



Paying More, Getting Less 2005

Measuring the Sustainability of Provincial Public Health Expenditure in Canada

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Executive summary

If recent trends in the annual growth rates for provincial public health-care expenditure and total provincial government revenue from all sources are used to project future growth in these measures, it becomes evident that health-care financing as it is currently structured in Canada is not financially sustainable. Health spending has been growing faster on average than revenue in all provinces for a long time and has also outpaced inflation and economic growth. This has resulted in health care taking up an increasing share of provincial revenue over time.

The analysis in this paper shows that if provincial governments continue to pursue policies that lead to the same rates of growth in health spending and revenue that have been observed in the recent past, public health-care expenditures will soon exceed their capacity to pay. Based on the most recent five-year trends, in seven out of 10 provinces public health spending is on pace to consume more than half of total revenue from all sources by the year 2022, two thirds by the year 2032 and all of provincial revenue by 2050. And, these projections do not take into account the added pressures from an aging population that will further accelerate the growth of provincial health spending as a percentage of total revenue and cause these sustainability dates to occur much earlier.

Ontario is the worst-case province with public health spending set to exceed 50% of revenue only six years from now in 2011, reaching two-thirds of revenue by 2017 and 100% of revenue by the end of 2026. Prince Edward Island, New Brunswick, British Columbia, Manitoba, Saskatchewan, and Newfoundland and Labrador are all in the middle of the pack, having from 12 to 17 years before public health spending consumes 50% of revenue. Meanwhile, Nova Scotia, Alberta, and Quebec are in relatively better positions to sustain health-care spending compared to the other provinces, reaching the 50% warning mark later. Quebec is the single best case with public health spending on pace to reach 50% of revenue by 2061 in that province.

However, the relatively successful ranking of Nova Scotia, Alberta, and Quebec is illusory because public health spending is still growing faster than revenue in each province, which means that no provincial health-care system is ultimately on a sustainable path. Second, in Nova Scotia and Quebec, as in all other provinces except Alberta, recent growth in revenue is temporary because it has been achieved by increasing tax burdens. Such fiscal policies are not sustainable over the long term unless people are willing to accept declining economic growth rates and lower potential standards of living over time.

For different reasons, Alberta's ability to sustain public health spending is also misleadingly optimistic. Alberta's general economic growth has been fairly impressive over this time period and has likely increased the size of the tax base, driving

revenue growth rates up. However, this accounts for a limited portion of any revenue growth observed. Increased natural resource royalties from escalating oil prices have also driven provincial revenues to very high levels in recent years. But the economic conditions driving oil prices might not persist in the future, making it unlikely that the growth rate of royalty revenues will continue at its present pace in Alberta. If instead, in the future Alberta's revenues grow at long-term historic rates, this will dramatically change the province's ability to sustain public health spending because at the same time that revenues have been growing, the province has been showing a far higher average annual growth rate for public health spending (11.2%) than any of its counterparts across the country. If future resource revenue growth slows, as it almost inevitably will, it will be difficult for the province to sustain such growth rates for public health spending.

On the other hand, public health spending has been growing relatively slower in Quebec than in other provinces. The province's relative success with cost control is loosely correlated (but not necessarily causally related) with greater use of privately delivered health services and higher levels of spending on pharmaceuticals, which tend to be more efficient substitutes for other health interventions.

Regardless of differences among the provinces, the problem remains the same for all: in order for public health spending to be financially sustainable, provincial governments must be able to pay the costs from current revenues over the long run. If governments must rely on current revenues and public health spending continues to account for increasing shares of revenue, public health spending will inevitably reduce the resources that are available for other areas of public spending and eventually bankrupt provincial governments altogether.

But, the policy options chosen by governments to avoid this from occurring must also be sustainable. Governments have two options: they can increase the growth rate in revenue or decrease the growth rate in public health spending.

First, perpetual budget deficits are by definition unsustainable and are therefore not a realistic solution to paying for increases in public health spending over the long-term. Second, relying on tax increases to accelerate the growth in revenue will also not work over the long run; *paying more* for health care through existing public financing arrangements is not a sustainable option. If governments decide to increase general tax rates annually to keep revenue growing as fast as public health spending, they will cause economic growth to slow down, with accompanying social costs like unemployment. In addition, the revenue problem can actually be made worse by tax increases because, as economic growth slows, the potential tax base shrinks, resulting in fewer revenues overall than would have been generated otherwise.

Furthermore, it is impossible for governments to raise tax rates indefinitely. Theoretically, such a policy would result in taxes eventually taking 100% of income. In fact, governments in Canada have spent the last 40 years borrowing against the

public debt to support the growth in social spending and then steadily increasing the percentage of income taken by taxes in order to pay for the accumulated debt, interest on the debt, and the maintenance of the entrenched budget obligations. However, it is now clear that there is very little economic room or political tolerance for further tax increases in Canada. This *tax ceiling* excludes the political feasibility of increasing tax rates at the same pace observed in the past.

On the other hand, there is a good deal of empirical evidence to show that it is possible to increase the growth in revenue by *reducing* taxes, which would be expected to accelerate economic growth and expand the size of the tax base. Such a policy for enhancing economic growth is recommended over the long run but it is still unlikely that even optimistic growth rates in GDP under constant or falling tax rates could produce the kind of long-term increases in revenue that would be required to keep up with the rapid annual growth in public health spending that has been observed in the past. Therefore, governments must reduce the growth in public health spending.

In the past, governments have relied on heavy-handed monopoly power to constrain growth in health spending. This has manifested itself in policies like rationing access to publicly covered health care—as evidenced by growing waits for medical services; limiting the supply of health professionals or the availability of high tech equipment; reducing the number of hospitals and allowing the capital deterioration of existing facilities; withdrawing public insurance coverage for previously insured medical goods and services; refusing or delaying public insurance coverage for new medical goods, services and technologies deemed “experimental” or “unproven”; and exploiting labour by artificially holding down wage rates for health professionals.

However, getting less from health care is not a sustainable policy option for controlling the annual growth in public health spending. First, patients will experience increasing medical risks from waiting if rationing is used to hold down the growth in public health spending indefinitely. Second, the Supreme Court’s decision to strike down Quebec’s public monopoly on health insurance, while applying only within Quebec at the moment, leaves open the question whether it will even remain legal for other provincial governments to maintain a public health-insurance monopoly while rationing access to medical services.

All of this suggests that the prescription for reform is to introduce the kinds of policies increasingly being used in other countries to deal with similar cost-control problems in their public health-care programs. In very general terms, these policies include:

- ◆ requiring patients to make co-payments for publicly insured health services;
- ◆ allowing people the option of paying privately (via private insurance or out-of-pocket) for all types of medical services, including hospitals and physician services;
- ◆ allowing both for-profit and non-profit health providers to compete for the delivery of publicly insured health services.

Introduction

In the summer of 2004, The Fraser Institute published a study called, *Paying More, Getting Less: Ontario's Health Premium and Sustainable Health Care*. That study examined the 2004 Ontario Budget and found that the provincial government had underestimated the future long-term annual average real (i.e., adjusted for inflation) growth in public spending on health care by about 4.5% per year, based on the most recent five-year trend. The study showed that public financing of health care in Ontario was not on a sustainable track when recent trends were projected into the future.

Using the Ontario government's own revenue projections from the 2004 Budget and realistic expectations for growth in health-care spending, it was demonstrated that public spending on health care would grow to approximately 50% of all revenues by 2013, over 60% by 2017, over 75% by 2023, and theoretically 100% of all provincial revenues by the mid-2030s. Furthermore, the study argued that provincial proposals for health-policy reform, including the new personal income surtax misleadingly labeled as a "health premium," would not adequately address the difference between relative future growth rates for total revenues and public health-care spending. It was calculated that Ontario's new "health premium" tax would need to triple by 2008 and grow by 10 times a decade after its introduction in order to keep provincial revenues growing at the same pace as public health-care spending. This enormous tax increase was expected to occur at the same time as the province was reducing the scope of public health-insurance coverage by making some previously insured services ineligible for public reimbursement.

For *Paying More, Getting Less 2005*, the analysis applied to Ontario has been refined, standardized, and expanded to include all 10 Canadian provinces. [1] Inter-provincial comparison provides a better analytical context to judge the merits of various public policies and gives Canadians information they need to hold their policy-makers accountable for important public decisions.

The basic definition of sustainability for public health-care financing remains the same: over the long run, governments must have enough current revenues to pay for public health-care expenditures. For this reason, it is the projected ratio of provincial public health-care expenditures to total provincial revenues from all sources that is used to measure the financial sustainability of public health spending.

The data on public health spending used in this study include only the expenditures of provincial health ministries. Health spending by worker's compensation boards, automobile insurers (statutory accident benefits), and all other private spend-

[1] For other analyses of the sustainability of public health-care financing in Canada, see [Brimacombe, 2001](#); [Robson, 2001](#); [Skinner, 2002a](#); [Esmail, 2004](#).

ing is excluded. Moreover, the revenue data include all revenue regardless of source (e.g., federal transfers), and thus represent the maximum provincial government capacity to pay for public health spending.

For the analysis in this study, the ratio of public health spending to revenue is used because it is better than other measures of sustainability like health spending as a percentage of programs spending or health spending as a percentage of GDP. First, the ratio of public health spending to revenue measures the ability of government to pay from current revenues, thus directly satisfying the definition of long-run sustainability and immediately exposing any attempt to use deficits to finance public health spending. Second, the ratio of public health spending to revenue 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 general economic growth alone, it is immediately clear that existing tax rates must rise or new taxes must be introduced. Third, 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.

By comparison, if the ratio of public health spending to program expenditure is used as a basis for analysis, the sustainability question is not immediately made clear because deficit financing could be used to keep public health spending at a stable percentage of programs spending, thus creating the illusion of sustainability. Similarly, if the ratio of public health spending to GDP is used, the tax implications and trade-offs in public spending are not immediately clear because public health spending could rise as a percentage of GDP as a result of the reallocation of existing revenues, increased revenues from new taxes or higher tax rates (or, tax cuts that grow the tax base), or deficit spending. Use of this measure may also mistakenly imply 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 or whether consumers value health care either more or less than indicated by the fixed level of public spending on medical goods and services.

For this study, all data are taken from Statistics Canada's Financial Management System (FMS) and are current for the period 1996/1997 to 2004/2005. [2] It should be noted that for the 2004 study, government budget expectations for future revenue were taken from the provincial budget and actual historic growth rates for health spending were referenced from the public accounts and past budgets. However,

[2] It should be noted that Statistics Canada makes annual revisions to the FMS data set to include more complete data. This may affect the occurrence of the sustainability dates projected in this analysis but will not affect the general conclusions of the study.

in our 2004 study it was shown that the Ontario government dramatically underestimated future growth in health spending. This again occurred in its 2005 budget, and indicates that provincial budget figures are not reliable sources of data on future expectations for spending or revenue. Another reason to use FMS data is that the data are comparable across provinces because of the application of standardized accounting across provincial and territorial jurisdictions. FMS data are also updated annually, retroactively adjusted for complete reporting, and provide detailed breakdowns that allow the separation of spending on public health care from private and other sources that are not directly part of the public health-care system.

All figures in this study are reported in current dollar terms. Projections are based on the most recent five-year average annual percentage growth in nominal terms (real growth plus inflation) for each comparator (public health spending and total revenue). The respective growth rates are held constant and projected 60 years into the future to show what will happen if recent trends continue. Inflation rates over the five-year trend period have remained stable, [Table 1] and are held constant into the future using this method. Under this approach, expected inflation equally affects the absolute growth in both comparators without changing their relative growth rates. GDP growth is also held constant, based on the recent five-year trend. This methodology most easily illustrates the financial implications of continuing the same policy logic that governments have used in the recent past.

Table 1: Annual Percentage Growth in the Provincial Consumer Price Index, 2000–2004

	2000	2001	2002	2003	2004	5-year average
Canada	2.7	2.6	2.2	2.8	1.9	2.4
Newfoundland & Labrador	3.0	1.1	2.4	2.9	1.8	2.2
Prince Edward Island	4.1	2.6	2.7	3.6	2.1	3.0
Nova Scotia	3.5	1.8	3.0	3.4	1.8	2.7
New Brunswick	3.3	1.7	3.4	3.4	1.5	2.7
Quebec	2.4	2.4	2.0	2.5	1.9	2.2
Ontario	2.9	3.1	2.0	2.7	1.9	2.5
Manitoba	2.5	2.6	1.6	1.8	2.0	2.1
Saskatchewan	2.6	3.1	2.8	2.3	2.2	2.6
Alberta	3.5	2.3	3.4	4.4	1.4	3.0
British Columbia	1.9	1.7	2.3	2.1	2.0	2.0

Source: Statistics Canada, 2005a. CANSIM, table 326-0002 and Catalogue nos. 62-001-XPB and 62-010-XIB.

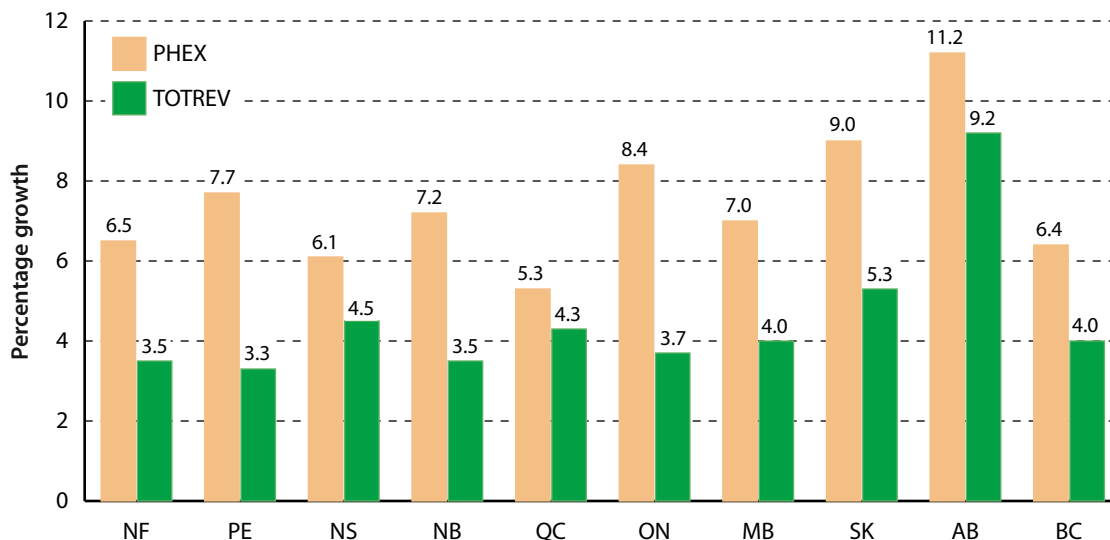
Findings and analysis

Recent growth rates for public health spending and total revenue (2000/2001–2004/2005)

The first finding of this study is that over the last five years (2000/2001–2004/2005), public health expenditure (PHEX) has been growing faster on average than total revenue (TOTREV) in all 10 provinces. [Figure 1] Therefore, by definition, public health care financing is on an unsustainable track in Canada.

It is significant that public health spending has continued to outgrow revenue during this time frame, because the period has been characterized by relatively solid economic growth across the provinces, which would have boosted the revenue growth observed in the data used for this study. [Table 2] This means that, if the economy grows more slowly in the future, the gap in the growth rate of public health spending and that of revenue might be even greater than has occurred during relatively good economic times.

Figure 1: Average annual percentage growth in public health expenditure (PHEX) and total revenue (TOTREV) by province, 2001–2005



Source: Author's calculations based on data from Statistics Canada, 2005c.

Table 2: Five-year average annual percentage growth in gross domestic product (GDP), expenditure-based, by provinces and territories, 2000 to 2004.

	Five-year average annual percentage growth of GDP
Newfoundland & Labrador	9.0
Prince Edward Island	4.4
Nova Scotia	5.1
New Brunswick	3.9
Quebec	4.4
Ontario	4.1
Manitoba	4.3
Saskatchewan	4.7
Alberta	6.8
British Columbia	4.5

Source: [Statistics Canada, 2005b](#). CANSIM, table 384-0002 and Catalogue no. 13-213-PPB.

It is equally important to note that the average annual growth rates in provincial revenues observed between 2000/2001 and 2004/2005 were partially affected by increases in selected provincial taxes and the introduction of new taxes in some years. This was offset somewhat by selected tax decreases in some provinces. [3] In 2004, all provinces introduced tax increases except Alberta. [Table 3](#) shows some of the changes to tax policy in the provinces in 2004/2005; these changes are in addition to other tax increases that occurred in earlier years in some provinces.

The boost to revenue growth rates from these measures is temporary. Unless tax rates continually rise in the future or more new taxes are introduced every year, the revenue growth generated by these tax measures will not repeat itself. It should be obvious that annually increasing the tax burden is not an economically sustainable policy option. Aside from the theoretical absurdity that constant annual increases in effective tax rates would put taxes on pace to eventually consume 100% of income, policy makers should realize that any increase in the overall tax burden, both in absolute terms as well as relative to competing jurisdictions could hinder potential provincial economic growth. Therefore, increasing taxes should not be seen as a viable long-term solution to dealing with runaway growth in public health-care costs.

[3] For example, British Columbia introduced significant new or increased taxes in 2002, 2003, 2004, and 2005 following earlier cuts to taxes.

Table 3: Types of tax increases introduced in the provinces in 2004/2005

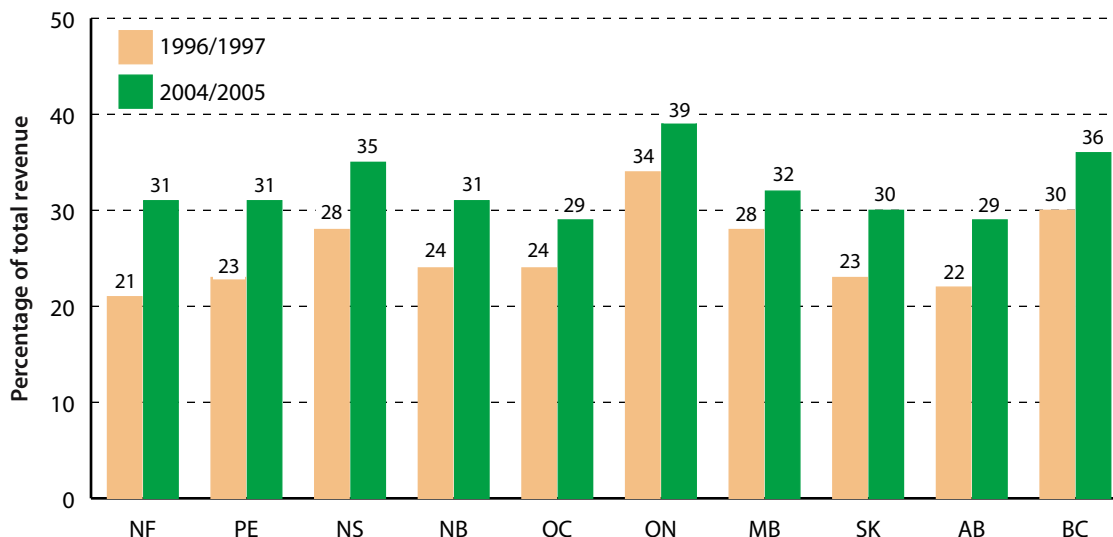
	Tax Mechanism
Newfoundland & Labrador	Tobacco and liquor taxes, fees and licenses
Prince Edward Island	Fuel taxes, tobacco and liquor taxes, capital taxes, sales taxes, tire taxes, corporate income taxes, fees and licenses, real property transfer taxes
Nova Scotia	Personal income taxes, capital taxes, corporate taxes
New Brunswick	Fees and licenses, income tax bracket indexation cancelled
Quebec	Tobacco and liquor taxes, income tax bracket creep, corporate taxes
Ontario	Health premium, tobacco and liquor taxes, fees and licenses, corporate taxes
Manitoba	Sales taxes, capital taxes, tobacco and liquor taxes, fuel taxes, land transfer taxes
Saskatchewan	Cancelled income tax bracket indexation, sales taxes, tobacco and liquor taxes, licenses and fees, fuel tax exemptions decreased
Alberta	None
British Columbia	Tobacco and liquor taxes

Sources: Provincial budget documents 2004/05.

Comparing provincial public health spending as a percentage of revenue over time

The data available for this study indicate that provincial public spending on health care has been growing as a percentage of total revenue from all sources for a long time. [Figure 2](#) shows the most recent data available from FMS for the years 1996/1997 and 2004/2005. The data indicates that public health spending currently swallows a significantly higher percentage of total revenue in every province than it did at the beginning of this eight-year period. The implication is that, as public health spending grows as a proportion of the total revenues available to the province, there are fewer dollars left over to fund other public spending items like education, social assistance, transportation, and policing.

Figure 2: Provincial public expenditure on health care as a percentage of total provincial revenue, 1996/1997 and 2004/2005



Source: Author's calculations based on data from Statistics Canada, 2005c.

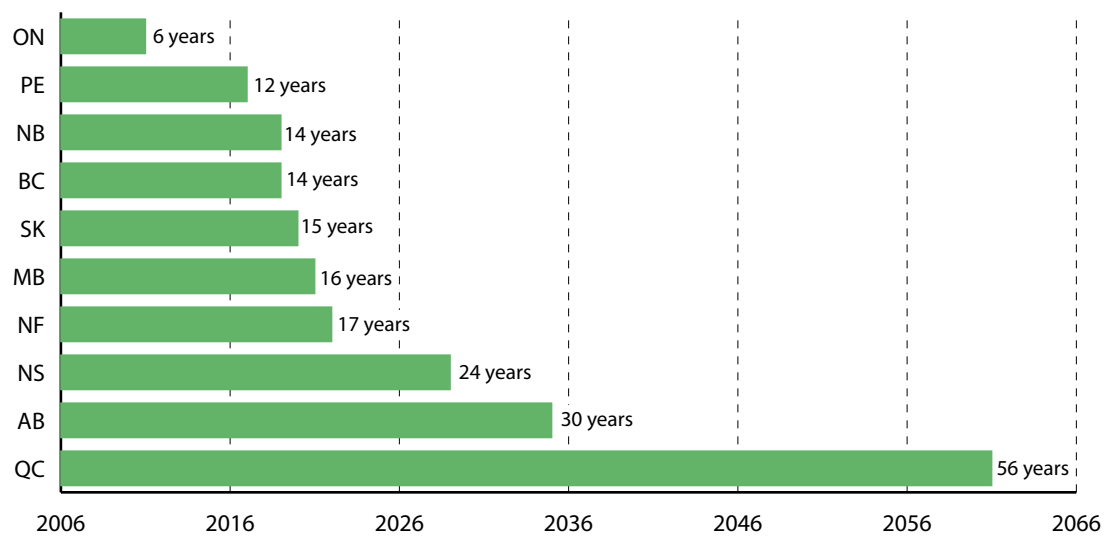
Projecting recent trends into the future

The current inability to sustain public health-care financing in Canada can also be illustrated by projecting the 2000/2001 to 2004/2005 average annual growth rates in public health spending and revenue in each province into the future and comparing their resulting ratios across provinces. The analysis in this paper shows that, if provincial governments continue to pursue policies that in the future lead to the same rates of growth in public health spending and revenue that have been observed in the recent past, public health spending will soon exceed the capacity of the provinces to pay for it.

Based on recent trends, in seven out of 10 provinces public health spending is on pace to consume more than half of total revenue from all sources by the year 2022, two thirds by the year 2032, and all of provincial revenue by 2050. These projections are conservative because they do not take into account the added pressures from an aging population, which will further accelerate the growth in provincial public health spending as a percentage of revenue.

Figure 3 compares the length of time it will take in each province for public health spending to consume 50% of revenue, if both continue to grow at the same average annual pace that occurred during the most recent five-year period. As the graph indicates, Ontario is the worst-case province, with public health spending set to exceed 50% of revenue only six years from now in 2011.

Figure 3: How long before provincial public health expenditure is greater than 50% of total revenue based on projection of most recent five-year trend, 2000/2001–2004/2005?



Future ratio of public health spending to total revenue in each province

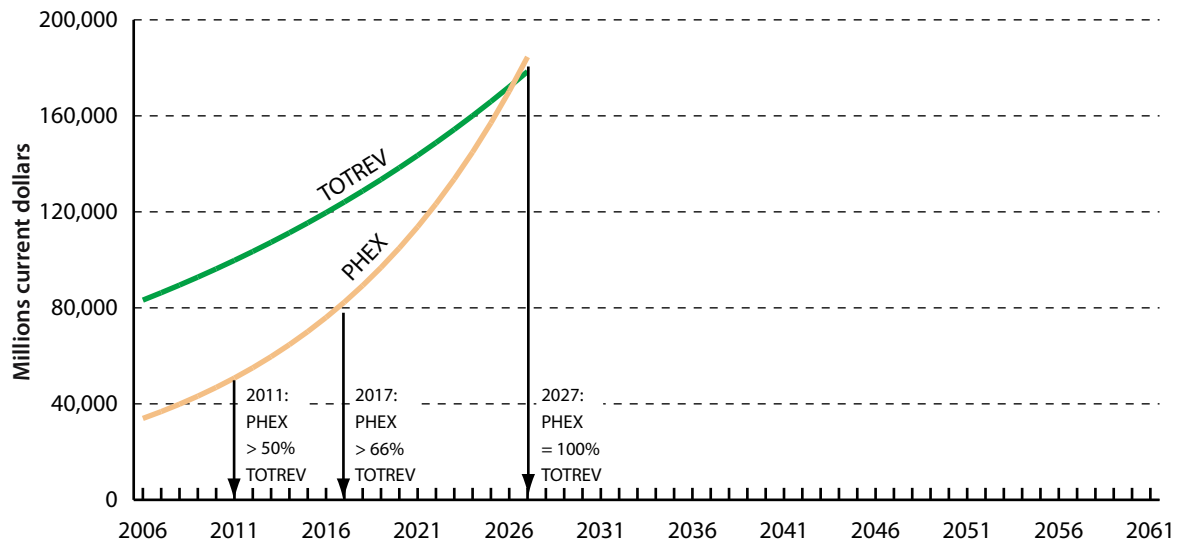
Projecting recent growth trends for public health spending and revenue in each province and plotting their trend lines on the same graph can further illustrate the inability to sustain public health-care financing by any of the provinces.

Worst Case

Using this method, [Figure 4](#) shows that in Ontario, the worst case among the provinces, public health spending is currently on pace to reach 50% of total revenue by 2011, two-thirds of revenue by 2017 and 100% by the end of 2026. [\[4\]](#) This ominous financial situation is occurring even after Ontario introduced significant new taxes in the form of its incorrectly labelled “health premium” in 2004.

[\[4\]](#) Using the Ontario government’s own budget figures for future revenues and historical public accounts data on health spending, our 2004 study projected that public spending on health care in Ontario would reach 50% of total revenue by 2013, 60% by 2017, and 100% by the mid-2030s. The 2005 study uses a more reliable data source to project future revenues and health spending and this explains the minor difference in the projections.

Figure 4: Ontario—projected public health expenditure (PHEX) and total revenue (TOTREV) from all sources based on average annual percentage growth in PHEX and TOTREV, 2000/2001–2004/2005



Middle Cases

By comparison, Prince Edward Island, New Brunswick, British Columbia, Manitoba, Saskatchewan, and Newfoundland and Labrador [Figures 5, 6, 7, 8, 9, and 10] are all in the middle of the pack, having from 12 to 17 years before public health spending consumes 50% of revenue. However, all of these provinces have relied on tax increases at some point over the last five years to temporarily boost the revenue growth used to make future projections in this study. It is unrealistic to assume that revenues can be grown indefinitely through additional yearly tax increases in the future. Such a fiscal policy is not sustainable over the long term unless the population in these provinces is willing to accept declining economic growth and lower relative standards of living over time. Therefore, the dates at which public health expenditures will reach 50% of total revenue in each of these provinces depends on provincial decisions about health and revenue policy, but will likely occur much sooner than is illustrated here if nothing is done about the growth rate of health expenditures. The rolling five-year average annual growth rate used for this analysis will capture the effect of any future policy changes.

Figure 5: Prince Edward Island—projected public health expenditure (PHEX) and total revenue (TOTREV) from all sources based on average annual percentage growth in PHEX and TOTREV, 2000/2001–2004/2005

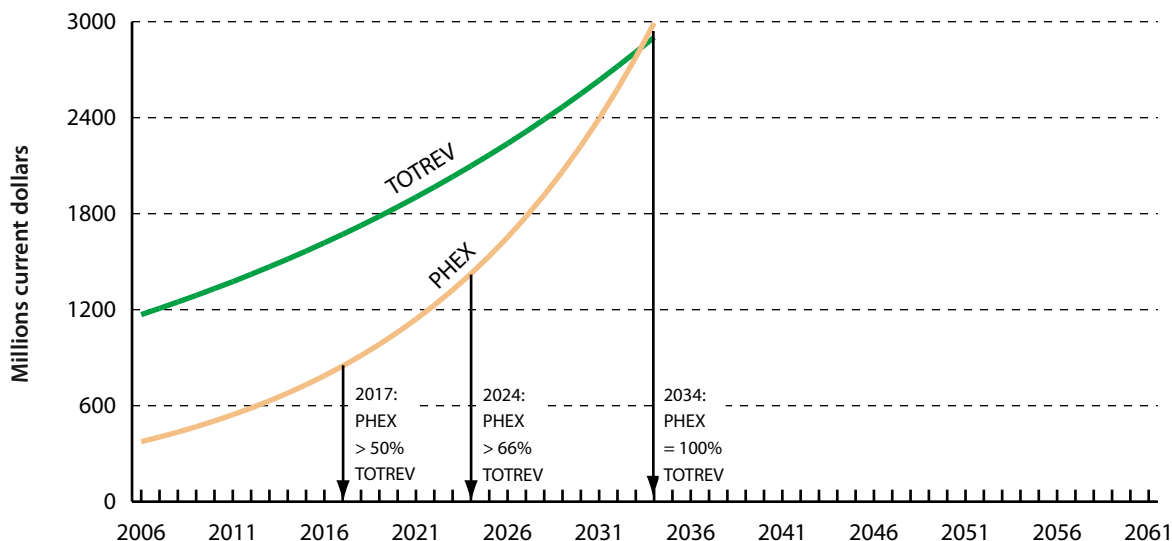


Figure 6: New Brunswick—projected public health expenditure (PHEX) and total revenue (TOTREV) from all sources based on average annual percentage growth in PHEX and TOTREV, 2000/2001–2004/2005

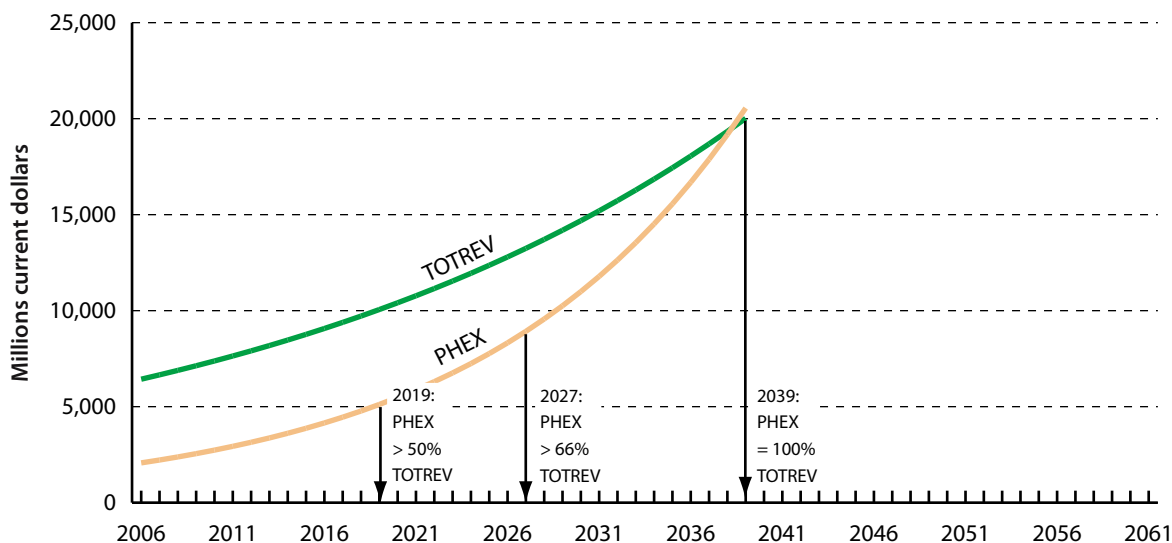


Figure 7: British Columbia—projected public health expenditure (PHEX) and total revenue (TOTREV) from all sources based on average annual percentage growth in PHEX and TOTREV, 2000/2001–2004/2005

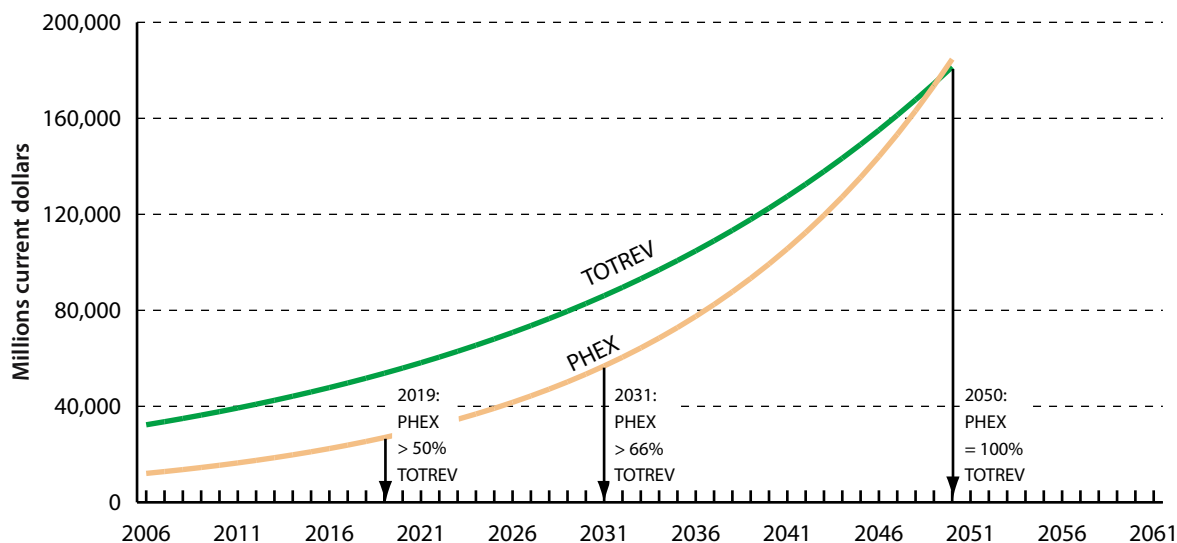


Figure 8: Manitoba—projected public health expenditure (PHEX) and total revenue (TOTREV) from all sources based on average annual percentage growth in PHEX and TOTREV, 2000/2001–2004/2005

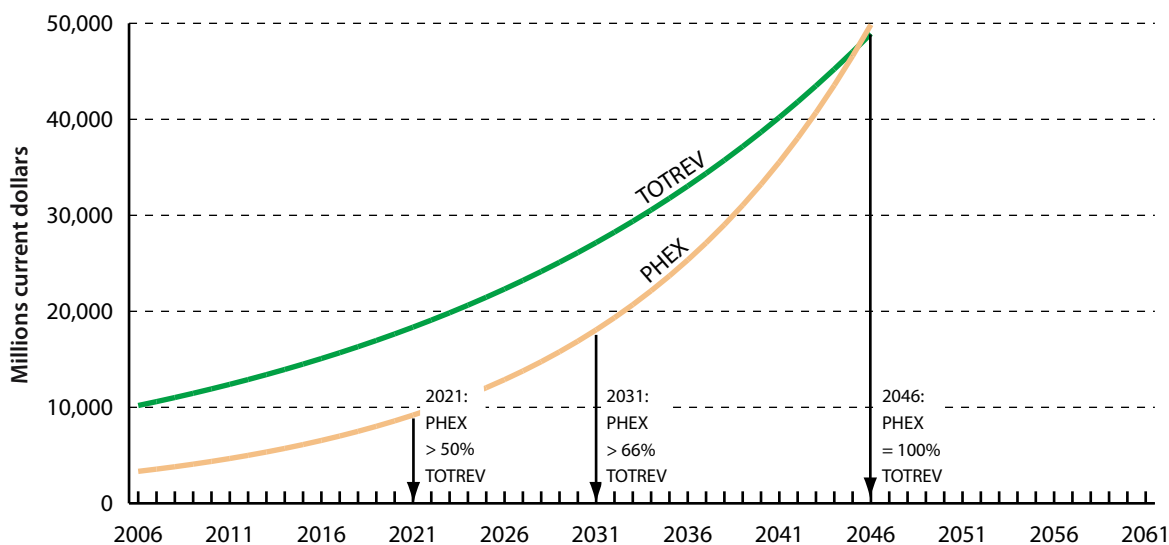


Figure 9: Saskatchewan—projected public health expenditure (PHEX) and total revenue (TOTREV) from all sources based on average annual percentage growth in PHEX and TOTREV, 2000/2001–2004/2005

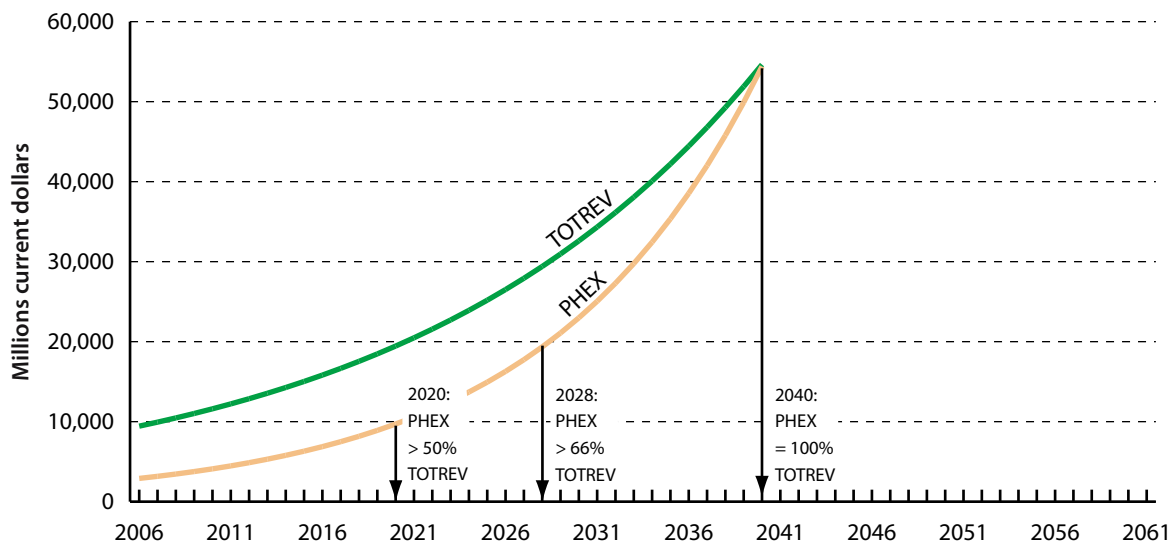
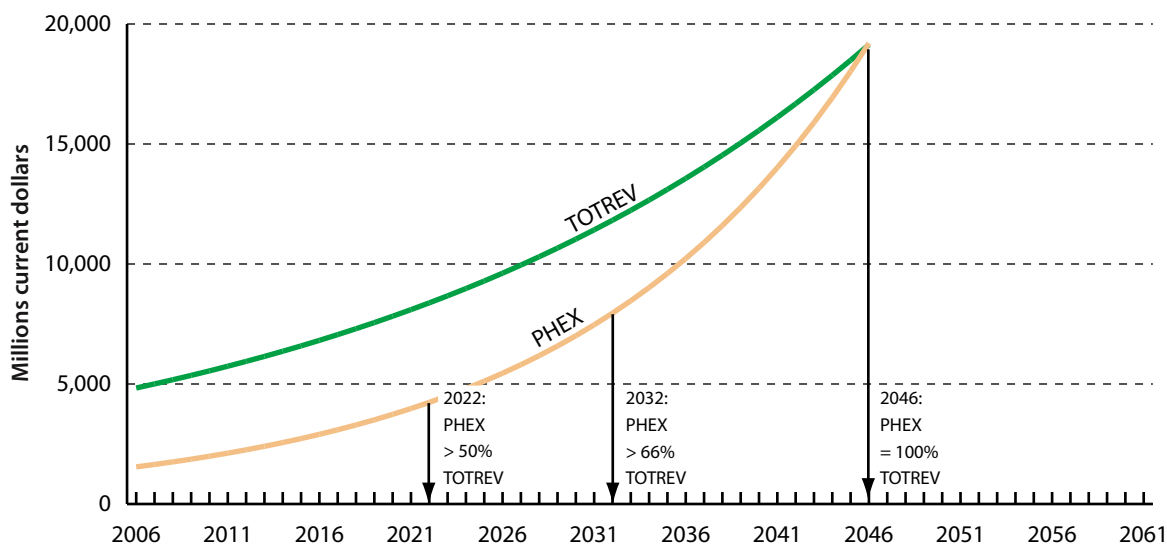


Figure 10: Newfoundland—projected public health expenditure (PHEX) and total revenue (TOTREV) from all sources based on average annual percentage growth in PHEX and TOTREV, 2000/2001–2004/2005

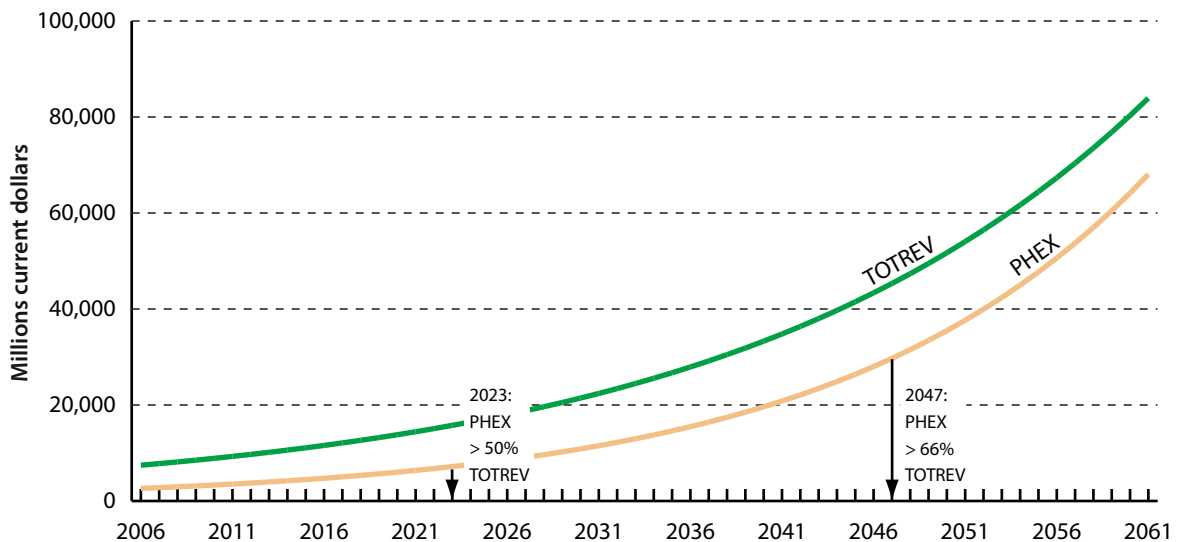


Better cases

At first glance, Nova Scotia, Alberta and Quebec [Figures 11, 12, & 13] appear to be in relatively better positions to sustain public health expenditures compared to the other provinces, reaching the ratio of 50% public health spending to revenue much later. Quebec is the single best case with public health spending on pace to reach 50% of revenue as late as 2061. This result is partially due to the fact that public health spending has been growing slower in Quebec relative to other provinces. The province’s relative success with cost control is loosely correlated (not necessarily causally related) with greater use of private delivery for health services and higher levels of spending on pharmaceuticals, which tend to be more efficient substitutes for other health interventions. [Esmail, 2005a]

On the revenue side, both Nova Scotia and Quebec have seen higher recent growth rates. However, this higher recent growth rate for provincial revenue has been partially achieved by increasing effective tax rates, which has the effect of temporarily boosting the average growth rate for provincial revenue that is used as a trend in this analysis to project into the future. [5] Because the revenue boosting effect of these tax measures is temporary and continuous annual increases in tax rates are not sustainable, the impression that these provinces will reach the ratio of 50% public health spending to revenue much later than other provinces is illusory. Ultimately, health spending is still growing faster than revenue on average, even after recent tax increases that have temporarily boosted the growth rate for total revenue in both provinces.

Figure 11: Nova Scotia—projected public health expenditure (PHEX) and total revenue (TOTREV) from all sources based on average annual percentage growth in PHEX and TOTREV, 2000/2001–2004/2005



[5] For a discussion of the relative tax burdens in each of the provinces, see Veldhuis (2005).

Figure 12: Alberta—projected public health expenditure (PHEX) and total revenue (TOTREV) from all sources based on average annual percentage growth in PHEX and TOTREV, 2000/2001–2004/2005

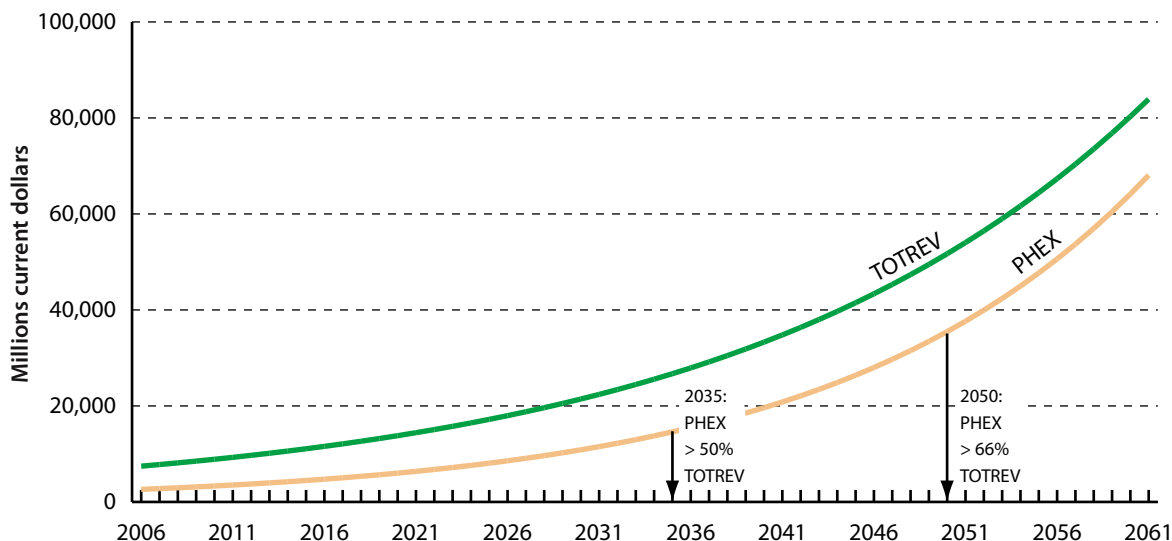
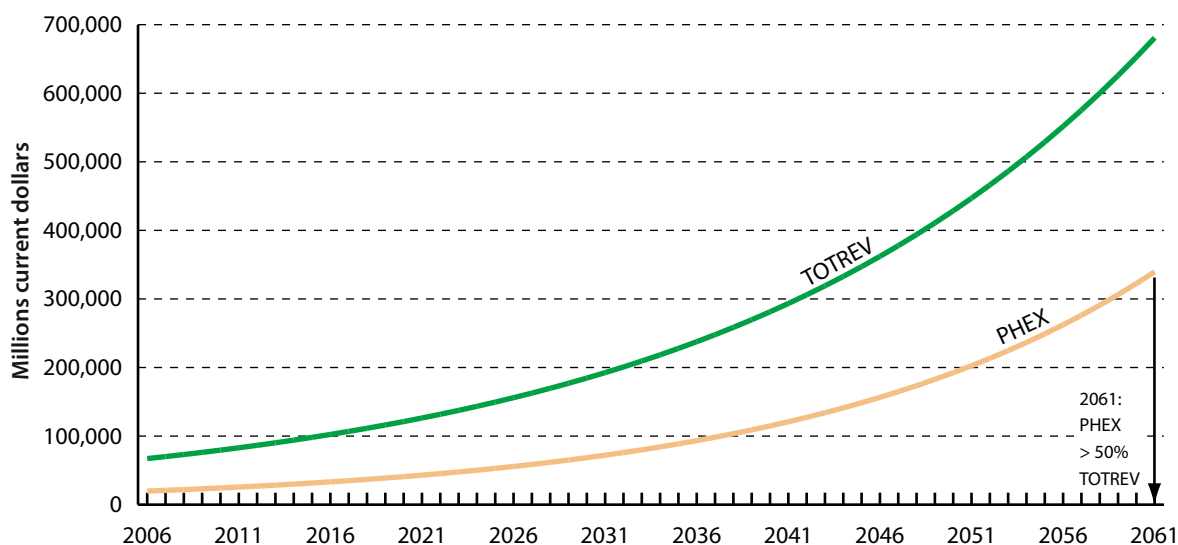


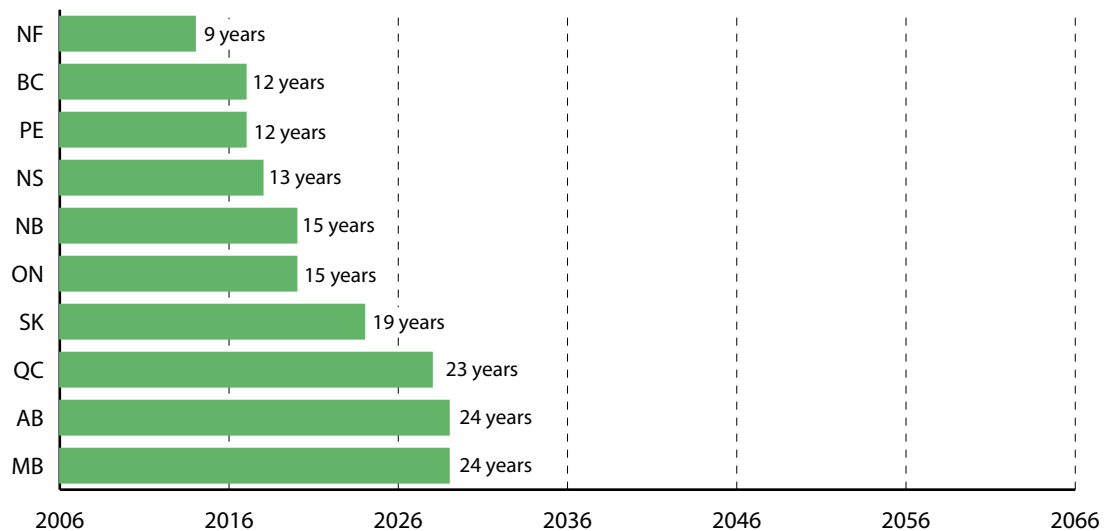
Figure 13: Quebec—projected public health expenditure (PHEX) and total revenue (TOTREV) from all sources based on average annual percentage growth in PHEX and TOTREV, 2000/2001–2004/2005



For special reasons, the impression that Alberta will reach the ratio of 50% public health spending to revenue later than other provinces is also misleading. Alberta's general economic growth has been fairly impressive over this time period and has likely increased the size of the tax base, driving revenue growth up. However, this accounts for a limited portion of any revenue growth observed. Increased natural resource royalties from escalating oil prices have also driven provincial revenues to very high levels in recent years. But the economic conditions driving oil prices might not persist in the future, making it unlikely that the growth rate of royalty revenues will continue at its present pace in Alberta. If instead, in the future Alberta's revenues grow at long-term historic rates, this will dramatically change the province's ability to sustain public health spending because, at the same time that revenues have been growing, the province has been showing a much higher average annual growth rate for public health spending (11.2%) than any of its counterparts across the country. If growth of resource revenue slows, as it almost inevitably will, it will be difficult for the province to sustain such growth rates for public health spending.

To demonstrate the illusion of sustainability created by the temporary effect of these tax measures and economic conditions, projections using recent trends can be compared to projections using slightly longer trends that reflect more realistic expectations for long-term growth rates in public health spending and revenues in each of the provinces. For example, [Figure 14](#) shows how the date at which public health spending will reach 50% of total revenue in Nova Scotia, Alberta, and Quebec occurs much earlier if the trend used for projections is extended to include those years when

Figure 14: How long before provincial public health expenditure is greater than 50% of total revenue based on projection of most recent eight-year trend, 1996/1997–2004/2005?



the tax burden was not increased as a means of boosting revenue growth or when temporary economic conditions were not driving revenues higher. For those provinces showing an improved ranking on Graph 14, this indicates that government policies, or economic conditions earlier in the period were more successful at producing a narrower ratio of public health spending to total revenue, at least temporarily. Whether such policies and conditions are sustainable over the long run is another question.

If the policy options provincial governments have been using to produce the most recent five-year trends observed in this study are themselves sustainable, then it is accurate to say that, if the same policy logic is followed into the future, it will produce the results projected in [Figure 3](#). However, if the policies used by provincial governments to temporarily constrain public health spending or boost provincial revenues are not sustainable over the long run, then the actual results in the future will be worse than those projected in Graph 3 and the dates at which public health spending will reach 50% of total revenue will occur sooner. If on the other hand, governments find a sustainable way to get public health-care spending and revenues to grow at the same pace, then actual outcomes will be better than those projected in either [Figure 3](#) or [Figure 14](#).

Conclusions and policy options

Data on public health-care spending and total provincial revenues from all sources clearly show that current health policy in Canada is not financially sustainable and that its logic is flawed. Regardless of differences among the provinces, the problem remains the same for all: in order for public health spending to be financially sustainable, provincial governments must be able to pay the costs from current revenues over the long run. If governments must rely on current revenues and public health spending continues to account for increasing shares of revenue, public health spending will inevitably reduce the resources that are available for other areas of public spending and eventually bankrupt provincial governments altogether.

But, the policy options chosen by governments to avoid this from occurring must also be sustainable. Governments have two options: they can increase the growth rate in revenue or decrease the growth rate in public health spending.

First, perpetual budget deficits are by definition unsustainable and are therefore not a realistic solution to paying for increases in public health spending over the long-term. Second, relying on tax increases to accelerate the growth in revenue will also not work over the long run; *paying more* for health care through existing public financing arrangements is not a sustainable option. If governments decide to increase general tax rates annually to keep revenue growing as fast as public health spending, they will cause economic growth to slow down, with accompanying social costs like unemployment. In addition, the revenue problem can actually be made worse by tax increases because, as economic growth slows, the potential tax base shrinks, resulting in fewer revenues overall than would have been generated otherwise.

Furthermore, it is impossible for governments to raise tax rates indefinitely. Theoretically, such a policy would result in taxes eventually taking 100% of income. In fact, governments in Canada have spent the last 40 years borrowing against the public debt to support the growth in social spending [Ferguson, 2002] and then steadily increasing the percentage of income taken by taxes in order to pay for the accumulated debt, interest on the debt, and the maintenance of the entrenched budget obligations. However, it is now clear that there is very little economic room or political tolerance for further tax increases in Canada. [Skinner, 2002b] This *tax ceiling* excludes the political feasibility of increasing tax rates at the same pace observed in the past.

On the other hand, there is a good deal of empirical evidence to show that it is possible to increase the growth in revenue by *reducing* taxes, which would be expected to accelerate economic growth and expand the size of the tax base. [Karabegović, Veldhuis, Clemens, and Godin, 2004] Such a policy for enhancing economic growth is recommended over the long run but it is still unlikely that even optimistic growth rates in GDP under constant or falling tax rates could produce the kind of long-term

increases in revenue that would be required to keep up with the rapid annual growth in public health spending that has been observed in the past. Therefore, governments must reduce the growth in public health spending.

In the past, governments have relied on heavy-handed monopoly power to constrain growth in health spending. This has manifested itself in policies like rationing access to publicly covered health care—as evidenced by growing waits for medical services; limiting the supply of health professionals or the availability of high tech equipment; reducing the number of hospitals and allowing the capital deterioration of existing facilities; withdrawing public insurance coverage for previously insured medical goods and services; refusing or delaying public insurance coverage for new medical goods, services and technologies deemed “experimental” or “unproven”; and exploiting labour by artificially holding down wage rates for health professionals. [Harriman, McArthur, Zelder et al., 1999; Skinner, 2002a; Esmail and Walker, 2004; Esmail, 2005b]

However, getting less from health care is not a sustainable policy option for controlling the annual growth in public health spending. First, patients will experience increasing medical risks from waiting if rationing is used to hold down the growth in public health spending indefinitely. Second, the Supreme Court’s decision to strike down Quebec’s public monopoly on health insurance, while applying only within Quebec at the moment, leaves open the question whether it will even remain legal for other provincial governments to maintain a public health-insurance monopoly while rationing access to medical services. [Chaoulli v. Quebec (Attorney General), 2005]

All of this suggests that the prescription for reform is to introduce the kinds of policies increasingly being used in other countries to deal with similar cost-control problems in their public health-care programs. In very general terms, these policies include:

- ◆ requiring patients to make co-payments for publicly insured health services;
- ◆ allowing people the option of paying privately (via private insurance or out-of-pocket) for all types of medical services, including hospitals and physician services;
- ◆ allowing both for-profit and non-profit health providers to compete for the delivery of publicly insured health services. [Esmail and Walker, 2005]

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