

# Paying More, Getting Less 2006

## Measuring the Sustainability of Public Health Insurance in Canada

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## Executive summary

This study is The Fraser Institute's third annual report on the financial sustainability of provincial public health insurance. Every year the data are updated and new projections generated. This year's analysis again uses the most recent five-year trends in the annual growth rates for total provincial public expenditure on health care and total provincial government revenue from all sources to project future growth in these measures. The results confirm 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, despite higher tax burdens in each of the provinces as well as government policies that restrict access to medically necessary goods and services.

The analysis in this study 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 the capacity of governments to pay for them. Based on the most recent five-year trends, public health spending in six of 10 provinces is on pace to consume more than half of total revenue from all sources by the year 2020, two thirds by the year 2035, and all of provincial revenue by 2050. Last year, public spending on health care in seven of 10 provinces was on pace to consume more than half of total revenues by 2022, two thirds by the year 2032, and all of provincial revenue by 2050.

The ranks of the provinces have changed in this year's report. The difference in the projections between this year and last year is a result of using a moving five-year average method of calculating trends.

This year, **Manitoba** and **Saskatchewan** are tied as the most urgent cases with public spending on health care consuming half of all revenues as early as 2016. Those provinces are nearly matched by **Alberta**, which falls from last year's 50% sustainability-warning date of 2035 (a temporary result of sharp increases in oil prices in 2001 that caused a boom in provincial resource-based revenue and inflated average revenue growth rates calculated from the five-year trend used in last year's study) to this year's projection of 2017 (the moving five-year average trend now reflecting lower but more normal patterns of revenue growth). **British Columbia** and **Prince Edward Island** are next, both having 50% warning dates falling in 2019.

Based on the previous five-year average used in last year's report, **Ontario** was the worst-case province with public health spending at that time growing at an average rate that would exceed half of total revenue by 2011. In this year's projection of the most recent five-year averages, the date at which public health expenditures in Ontario will reach 50% of total revenues occurs nine years later, in 2020. Based on our measure

of sustainability this is an improvement, but the result only suggests a slight delay of the inevitable: public health insurance remains financially unsustainable.

Public health expenditures are projected to reach 50% of total revenues by 2024 in **Nova Scotia**, by 2029 in **New Brunswick**, and by 2030 in **Newfoundland**. Last year, Nova Scotia and Newfoundland were the beneficiaries of a windfall boost to their revenue base resulting from the launch of offshore oil production and their striking a deal with the federal government to keep resource revenue without any reduction in federal transfers for equalization. For instance, Newfoundland's one-year revenue growth rate for 2005/06 was more than 55%. The effect was a one-time boost to revenues in the fiscal year ending March 31, 2006 that, unlike fluctuations in oil prices, will not be repeated year over year. Because this windfall boost to revenue growth will not be repeated every year, this study selectively removed the most recent year's revenue figure from the calculation of the most recent five-year trend and substituted the previous four-year average as a more realistic expectation for long-term revenue growth in Nova Scotia and Newfoundland.

Consistent with its 2005 ranking, **Quebec** remains the single best case with public health spending on pace to reach 50% of revenue by 2056. This date is five years earlier than last year's projection of 2061.

### **Conclusions**

The "better" performance of some provinces is illusory because public health spending in every province is growing faster than revenue and no provincial health-care system is ultimately on a sustainable path. Further, in many provinces 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 standards of living over time. Finally, aside from one-time windfall revenues (for which we have made adjustments), increased natural resource royalties from escalating oil prices have also driven provincial revenues in some provinces to higher levels in recent years. Yet the economic conditions driving the growth rate in 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 fact, even in Alberta (the nation's largest oil-producing province) revenues are showing signs of returning to long-term, historic growth rates. Finally, it should be noted that the relatively better health-care sustainability performance of provinces like Nova Scotia, New Brunswick, Newfoundland, and Quebec are achieved at the expense of wealthier provinces like Alberta and Ontario because various federal transfers take money from populations in the latter provinces to boost the revenue base of all other provinces. This makes the poor sustainability performance of Manitoba and Prince Edward Island even more alarming because they are among the biggest recipients of federal transfers.

On the other side of the sustainability ratio, it is observed that public health spending has been growing relatively more slowly in Quebec than in other provinces. Quebec's relative success with cost control is loosely correlated (but not necessarily causally related) with greater use of privately delivered health services, which evidence indicates is more efficient than public delivery; and higher levels of spending on pharmaceuticals, which research shows tend to be efficient substitutes and complements for other medical interventions.

***What are the options?***

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. Perpetual budget deficits are by definition not sustainable and are therefore not a realistic solution to paying for increases in public health spending over the long term. 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.

*Paying more?*

In order to avoid this financial crisis, governments have two options: they can increase the growth rate in revenue or decrease the growth rate in public health spending. But, the policies chosen by governments to achieve these solutions must be feasible. Paying more for health care by relying on tax increases to accelerate the growth in revenue will not work over the long run. 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, bringing 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 also reduce the growth in public health spending.

### *Getting less?*

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 medical labour by arbitrarily holding down wage rates for health professionals.

Getting less from health care is also not a sustainable policy option for controlling the annual growth in public health spending. Patients will experience increasing medical risks from waiting if rationing is used to hold down the growth in public health spending indefinitely. And the Supreme Court’s 2005 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. Legal and constitutional experts are suggesting that the Court’s ruling is in *de facto* application in all provinces as soon as someone challenges the ban on private health insurance elsewhere in the country.

### **Policy prescription**

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;
- ⌘ acknowledging the individual right of patients to pay privately (via private insurance or out of pocket) for all types of medical services, including hospitals and physician services;
- ⌘ allowing providers to charge extra fees directly to patients above the public health-insurance reimbursement level and to receive reimbursement for their services from any insurer whether public or private;
- ⌘ permitting 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, 75% by 2023, and theoretically 100% of total 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 10 times as large only 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. The province has since moved away from the proposition that the health surtax could be used to fund future increases in public health-care expenditures.

For *Paying More, Getting Less 2005: Measuring the Sustainability of Provincial Public Health Expenditure in Canada*, the analysis applied to Ontario was refined, standardized, and expanded to include all 10 Canadian provinces. Interprovincial 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.

### ***Sustainability, public health spending, and revenue***

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. All federal and territorial public spending on health care is excluded. All private spending on health care is also 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. While debt-service charges represent fixed expenditures of government that reduce the revenues that are actually available for program expenditures, this analysis does not adjust total provincial revenues by subtracting debt-service charges.

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 such as health spending as a percentage of programs spending or health spending as a percentage of GDP. 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. 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 general economic growth alone, it is immediately clear that existing tax rates must rise or new taxes must be introduced. 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.

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 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.

### **Sources of data**

For this study, all data for public health expenditures and for total revenues are taken from Statistics Canada's Financial Management System (FMS) and are current for the period 1996/1997 to 2005/2006. Annual periods reflect the fiscal year ending March 31.

Statistics Canada makes annual revisions to the FMS data set to include more complete data. This may slightly affect the occurrence of the sustainability dates projected in this analysis but will not affect the general conclusions of the study. It should be noted that for the 2004 study of Ontario, 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, 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.

### **Projections**

All figures in this study are reported in current (or nominal) 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 measured by changes in the Consumer Price Index (CPI) 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. Economic growth measured by changes in Gross Domestic Product (GDP) [Table 2] is also implicitly held constant by projecting the most recent five-year trend. This methodology most easily illustrates the financial implications of continuing the same policies that governments have used in the recent past.

### **Adjustments for Nova Scotia and Newfoundland**

There were two adjustments made to the expected future growth rates for revenue in Nova Scotia and Newfoundland in this year's report. Last year, Nova Scotia and Newfoundland were the beneficiaries of a windfall boost to their revenue base resulting from new offshore oil production and the striking of a deal with the federal government to keep resource revenue without reducing federal transfers to these provinces for equalization. The effect was a one-time boost to revenues in the fiscal year ending March 31, 2006 that will not be repeated year over year. This one-time increase would unrealistically distort future projections if the 2005/2006 figure were included in a



**Table 1: Annual percentage growth in the Consumer Price Index (CPI), 2001–2005**

	2001	2002	2003	2004	2005	5-year average
Canada	2.5	2.3	2.8	1.9	2.2	2.3
British Columbia	1.7	2.3	2.1	2.0	2.0	2.0
Alberta	2.3	3.4	4.4	1.4	2.1	2.7
Saskatchewan	3.1	2.8	2.3	2.2	2.2	2.5
Manitoba	2.6	1.6	1.8	2.0	2.7	2.1
Ontario	3.1	2.0	2.7	1.9	2.2	2.4
Quebec	2.4	2.0	2.5	1.9	2.3	2.2
New Brunswick	1.7	3.4	3.4	1.5	2.4	2.5
Nova Scotia	1.8	3.0	3.4	1.8	2.8	2.6
Prince Edward Island	2.6	2.7	3.6	2.1	3.2	2.8
Newfoundland & Labrador	1.1	2.4	2.9	1.8	2.6	2.2

Source: Statistics Canada (2006a). CANSIM Table 326-0002.

**Table 2: Nominal annual percentage growth in Gross Domestic Product (GDP), expenditure based, 2001–2005**

	2001	2002	2003	2004	2005	5-year average
Canada	2.9	4.2	5.4	6.1	6.1	4.9
British Columbia	1.7	3.5	5.6	7.7	6.8	5.1
Alberta	4.5	-0.3	13.5	9.3	15.3	8.5
Saskatchewan	-2.1	3.6	6.0	9.9	6.2	4.7
Manitoba	3.2	4.2	2.9	6.0	4.9	4.2
Ontario	2.9	5.4	3.2	4.9	3.9	4.1
Quebec	3.0	4.5	4.3	5.0	3.7	4.1
New Brunswick	3.0	2.3	4.9	3.6	3.3	3.4
Nova Scotia	5.1	4.5	6.0	4.1	5.3	5.0
Prince Edward Island	1.9	8.3	3.5	4.6	3.0	4.3
Newfoundland & Labrador	1.8	16.0	10.2	7.2	10.8	9.2

Source: Statistics Canada (2006b). CANSIM Table 384-0002.

calculation of the trend. For instance, Newfoundland's one-year revenue growth rate for 2005/06 was more than 55%. Because this windfall boost to revenue growth will not be repeated every year, this study selectively removed the most recent year's revenue figure from the calculation of the most recent five-year trend and substituted the previous four-year average as a more realistic expectation for revenue growth in Nova Scotia and Newfoundland.

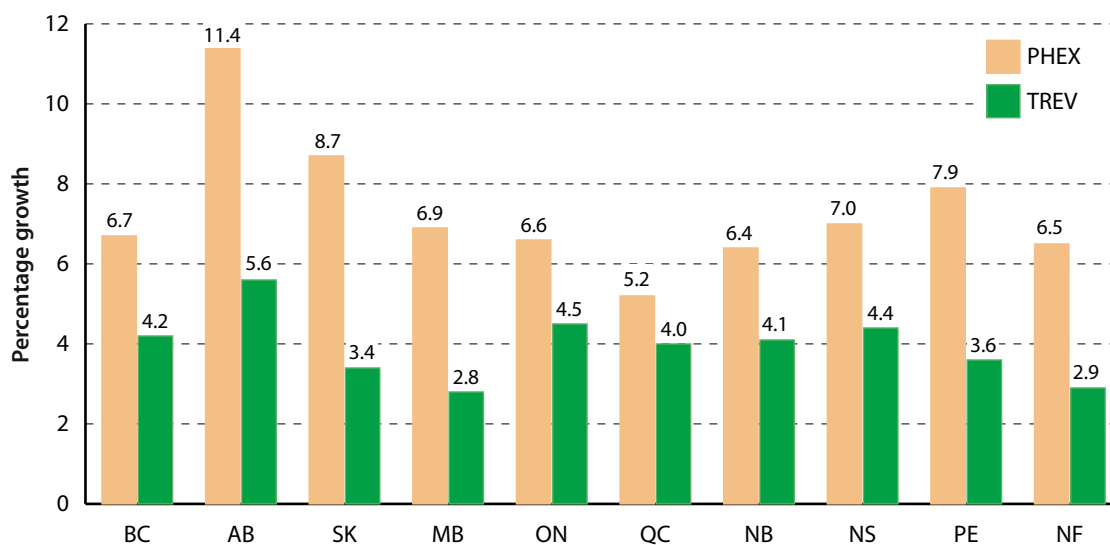
## Findings and analysis

### Recent growth rates for public health spending and total revenue (2001/02–2005/06)

The first finding of this study is that over the last five years (2001/2002–2005/2006), public health expenditure (PHEX) has been growing faster on average than total revenue (TREV) in all 10 provinces. [Figure 1] This continues the same general trend as observed last year. Therefore, by definition, the financing of public health care is on an unsustainable track in Canada. Except in Newfoundland, public health spending has also been growing faster on average than Gross Domestic Product (GDP), or faster than our absolute ability to pay for it from economic growth. And, in all provinces public health expenditure is growing faster on average than the Consumer Price Index (CPI), or faster than all other goods and services in the economy. [Figure 2]

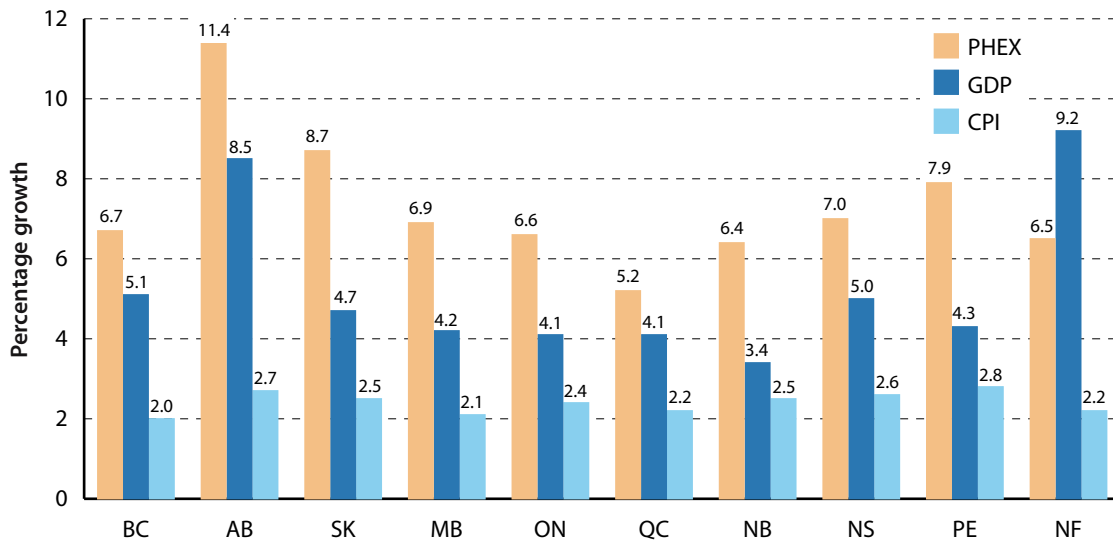
It is significant that public health spending has continued to outgrow revenue during this time frame, because the period has been characterized by relatively solid economic growth across the provinces, [Table 2, p. 8] which would have boosted the revenue growth observed in the data used for this study. This means that, if the economy grows more slowly in the future, the gap in the growth rate between public health spending and total 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 (TREV), by province (2001/02–2005/06, except Newfoundland and Nova Scotia, 2001/02–2004/05)**



Source: Author's calculations based on data from Statistics Canada, 2006c.

Figure 2: Average annual percentage growth in public health expenditure (PHEX), gross domestic product (GDP), and consumer price index (CPI), by province (2001/02–2005/06)



Source: Author's calculations based on data from Statistics Canada, 2006c.

It is equally important to note that the average annual growth rates in provincial revenue observed between 2001/2002 and 2005/2006 were partially affected by increases in some provincial taxes and the introduction of new taxes in some years. This was offset somewhat by tax decreases in some provinces. For example, British Columbia introduced significant new or increased taxes in 2002, 2003, 2004, and 2005 following earlier cuts to taxes. Table 3 shows the change in total taxes as a percentage of cash income for families with two or more individuals in each of the provinces between 1981 and 2005.

The boost to revenue growth rates from tax increases is temporary. Unless tax rates continually rise in the future or more new taxes are introduced every year, the revenue growth generated by tax measures will not repeat itself. It should be obvious that annually increasing the tax burden is not an economically sustainable policy. 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.

**Table 3: Total taxes as a percentage of cash income for families with two or more individuals, by province, 1995, 2000 and 2005.**

	1995	2000	2005
British Columbia	45%	48%	47%
Alberta	42%	47%	46%
Saskatchewan	45%	49%	50%
Manitoba	44%	47%	48%
Ontario	44%	47%	46%
Quebec	45%	50%	49%
New Brunswick	42%	43%	45%
Nova Scotia	42%	45%	46%
Prince Edward Island	38%	43%	45%
Newfoundland & Labrador	38%	43%	46%

Source: The Fraser Institute's Canadian Tax Simulator (2006).

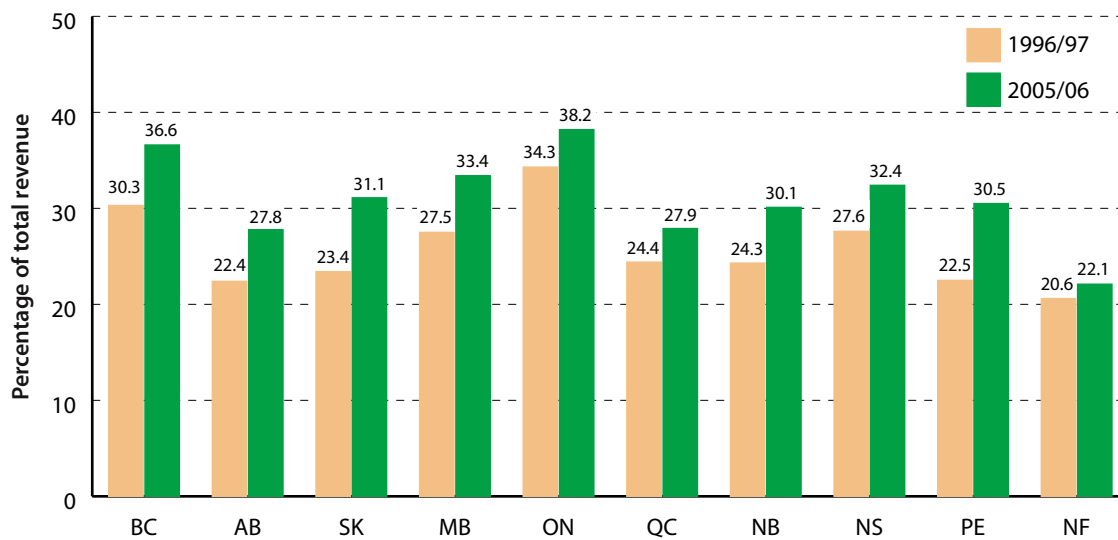
## Comparing provincial public health spending as a percentage of revenue over time

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 3** shows the most recent data available from FMS for the years 1996/1997 and 2005/2006. The data indicate that by the end of the fiscal year 2006 public health spending was consuming a significantly higher percentage of total revenue in every province than it did at the beginning of this 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.

## Projecting recent trends into the future

The current inability to sustain public health-care financing in Canada can also be illustrated by projecting the average annual growth rates in public health spending and revenue from 2001/2002 to 2005/2006 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.

**Figure 3: Public health expenditure (PHEX) as a percentage of total revenue, by province, 1996/97 and 2005/06**



Source: Author's calculations based on data from Statistics Canada, 2006c.

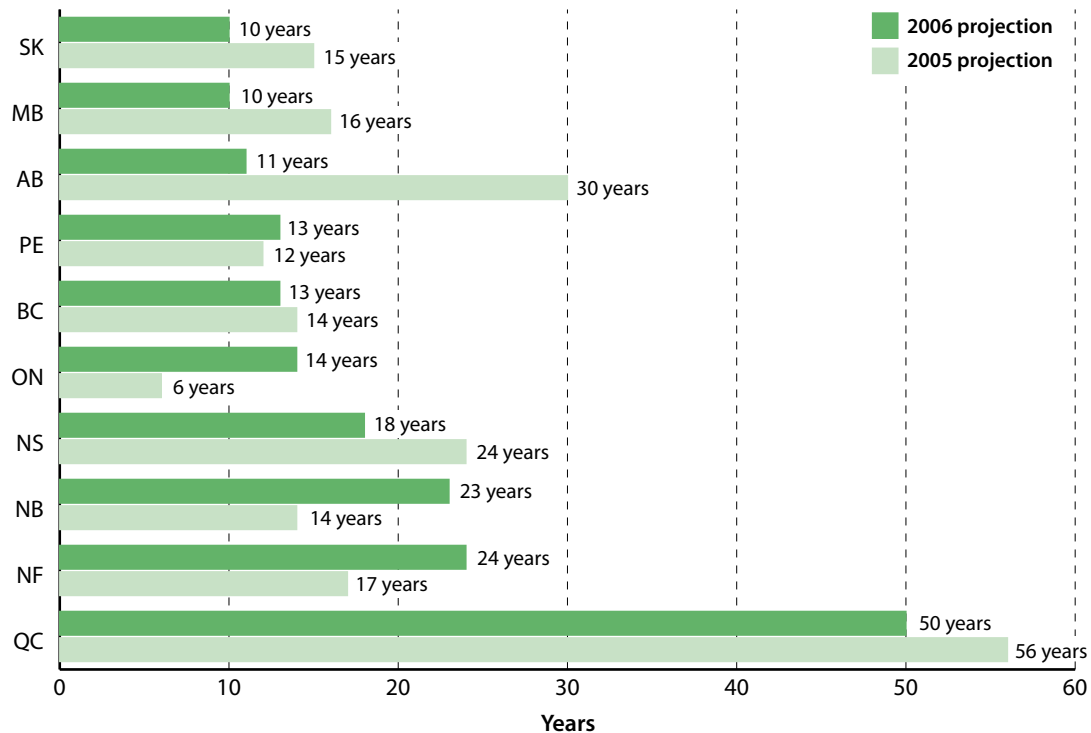
Based on the most recent five-year trends, in six of 10 provinces public health spending is on pace to consume more than half of total revenue from all sources by the year 2020, two thirds by the year 2035, and all of provincial revenue by 2050. Last year, in seven of 10 provinces public spending on health care was on pace to consume more than half of total revenues by 2022, two thirds by the year 2032, and all of provincial revenue by 2050.

Figure 4 compares the length of time it will take for public health spending in each province to consume 50% of revenue if both continue to grow at the same average annual rate observed during the most recent five-year period. 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.

### 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 shows that no province can sustain current public health-care financing. The ranks of the provinces have changed. The difference in the projections between this year and last year is a result of using a moving five-year average method of calculating trends.

**Figure 4: Number of years until public health expenditure consumes 50% of total revenue, by province, 2006 forward**



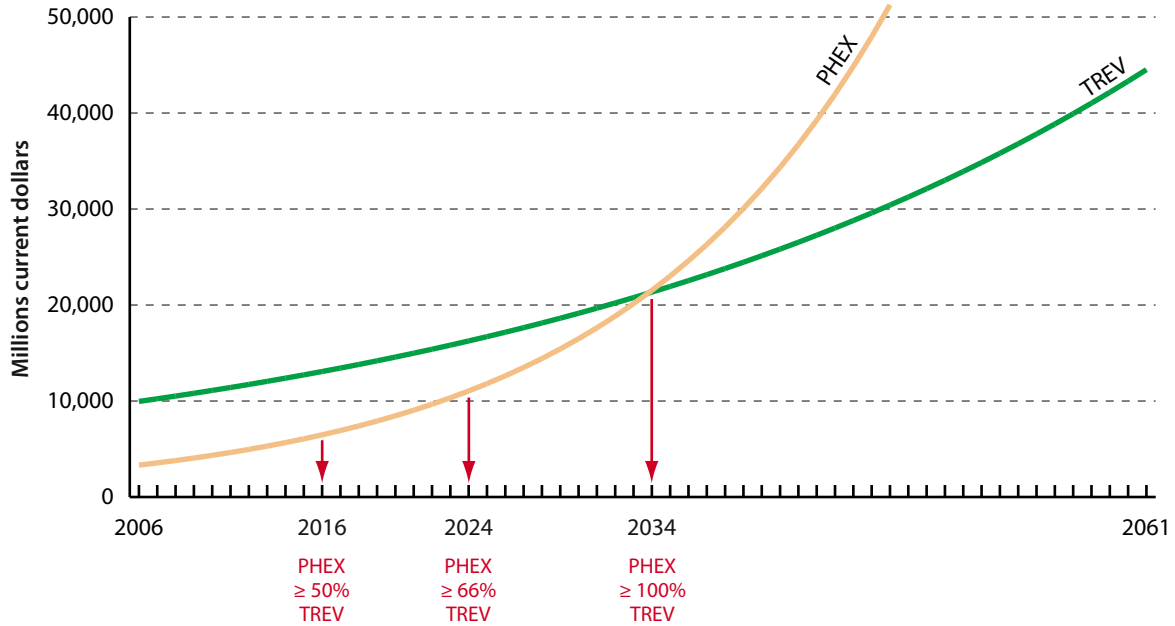
**Worst Cases**

In this year’s report, **Manitoba** [Figure 5] and **Saskatchewan** [Figure 6] are tied as the most urgent cases, with public spending on health care projected to consume half of all revenues as early as 2016. Those provinces are nearly matched by **Alberta**, [Figure 7] which falls from last year’s 50% sustainability-warning date of 2035 (a temporary result of sharp increases in oil prices in 2001 that caused a boom in provincial resource-based revenue and inflated average revenue growth rates calculated from the five-year trend used in last year’s study) to this year’s projection of 2017 (the moving five-year average trend now reflecting lower but more normal patterns of revenue growth). **British Columbia** [Figure 8] and **Prince Edward Island** [Figure 9] are next, both having 50% warning dates occurring in 2019.

Based on the previous five-year average used in last year’s report, **Ontario** [Figure 10] was the worst-case province with public health spending at that time growing at an average rate that would exceed half of total revenue by 2011. In this year’s projection of the most recent five-year averages, the date at which public health expenditures in Ontario will reach 50% of total revenues occurs nine years later, in 2020. Based on our measure of sustainability this is an improvement, but the result only suggests a slight delay of the inevitable: public health insurance remains financially unsustainable. This ominous financial situation is occurring even after Ontario introduced significant new taxes in the form of its incorrectly labeled “health premium” in 2004.



**Figure 5: Manitoba—projected public health expenditure (PHEX) and total revenue (TREV) from all sources based on average annual percentage growth in PHEX and TREV, 2001/02–2005/06**



**Figure 6: Saskatchewan—projected public health expenditure (PHEX) and total revenue (TREV) from all sources based on average annual percentage growth in PHEX and TREV, 2001/02–2005/06**

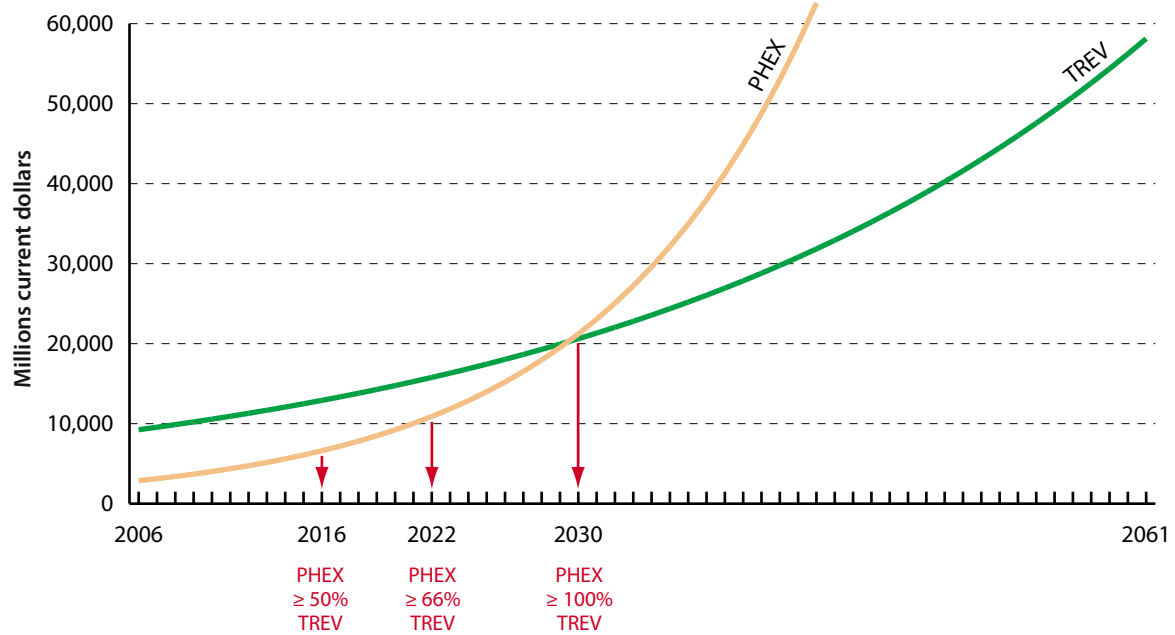


Figure 7: Alberta—projected public health expenditure (PHEX) and total revenue (TREV) from all sources based on average annual percentage growth in PHEX and TREV, 2001/02–2005/06

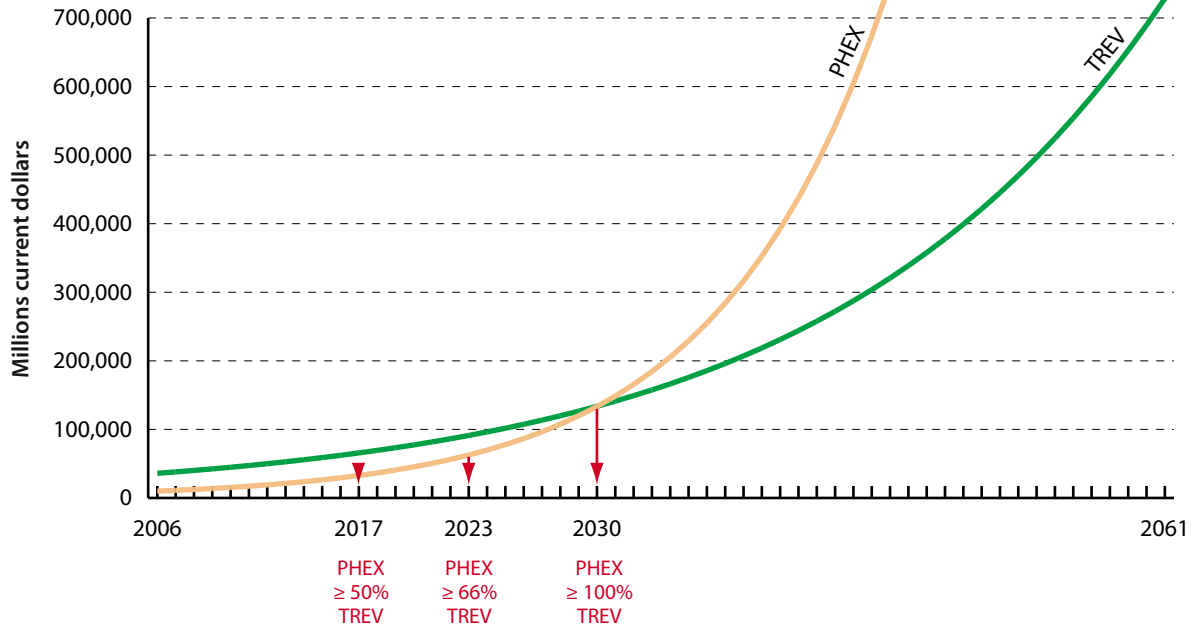
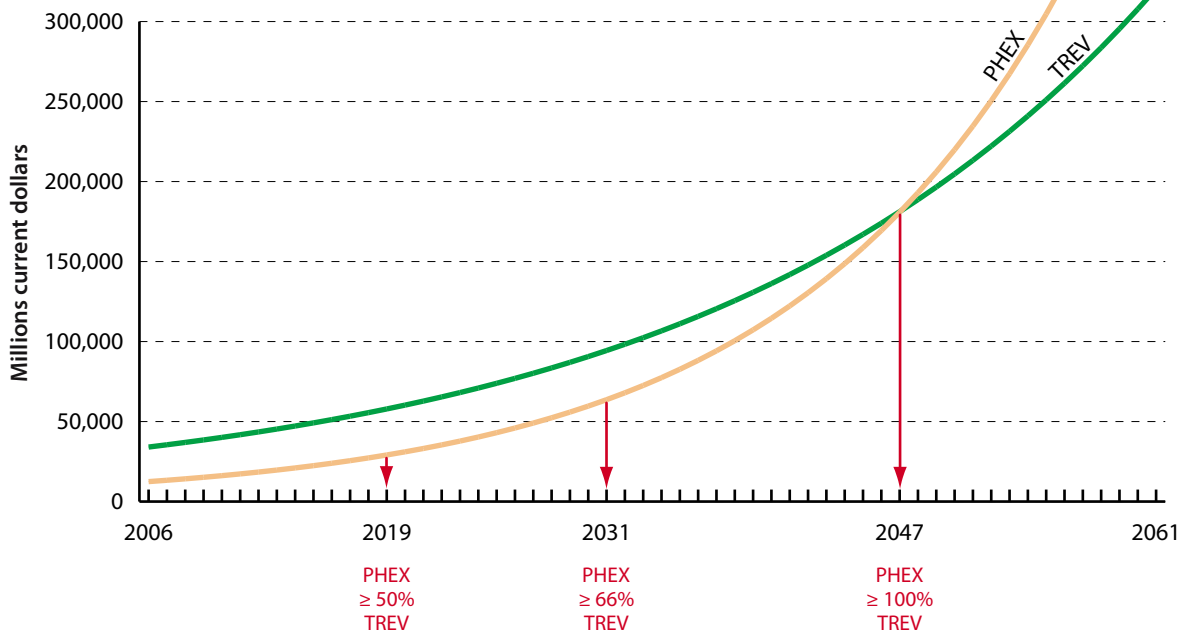
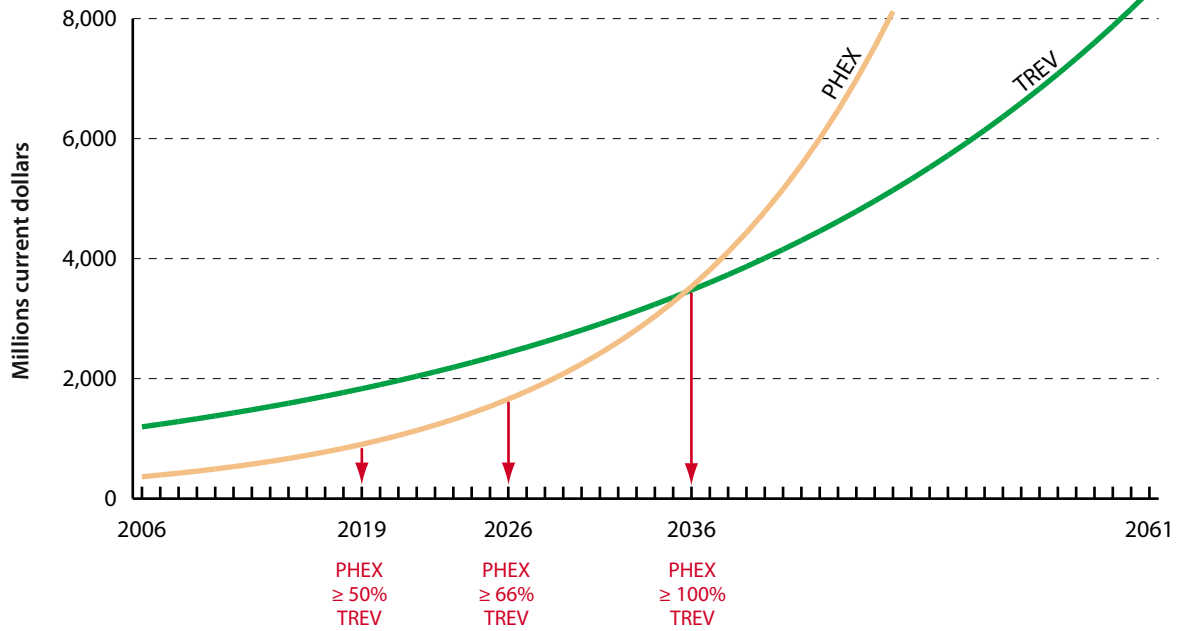


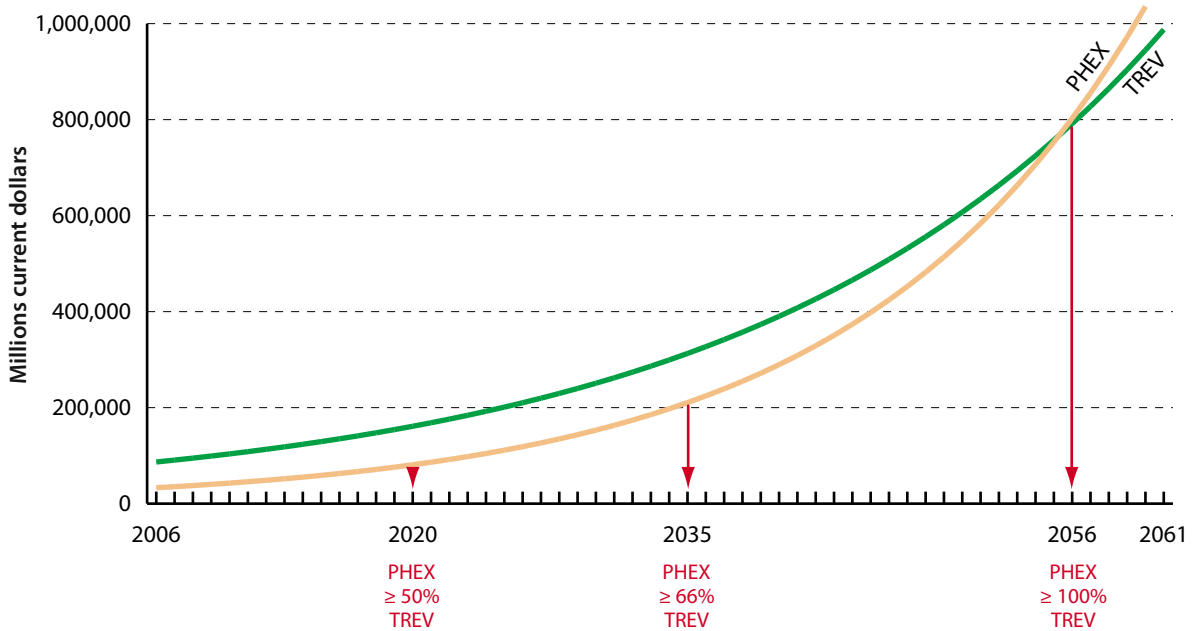
Figure 8: British Columbia—projected public health expenditure (PHEX) and total revenue (TREV) from all sources based on average annual percentage growth in PHEX and TREV, 2001/02–2005/06



**Figure 9: Prince Edward Island—projected public health expenditure (PHEX) and total revenue (TREV) from all sources based on average annual percentage growth in PHEX and TREV, 2001/02–2005/06**



**Figure 10: Ontario—projected public health expenditure (PHEX) and total revenue (TREV) from all sources based on average annual percentage growth in PHEX and TREV, 2001/02–2005/06**



**Middle Cases**

Public health expenditures are projected to reach 50% of total revenues by 2024 in **Nova Scotia**, [Figure 11] by 2029 in **New Brunswick**, [Figure 12] and by 2030 in **Newfoundland**. [Figure 13] Last year, Nova Scotia and Newfoundland were the beneficiaries of a windfall boost to their revenue base resulting from the launch of offshore oil production and their striking a deal with the federal government to keep resource revenue without any reduction in federal transfers for equalization. For instance, Newfoundland’s one-year revenue growth rate for 2005/06 was more than 55%. The effect was a one-time boost to revenues in the fiscal year ending March 31, 2006 that, unlike fluctuations in oil prices, will not be repeated year over year. Because this windfall boost to revenue growth will not be repeated every year, this study selectively removed the most recent year’s revenue figure from the calculation of the most recent five-year trend and substituted the previous four-year average as a more realistic expectation for long-term revenue growth in Nova Scotia and Newfoundland.

**Figure 11: Nova Scotia—projected public health expenditure (PHEX) and total revenue (TREV) from all sources based on average annual percentage growth in PHEX and TREV, 2001/02–2004/05**

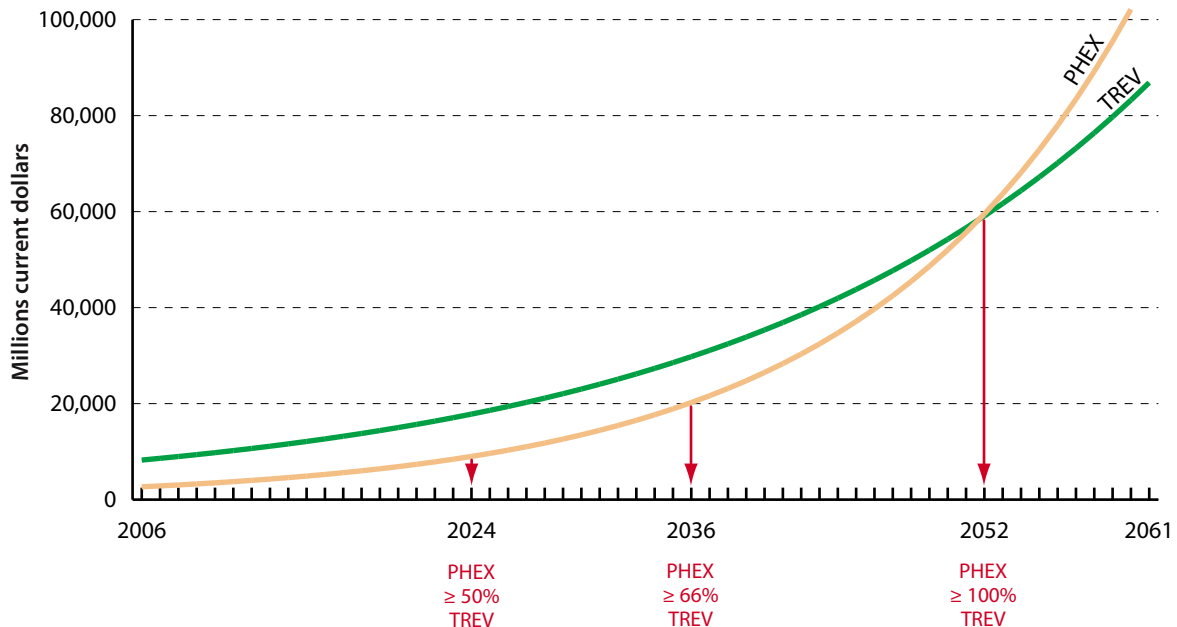


Figure 12: Newfoundland—projected public health expenditure (PHEX) and total revenue (TREV) from all sources based on average annual percentage growth in PHEX and TREV, 2001/02–2004/05

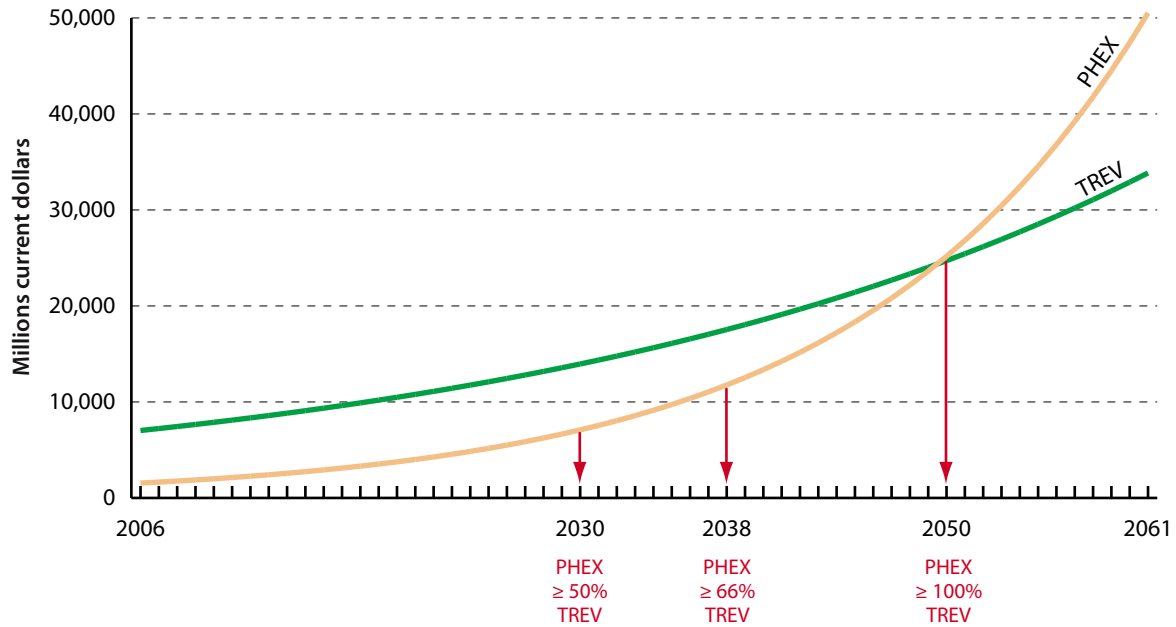
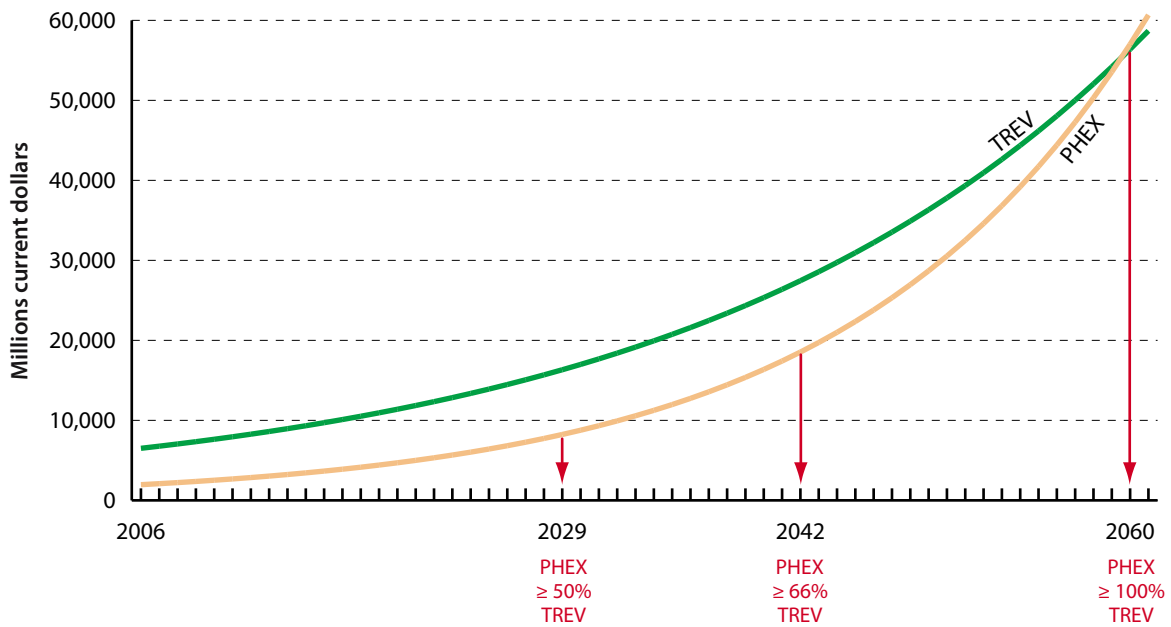


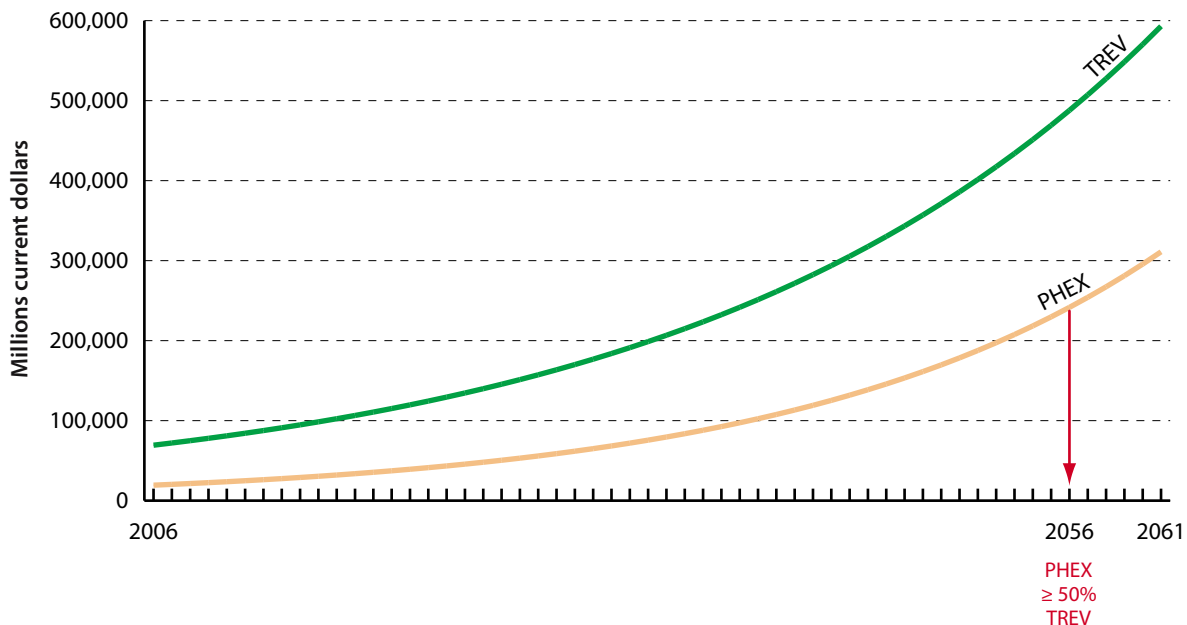
Figure 13: New Brunswick—projected public health expenditure (PHEX) and total revenue (TREV) from all sources based on average annual percentage growth in PHEX and TREV, 2001/02–2005/06



**Best Case**

**Quebec** [Figure 14] is the single best case with public health spending on pace to reach 50% of revenue as late as 2056. This is a five-year deterioration from the 50% sustainability-warning date projected last year but still far better than the performance of the other provinces. Quebec’s better performance relative to other provinces is a function of a narrower gap between the relative growth rates in public health expenditure and total revenue. The reason for the narrow gap is mostly due to the fact that public health spending has been growing more slowly in Quebec than in other provinces. The province’s relatively slower growth rate in public health expenditure is loosely correlated (though not necessarily causally related) with greater use of private delivery for health services and higher levels of spending on pharmaceuticals than in other provinces. These links are consistent with economic evidence that privately delivered health services are more efficient than publicly delivered services and pharmaceuticals tend to be more efficient substitutes for other medical interventions. [Esmail, 2005a]

**Figure 14: Quebec—projected public health expenditure (PHEX) and total revenue (TREV) from all sources based on average annual percentage growth in PHEX and TREV, 2001/02–2005/06**





## Conclusions and policy options

The “better” performance of some provinces is illusory because public health spending in every province is growing faster than revenue and no provincial health-care system is ultimately on a sustainable path. Further, in many provinces 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 standards of living over time. Finally, aside from one-time windfall revenues (for which we have made adjustments), increased natural resource royalties from escalating oil prices have also driven provincial revenues in some provinces to higher levels in recent years. Yet the economic conditions driving the growth rate in 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 fact, even in Alberta (the nation’s largest oil-producing province) revenues are showing signs of returning to long-term, historic growth rates. Finally, it should be noted that the relatively better health-care sustainability performance of provinces like Nova Scotia, New Brunswick, Newfoundland, and Quebec are achieved at the expense of wealthier provinces like Alberta and Ontario because various federal transfers take money from populations in the latter provinces to boost the revenue base of all other provinces. This makes the poor sustainability performance of Manitoba and Prince Edward Island even more alarming because they are among the biggest recipients of federal transfers.

On the other side of the sustainability ratio, it is observed that public health spending has been growing relatively more slowly in Quebec than in other provinces. Quebec’s relative success with cost control is loosely correlated (but not necessarily causally related) with greater use of privately delivered health services, which evidence indicates is more efficient than public delivery; and higher levels of spending on pharmaceuticals, which research shows tend to be efficient substitutes and complements for other medical interventions.

### ***Reasons that this analysis is conservative***

- [1] Projections of public health expenditures do not include the impact of an aging population, yet it is known that 50% 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.
- [2] The trend upon which projections of public health expenditures are made captures the impact of all government decisions to ration access to publicly insured medical goods and services and to reduce the scope of coverage under public health insurance by delisting previously insured goods and services and not listing new goods

and services for public reimbursement. The trend also captures the impact on public health expenditures of all reform efforts enacted by governments to date.

- [3] Projections of total revenues are overstated because net of debt-service costs, revenues available for program expenditures are actually lower than the base used in this analysis.
- [4] The trend used for projections of total revenues captures the impact on revenues from all tax increases to date.
- [5] Total revenue figures count revenue from all sources including all taxes and fees, federal transfers, crown corporations, and the investments and other operations of government.

## What are the options?

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. Perpetual budget deficits are by definition not sustainable and are therefore not a realistic solution to paying for increases in public health spending over the long term. 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.

### *Paying more?*

In order to avoid this financial crisis, governments have two options: they can increase the growth rate in revenue or decrease the growth rate in public health spending. But, the policies chosen by governments to achieve these solutions must be feasible. Paying more for health care by relying on tax increases to accelerate the growth in revenue will not work over the long run. 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, bringing 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, 2002] 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 also reduce the growth in public health spending.

### **Getting less?**

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 medical labour by arbitrarily holding down wage rates for health professionals. [Harriman, McArthur, Zelder et al., 1999; Skinner, 2002a; Esmail and Walker, 2004; Esmail, 2005b]

Getting less from health care is also not a sustainable policy option for controlling the annual growth in public health spending. Patients will experience increasing medical risks from waiting if rationing is used to hold down the growth in public health spending indefinitely. And the Supreme Court’s 2005 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. Legal and constitutional experts are suggesting that the Court’s ruling is in *de facto* application in all provinces as soon as someone challenges the ban on private health insurance elsewhere in the country. [Chaoulli v. Quebec (Attorney General), 2005]

***Policy prescription***

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. [Esmail and Walker, 2005] In very general terms, these policies include:

- ⌘ requiring patients to make co-payments for publicly insured health services;
- ⌘ acknowledging the individual right of patients to pay privately (via private insurance or out of pocket) for all types of medical services, including hospitals and physician services;
- ⌘ allowing providers to charge extra fees directly to patients above the public health-insurance reimbursement level and to receive reimbursement for their services from any insurer whether public or private;
- ⌘ permitting both for-profit and non-profit health providers to compete for the delivery of publicly insured health services.

## Other warnings that public health-care expenditures are not sustainable

Using various methodologies other researchers have also concluded that public expenditures on health care are growing at unsustainable rates in Canada. Below is a list of government and private-sector studies that have reached conclusions similar to those presented in this study.

### **Government Commissions and Reports**

Clair, M. (2000). *Emerging Solutions*. Commission d'étude sur les services de santé et les services sociaux.

Fyke, K.J. (2001) *Caring for Medicare: Sustaining a Quality System*. Saskatchewan Commission on Medicare.

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.

Mackinnon, Janice (2004). "The Arithmetic of Health Care." *Policy Matters* 5, 3 (July) Institute for Research on Public Policy (IRPP). <<http://www.irpp.org/pm/archive/pmvol5no3.pdf>>. (Janice MacKinnon was finance minister in Roy Romanow's NDP government in Saskatchewan.)

Mazankowski, D., et al. (2001). *A Framework For Reform*. Premier's Advisory Council on Health.

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.

### **Private Sector Studies**

Brimacombe, Glenn G., et al. (2001). *The Future Cost of Health Care in Canada, 2000–2020: Balancing Affordability and Sustainability*. Conference Board of Canada.

Crowley, B.L., B. Ferguson, D. Zitner, and B.J. Skinner (2002). *Definitely Not the Romanow Report: Achieving Equity, Sustainability, Accountability and Consumer Empowerment in Canadian Health Care*. Atlantic Institute for Market Studies.

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Skinner, Brett J. (2002b). *The Benefits of Allowing Business Back into Canadian Health Care*. The Atlantic Institute for Market Studies (AIMS).



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## Data definitions

### Public health expenditure

According to Statistics Canada (2006c), the figures for public health spending used for this study include the following.

**6.21 Health**—Includes expenditures made to ensure that necessary health services are available to all citizens. Residential care facilities and other health and social services institutions providing medical care and professional nursing supervision are considered as institutions providing health services while those providing room and board with no or limited medical care and nursing supervision are considered as institutions providing social services (see also paragraph 6.22). Also included are expenditures of hospitals' ancillary enterprises, i.e., entities that exist to provide goods and services to patients, staff and others (food services, parking, etc.). This function is composed of four sub-functions.

**(a) Hospital care**—Covers outlays in respect of all kinds of hospital services, i.e., those provided by general hospitals, public health clinics, as well as by acute disease, chronic disease, convalescent, isolation and mental hospitals. It also includes expenditures pertaining to nursing schools attached to hospitals. Where nursing schools come under the responsibility of the Department of Education, the related expenditures are allocated to the sub-function "Education - post-secondary." Expenditures of all hospitals (private, public, religious, etc.) are included except for national defence and veterans hospitals whose costs are allocated to the "National defence" and "Veterans benefits" sub-functions respectively.

**(b) Medical care**—Comprises outlays in respect of general medical care and drug programs as well as outlays incurred for dental and visiting-nurse services and on out-patient care services. It also includes outlays for medical care provided by hospitals, public residential care facilities, WCBs and other public health and social service institutions. Transfers to private residential care facilities and other health and social service institutions to help them finance their medical care activities are included here.

**(c) Preventive care**—Consists of a wide variety of outlays which are intended to prevent the occurrence of diseases and to mitigate their effect. It covers public health clinics; communicable disease control services, including immunization, treatment, isolation and quarantine outside hospital premises; food and drug

inspection services; hospitals which offer preventive services to patients; government establishments (not located in hospitals, e.g., residential care facilities and other health and social services institutions) providing nursing, hygiene and nutrition advisory services, and government organizations conducting research on the causes and consequences of particular diseases or addictions. Also included are transfers to private facilities providing preventive care, such as private residential care facilities.

**(d) Other health services**—Includes outlays on clinics for the treatment of retarded or emotionally disturbed persons and on laboratory and diagnostic services, grants to health-oriented organizations, and expenditures on other health-related services such as health department administration, health statistics, staff training and other services of health establishments (e.g., hospitals and other health and social service institutions), ambulance services, medical rehabilitation and indemnities to injured persons and their dependants which cannot be allocated to the other sub-functions. Also included are outlays on protection of health and health inspection, and expenditures of ancillary enterprises of health and social services institutions. Included are the Canada Health Transfer (CHT) payments.

## Total revenue from all sources

According to Statistics Canada [2006c], the total revenue figures used for this study include the following.

### **Provincial Own Source Revenue**

#### *Income taxes*

- Personal income taxes
- Corporation income taxes
- Mining and logging taxes

#### *Consumption taxes*

- General sales tax
- Alcoholic beverages and tobacco taxes
- Amusement tax
- Gasoline and motive fuel taxes
- Liquor profits
- Remitted gaming profits
- Other consumption taxes

*Property and related taxes*

- General property taxes
- Capital taxes
- Other property and related taxes

*Other taxes*

- Payroll taxes
- Motor vehicle licences
- Natural resource taxes and licences
- Miscellaneous taxes

*Health and drug insurance premiums*

*Contributions to social security plans*

*Sales of goods and services*

*Investment income*

*Other revenue from own sources*

**Transfer Revenue**

- General purpose transfers from other government subsectors
- Specific purpose transfers from other government subsectors

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