhalla and Béland based their conclusions on data from a period (for Dhalla it is from 1992 to 2004 (p. 52, para 6); for Béland it is 1990 to 2004 (p. 56, para 1) that includes a temporary episode of strict government-imposed spending controls

and restrictions that occurred between 1992 and 1997 (see figure 1). Dhalla argued that health expenditure growth could slow to sustainable rates in the future as it once did in Ontario where, after a long period of increases, public health spending began decreasing as a percentage of total expenditures in the province over the 10 years between 1988 and 1997 (p. 51, para 6). Yet Dhalla does not mention that since 1997, the percentage of total provincial expenditures consumed by health spending has increased to its highest point ever (see table 1), highlighting the temporary nature of the spending contractions observed from 1992 to 1997. And both Dhalla and Béland fail to acknowledge how the temporary slowing in health expenditures was achieved during this period or the painful price that patients paid in terms of reduced access to medical goods and services. Blunt rationing is not a sustainable way to control health expenditure growth in the long-run, either from a medical or a political perspective. Therefore, expectations about future growth cannot be based on trend periods that are overly affected by the rates of growth observed between 1992 and 1997.

Initially Dhalla analyzed the sustainability of public health spending by comparing its growth rate relative to total public expenditures. Previous research has explained why Dhalla's use of the ratio of public health spending to total expenditures is an improper way to estimate sustainability (Skinner 2004, 2005; Skinner and Rovere

Figure 1: Real (inflation-adjusted) per-capita (population-adjusted) consolidated federal-provincial-territorial government health expenditures, 1975–2005



Source: [GHEX] CIHI (2005). Table B.3.2. Public Sector Health Expenditure, by Province/Territory and Canada, 1975 to 2005—Current Dollars; [CPI] Statistics Canada (2006b), CANSIM, table 326-0002 and catalogue nos. 62-001-X, 62-010-X, and 62-557-X (last modified: 2006-01-18); calculations by author.

Table 1: Total Revenue (TREV), Own-source Revenue (OREV), Total Expenditure (TEX) and Government Health Expenditure (GHEX), Ontario, 1988–97, millions current \$

	1988/89	1989/90	1990/91	1991/92	1992/93	1993/94	1994/95	1995/96	1996/97
TREV	\$41,937	\$46,829	\$48,783	\$46,642	\$47,099	\$48,805	\$51,352	\$55,026	\$54,974
OREV	\$36,550	\$41,093	\$42,667	\$40,014	\$39,163	\$41,269	\$43,369	\$46,992	\$48,817
TEX	\$42,560	\$45,575	\$50,892	\$57,299	\$59,173	\$59,340	\$60,400	\$62,304	\$59,805
GHEX	\$13,131	\$14,790	\$15,812	\$17,932	\$18,180	\$17,986	\$17,995	\$18,923	\$18,845
Fed Trans % TREV = (TREV-OREV) / TREV	12.8%	12.2%	12.5%	14.2%	16.8%	15.4%	15.5%	14.6%	11.2%
Total surplus or deficit	-\$624	\$1,254	-\$2,110	-\$10,657	-\$12,074	-\$10,535	-\$9,048	-\$7,278	-\$4,831
Own-source surplus or deficit	-\$6,010	-\$4,482	-\$8,226	-\$17,286	-\$20,010	-\$18,071	-\$17,031	-\$15,312	-\$10,988
Tdef / TREV or Tsurp / TREV	-1.5%	2.7%	-4.3%	-22.8%	-25.6%	-21.6%	-17.6%	-13.2%	-8.8%
Odef / OREV	-16.4%	-10.9%	-19.3%	-43.2%	-51.1%	-43.8%	-39.3%	-32.6%	-22.5%
GHEX / TEX	30.9%	32.5%	31.1%	31.3%	30.7%	30.3%	29.8%	30.4%	31.5%
GHEX / TREV	31.3%	31.6%	32.4%	38.4%	38.6%	36.9%	35.0%	34.4%	34.3%
GHEX / OREV	35.9%	36.0%	37.1%	44.8%	46.4%	43.6%	41.5%	40.3%	38.6%

Source: Statistics Canada Financial Management System, 2006c; calculations by author.

2006). This metric hides the exaggerating effect of deficit spending on the actual long-term availability of revenues, creating an illusion of sustainability. But it should be obvious that deficit financing cannot continue indefinitely. Eventually debt and interest must be paid out of current revenues if bankruptcy is to be avoided. This realization is what has made the unsustainability of public health spending more acutely obvious to policy makers since the 1990s. Financial Management System (FMS) data covering the period from 1988/89 to 1996/97 (see table 1) illustrate the way in which deficit spending creates the illusion of sustainability.

Statistics Canada's Financial Management System is the only source for detailed, reliable, standardized, and comparable data on provincial revenues and expenditures. However, FMS data are only available as far back as 1988/89. The data cover 9 of the years corresponding to the 10-year period Dhalla selected using a different data source. The fact is that Ontario was in deficit (total expenditures exceeded total revenues) in 8 of the 9 years. Notably, in the 5-year period (1992 to 1997) prior to the strict spending retrenchment and rationing of health care mentioned earlier, government health expenditures appeared to be virtually unchanged when measured against total expenditure, going from 30.9 percent of total expenditures in 1988/89 to 30.7 percent by 1992/93. Yet, the percentage of total revenues consumed by public health spending increased from 35.8 percent in 1988 to 38.6 percent by 1992/93.

Dhalla eventually suggests the ratio of public health spending to GDP as a better metric for sustainability. Dhalla acknowledges that total health spending has risen faster than GDP (our absolute ability to pay for anything) over time. Indeed, according to the most recent and complete data from the Canadian Institute for Health Information (CIHI) (the only available source for detailed health spending data from earlier periods) and Statistics Canada, public health spending has also risen as a percentage of GDP, going from 5.4 percent in 1975 to 7.2 percent by 2005 (CIHI 2005b; Statistics Canada 2006b). But Dhalla's thesis is that as long as non-health spending rises in absolute terms, the growth of public health spending as a percentage of GDP is "sustainable for the foreseeable future" (p. 51). There are a number of problems with this argument. First, it is based on the fanciful assumption that future demand for additional non-health care spending will proportionately decline indefinitely relative to the demand for health care spending. It also mistakenly assumes that individual demand preferences for health care spending versus non-health care spending are universally similar (something obviously not true) and can therefore be known and satisfied as efficiently through central planning as through consumer driven markets. The argument also paternalistically implies that governments have a justifiable claim on a fixed percentage of economic output to support Medicare programs, regardless of whether such a level of spending is reasonable relative to consumer demand preferences, or produces optimal value for money.

The policy solutions that Dhalla and Béland offer are themselves unsustainable. Both recommend increased federal transfers and tax rates. But the logic behind both suggestions is fatally flawed. In order for federal transfers to push provincial revenue growth at the same pace as that observed for health expenditures, the level of federal transfers must increase in perpetuity. This would put federal health transfers on pace to indefinitely consume increasing shares of federal revenue—the same unsustainable policy logic affecting the provinces. It can also be shown empirically that it is incorrect to think that a lack of support from the federal government is to blame for the lack of financial sustainability for Canada's health care system. According to the most recent research (Esmail et al. 2007) the federal government has provided the provinces with \$234.5 billion in cash transfers for health since 1980/81. More than half that amount (\$115.7 billion) has been provided since 1997/98. The fiscal year 1997/98 is the first year the federal government recorded a financial surplus during the period examined. As mentioned earlier, 1997/98 represents an important turning point as health care transfers began to grow at a higher rate and inflation-adjusted health spending per capita began to increase after a number of years of decline. The average annual growth rate in federal cash transfers for health since 1997/98 is 12.9 percent—more than four times the rate required to keep up with population growth and inflation (3.09 percent). This means that since 1997/98, Ottawa has increased its cash transfers for health care to the provinces by \$36.0 billion more than needed to compensate for population growth and inflation. Despite this high level of federal funding, government expenditures for health care continue to outpace our ability to pay for them. It is interesting, too, that in Ontario for example, over the same period, federal transfers increased from 12.8 percent of total provincial revenues to 16.8 percent (table 1). This confirms that despite a boost to provincial revenues from federal transfers, provincial public health expenditures in Ontario still increased at unsustainable rates relative to total revenue during these years.

Dhalla and Béland each call for increased taxation—a recommendation that is also flawed. In order for tax increases to push provincial revenue growth at the same pace as health expenditures, the tax burden must increase in perpetuity. This is of course unsustainable, as it would put taxes on pace to consume ever-increasing shares of real income. In the meantime, increasing taxes will cause GDP growth to slow, ultimately constraining the tax base and reducing the public money available for health or non-health related spending. Empirical evidence shows the long-term futility of such a policy. For example, provincial public health expenditures grew faster than total revenue (table 1) even while the tax burden was regularly increasing in Ontario between 1988/89 and 1996/97 (table 2).

The suggestion that it is sustainable to allow public health spending to rise as a percentage of GDP and fund it by raising taxes to keep revenue growing as fast as spending is also based on the false assumption that such a policy is politically

acceptable. But the tax burden is not distributed equally across all income contributors to GDP; heavy redistribution means that increasing taxes disproportionately affects middle to higher income taxpayers. Many Canadians are paying more and getting less over time, which is making Medicare a declining value proposition. Maintaining political support for a public health insurance monopoly under this scenario is unlikely.

Table 2: Tax Rates* (percent)

	1981	1985	1995 ^{re}	2000 ^{re}	2005 ^{re}	2006 ^{re}	2007 ^{pe}
Newfoundland & Labrador	37.4	34.9	37.9	42.6	47.5	47.8	49.4
Prince Edward Island	34.2	42.8	38.1	41.8	45.2	45.0	44.7
Nova Scotia	35.5	37	42.1	44.5	47.1	46.9	46.1
New Brunswick	34.2	41.6	42.3	43.3	44.6	44.7	44.7
Quebec	42.9	45.6	44.5	50.0	48.6	48.8	48.0
Ontario	40.3	39.5	44.4	46.5	46.5	46.6	46.1
Manitoba	37.2	33.8	44.3	46.9	46.2	46.0	45.4
Saskatchewan	39.0	37.1	45.6	49.6	49.8	49.1	47.1
Alberta	40.6	38.5	42.4	46.9	44.9	43.3	41.2
British Columbia	43.4	45.2	44.5	47.9	47.4	46.6	45.4
Canada	40.8	42.7	44.4	47.8	47.6	47.4	46.5
<i>Without Natural Resources</i>							
Newfoundland & Labrador	37.2	34.6	37.8	42.3	45.2	46.0	44.7
Saskatchewan	36.5	34.8	43.7	46.4	46.3	46.0	44.5
Alberta	34.2	33.3	40.0	40.4	38.9	38.9	37.7
British Columbia	42.6	44.3	43.2	45.6	45.4	44.9	43.8
Canada	39.9	42.1	43.8	46.7	46.5	46.6	45.8

Notes: *Based on total taxes as a percentage of cash income for families with two or more individuals;
^{re} = revised estimate; ^{pe} = preliminary estimate.

Source: Palacios and Veldhuis 2007.

Appropriate estimates of sustainability

A more appropriate metric for estimating sustainability is the ratio of total provincial health expenditures to total provincial revenue from all sources. This is the only method that explicitly compares actual expenses with actual ability to pay. The ratio of public health spending to revenue measures the ability of government to pay from current revenues. This metric directly satisfies the definition of long-run sustainability and immediately exposes any attempt to use deficits to finance public health spending. The ratio of public health spending to revenue also makes the tax implications clear. For example, if public health spending is to be kept at a stable percentage of revenue, then revenue must grow at least as fast as public health spending. Therefore, if the required growth rate for revenue is higher than can be generated by GDP growth alone, it is immediately clear that, if governments insist on clinging stubbornly to the existing system of financing health care, tax rates must rise or new taxes must be introduced. By making these tax implications clear, the metric warns taxpayers about the real personal financial consequences of continuing to give political support to the Medicare-monopoly approach to health insurance. Finally, the ratio of health spending to revenue makes trade-offs with competing public spending clear: if public health spending increases as a percentage of revenue, then spending in other areas must decrease as a percentage of revenue.

Using FMS data, previous analyses have monitored trends using this metric on a moving-annual basis by comparing the most recent five-year average annual growth rates in each of the provinces and projecting the trend forward (Skinner 2005; Skinner and Rovere 2006). When capturing the short-term trend, a five-year average metric has the effect of smoothing out aberrant years and is just long enough to isolate the effects of the most recent policy regime. Based on the most recently published five-year trends (2001/02 to 2005/06) public health spending in six of 10 provinces was on pace to consume more than half of total revenue from all sources by the year 2020.

These projections are conservative because the metric does not account for the expected impact of an aging population, yet it is known that half of per capita, lifetime health expenditures occur after the age of 65 (Brimacombe et al., 2001). All else being equal, as the population ages the growth in health expenditure should accelerate faster than projected here. Future revenue growth could also be slower than recent trends because an aging population will proportionately reduce the size of the workforce in the absence of offsetting immigration or increased domestic birth rates.

The metric also captures any alleged cost-slowing effects from rationing that occurred during the period and all previous incremental organizational reforms. Total revenue projections are conservative because net of debt service costs, revenues available for program expenditures are actually lower than the base used in this metric. The

metric also includes the impact on revenue growth from the long-term general increase in the tax burden and counts revenue from all sources including taxes and fees, federal transfers, crown corporations, investments and other operations of government.

Table 3 shows the five-year average annual growth rates for provincial public spending on health care and total revenues from all sources. Ten-year average annual growth rates are also shown for comparison beyond the short-term trend. There are two notable adjustments to the data. In 2005, Nova Scotia and Newfoundland were the beneficiaries of a windfall boost to their revenue base resulting from the launch of offshore oil production and a deal with the federal government to keep resource revenue without any reduction in federal transfers for equalization. This effectively skewed projections based on the most recent five-year average. For instance, Newfoundland's actual one-year revenue growth rate for 2005/06 was almost 56 percent. The effect, however, was a one-time boost to revenues in the fiscal year ending March 31, 2006 that will not be repeated year over year. Because this windfall boost to revenue growth will not be repeated every year, the 2005 figure was removed from the trend calculation

Table 3: Most Recently Published Five-Year and Ten-Year Trends in the Average Annual Growth of Provincial Government Health Expenditures (GHEX) and Total Revenues (TREV) from all sources

	10-year Average Annual Growth, by Province, 1996/97 to 2005/06		5-year Average Annual Growth, by Province, 2001/02 to 2005/06	
	GHEX	TREV	GHEX	TREV
Alberta	10.4	9.3	11.4	5.6
British Columbia	6.4	3.8	6.7	4.2
Manitoba	6.5	3.4	6.9	2.8
New Brunswick	5.4	3.1	6.4	4.1
Newfoundland & Labrador	7.4	2.0	6.5	4.1
Nova Scotia	6.5	5.1	7.0	6.5
Ontario	5.9	4.7	6.6	4.5
Prince Edward Island	7.6	3.8	7.9	3.6
Québec	6.1	4.7	5.2	4.0
Saskatchewan	7.5	4.4	8.7	3.4
Average	7.0	4.4	7.3	4.3

Note: For expectations about future projections, Newfoundland & Labrador and Nova Scotia use earlier 4-year and 9-year averages for reasons stated in the text.

Source: Statistics Canada, Financial Management System (2006c). Published in Skinner (2007).

and the previous four-year average was substituted as a more realistic expectation for long-term revenue growth in Nova Scotia and Newfoundland when making the projections referred to in the previous paragraph.

As an expectation for the future, longer term trends are consistent with the short-term moving average trend. Over the 10-year period (9 years for Newfoundland and Nova Scotia) between 1996/97 and 2005/06 (table 3) provincial government health expenditures have grown on average at a faster annual rate than total provincial revenue from all sources in every province.

In an alternative approach to this issue, researchers have also generated estimates of the unfunded liability of Canada's public health insurance system using Statistics Canada's own micro-simulation model and detailed data from Statistics Canada and the Canadian Institute for Health Information (Palacios and Veldhuis, 2006). Their estimates suggest that as of 2003, Canadian governments faced future funding obligations for health care that exceeded expected future revenues by \$555 billion or 46 percent of Canada's 2003 total economic output (GDP) of just over \$1.2 trillion. Most worrisome is that this unfunded liability grew by 28.5 percent between 1999 and 2003, from \$432.2 billion to \$555.3 billion.

Using various methodologies, other researchers have also concluded that public expenditures on health care are growing at unsustainable rates in Canada (see table 4).

Table 4: Other Studies and Reports Citing a Financial Sustainability Problem for Medicare

- ⌘ Taylor, Carole (2006). *Economic and Fiscal Update: First Quarterly Report*. Power-Point presentation (September 15). British Columbia, Ministry of Finance.
- ⌘ Menard, J.L. (2005). *Pour sortir de l'impasse: la solidarité entre nos générations*. Le Comité de travail sur la pérennité du système de santé et de services sociaux du Québec.
- ⌘ PriceWaterhouseCoopers Health Research Institute. (2005). *Health Cast 2020: Creating a Sustainable Future*.
- ⌘ Mackinnon, Janice (2004). "The Arithmetic of Health Care." *Policy Matters* 5, 3 (July). Institute for Research on Public Policy (IRPP). (Janice MacKinnon was finance minister in Roy Romanow's NDP government in Saskatchewan.)
- ⌘ Esmail, N. (2004). "Hitting the Health Care Wall." *Fraser Forum* (July): 28–29. Vancouver: The Fraser Institute.

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- ⌘ Mullins, M. (2004). *2028 or Bust: Ontario's Unsustainable Hospital Funding*. Fraser Alert. Vancouver: The Fraser Institute.
 - ⌘ Crowley, B.L., B. Ferguson, D. Zitner, and Brett J. Skinner (2002). *Definitely Not the Romanow Report: Achieving Equity, Sustainability, Accountability and Consumer Empowerment in Canadian Health Care*. Atlantic Institute for Market Studies.
 - ⌘ Kirby, Michael J.L. (2002). *The Health of Canadians—The Federal Role Volume Five: Principles and Recommendations for Reform—Part I*. The Standing Senate Committee on Social Affairs, Science and Technology.
 - ⌘ Fyke, K.J. (2001). *Caring for Medicare: Sustaining a Quality System*. Saskatchewan Commission on Medicare.
 - ⌘ Mazankowski, D., et al. (2001). *A Framework for Reform*. Premier's Advisory Council on Health.
 - ⌘ Brimacombe, Glenn G., et al. (2001). *The Future Cost of Health Care in Canada, 2000–2020: Balancing Affordability and Sustainability*. Conference Board of Canada.
 - ⌘ Robson, William B.P. (2001). *Will the Baby Boomers Bust the Health Budget? Demographic Change and Health Care Financing Reform*. Commentary 148. Toronto: C.D. Howe Institute.
 - ⌘ Clair, M. (2000). *Emerging Solutions*. Commission d'étude sur les services de santé et les services sociaux.

Conclusion

Both Dhalla and Béland failed to address the empirical reality that governments have only been able to restrain the costs of public health insurance in Canada through blunt rationing and the reduction in the scope of public health insurance coverage. While governments rhetorically defend the Medicare model, they have in practice reacted to the unsustainable growth of health spending by abusing their monopsony power over medical insurance. Examples include: ending coverage of previously insured goods and services (Skinner 2004) and refusing coverage for new drugs and medical technologies (Skinner et al. 2007); under-funding the capital deficits of hospitals (OHA 2003); under-investing in diagnostic equipment (Esmail and Walker 2006a); directly regulating the price of new medicines (Patented Medicine Prices Review Board and various provincial reimbursement regulations); reducing the effective supply of health professionals (Esmail 2006); and exploiting medical labour by suppressing wages (Mullins 2004). All of this has coincided with increasing waits for hospital services (Esmail and Walker 2006b) and new medicines (Skinner et al. 2007).

Medicare promises to pay for everything for everybody without any price at the point of consumption. This is the major reason why public health insurance is financially unsustainable. Consumers (patients) face no price incentives to rationalize demands for low intensity medical care and providers face no price or profit incentives to efficiently allocate supply, substitute treatment alternatives, or invest in new technologies. Flat percentage co-payments, user fees, extra-billing, and flat-rated premium based financing are ways to introduce price mechanisms that would make public health insurance more sustainable while empowering consumers with greater choice. Permitting private insurance options (or requiring the purchase of private insurance as Switzerland and the Netherlands do) would also allow costs to be shifted off the public system. Other countries employ such policies and show that there are better ways to achieve universal health insurance coverage than through a government-run health insurance monopoly (Esmail and Walker 2006a).

Researchers who deny that the growth of government spending on health care observed in Canada is unsustainable base their analyses on three unrealistic assumptions: (1) that the disproportionate demand for publicly funded health spending can increase indefinitely relative to other spending; (2) that tax rates can increase indefinitely to fund health spending growth, or (3) that the scope of coverage for and access to medically necessary care can be reduced indefinitely while maintaining a government health insurance monopoly. They also assume that all of these things can happen without any economic, political, or medical consequences. Such assumptions are demonstrably false and analyses that are based on them mislead policy makers and the public about the actual declining value and increasing cost of current health policy in Canada.

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About the author

Brett J. Skinner is the Director of Health and Pharmaceutical Policy Research and of Insurance Policy Research at The Fraser Institute and works from the Institute's Toronto office. He is a Ph.D. candidate in Public Policy and Political Science, specializing in public policy, at the University of Western Ontario in London, Ontario, where he has lectured in both the Faculty of Health Sciences and the Political Science Department. He earned a B.A. through the University of Windsor in Windsor, Ontario, and an M.A. through joint studies between the University of Windsor and Wayne State University in Detroit, Michigan. He also spent a year working as a research consultant to the Insurance Bureau of Canada in Toronto. Mr Skinner's research has been published in many major papers, articles, and opinion editorials through The Fraser Institute in Vancouver and Toronto as well as the Atlantic Institute for Market Studies in Halifax, Nova Scotia. He appears frequently as an expert in the North American media and his research and opinions have been cited in media from around the world. Mr Skinner has presented his research at government, academic, and other conferences around the world and has twice testified about his research before the Canadian House of Commons Standing Committee on Health.

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