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Paying More, Getting Less 2007

Measuring the Sustainability of Government Health Spending in Canada

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THE FRASER INSTITUTE

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Executive summary

This is The Fraser Institute's fourth annual report on the financial sustainability of health spending by provincial governments in Canada. The report uses a moving-trend analysis to measure sustainability. The trend is derived from the average, annual growth rates for total provincial government health expenditures (GHEX) and total available provincial government revenue from all sources (TAREV) over the most recent ten-year period. Government spending on health care is deemed unsustainable when it grows faster on average than revenue over the trend period. Future growth in government health spending and revenue is projected on the basis of the trend to estimate the urgency of the sustainability problem.

The report also examines the long-term feasibility of attempts by provincial governments to deal with the unsustainable growth in health spending through increased tax burdens and centrally planned rationing. The analysis partially exposes the degree to which Canadians are paying more for government health insurance over the trend period and getting less.

Policy environment

The annual growth of government spending on health care is partially affected by the structure of medical and drug insurance in Canada. Canada's current approach to health policy is unique among the advanced countries of the world. Generally speaking, since the late 1960s the private sector has effectively been prohibited from providing insurance for medically necessary health care in Canada. Instead, each province has established its own government-run monopoly over the market for medical insurance (for, e.g., hospital, clinical, and physician services). The provincial medical insurance monopolies also insulate consumers from the cost of medical care because they provide coverage without user-based premiums, co-payments, or deductibles. In addition, private-sector health-care providers are prohibited from competing for the delivery of publicly insured medical services. Each province also has separate, publicly-funded drug programs that occupy and encroach upon large shares of the market for drug insurance.

Findings

Over the ten-year trend period (1997/98 to 2006/07), health spending has been growing at an unsustainable pace in nine of ten provinces. Alberta is the only province where provincial revenue has kept pace with government health spending over the last ten years. Averaged nationally across all provinces, government health spending has grown at an annual rate of 7.3% over the period. The national average, annual growth rate for total available provincial revenue has been only 5.9%. Government health spending has also grown faster than provincial GDP, which averaged only 5.6% annual growth across all provinces over the same period.

The severity of the unsustainable rate of growth in spending on health care varies significantly from province to province. Projecting the ten-year trend into the future suggests that government health spending in six of ten provinces is on pace to consume more than half of total revenue from all sources by the year 2035. Newfoundland & Labrador and Nova Scotia, where growth in government spending on health care is on pace to consume half of all provincial revenues as early as 2017, are the worst cases. [1]

Paying more

High rates of growth in government health spending must be checked or taxpayers will be faced with the constant prospect of paying more. If government health spending is to be kept at a stable percentage of revenue, then revenue must grow at least as fast as public health spending. When the economy is expanding rapidly, revenue often grows fast enough to keep up with government health spending. But when the economy grows at historically normal or slower rates, health spending usually outpaces revenue, increasing the possibility that future tax rates will rise, new taxes will be introduced, or spending on other government responsibilities will be reduced.

Getting less

All provinces continue to use rationing in an effort to contain the growth in government health spending. Instead of introducing policies that would take pressure off public finances, governments restrict access to publicly insured medical goods and services. This continued rationing results in long waits for specialist services and access to new medicines. As long as centrally planned rationing is used to control the growth of health spending, patients will be faced with the prospect of getting less.

Analysis

Based on an analysis of recent economic circumstances and the policies affecting the trends in government spending on health care, it is clear that despite high rates of growth in total available revenue over the trend period, in nine out of ten provinces, government health spending is still growing faster than the ability to pay for it through public means alone. In some provinces—British Columbia, Alberta, Saskatchewan, Newfoundland & Labrador, and Nova Scotia—recent revenue growth has been caused, to some extent, by increased GDP growth linked to escalating energy prices. If GDP in these provinces continues to grow at a high rate as a result of high energy prices, then provincial revenues could grow fast enough to sustain relatively high rates of growth in government health spending—even if the current system is less efficient

[1] Given recent growth in provincial GDP associated with high energy prices in these two provinces, as the ten-year trend period moves forward in future reports, the ranking of Newfoundland & Labrador and Nova Scotia might improve significantly, assuming that growth on health spending is held constant or decreases.

than alternative ways of financing health care. However, it is uncertain that the economic conditions driving high energy prices will persist in the future. Furthermore, energy-driven revenue increases in Saskatchewan, Newfoundland & Labrador, and Nova Scotia have still not kept pace with the growth in health spending when averaged over the trend period.

In some provinces without large energy resources, recent growth rates for revenue have been raised by increasing the tax burden (e.g., Ontario's introduction in 2004 of a new income surtax called a "health premium"). However, the effect on revenue growth rates is only temporary because the tax burden cannot continue to rise over the long term unless people are willing to accept declining rates of economic growth and lower standards of living. Moreover, the growth in government health spending is still not sustainable in the provinces where tax increases have occurred.

The percentage of own-source revenue consumed by health spending differs from province to province. In some provinces—Manitoba, New Brunswick, Newfoundland & Labrador, Nova Scotia, and Prince Edward Island—high rates of growth for government health spending are heavily subsidized by money transferred from other provinces. Federal transfer programs take money from populations in wealthy provinces to boost the revenue base of less wealthy provinces.

In many provinces, governments also continue to restrict or delay access to publicly insured health care in an attempt to slow the growth of health spending. For example, the most recent data shows that wait times for access to medical services have in fact increased over the ten-year trend period in every province. Provincial, publicly funded drug programs also only cover a small percentage of new medicines. Such policies have the effect of slowing the growth in government health spending. However, strict rationing cannot continue indefinitely without causing medical risks for patients.

Conclusion & recommendations

Based on the data and analysis in this report, we conclude that public health insurance, as it is currently structured in Canada, tends to produce rates of growth in government spending on health care that are not financially sustainable through public means alone. This is occurring while governments are restricting and reducing the scope of benefits covered under publicly funded health insurance. As an alternative to the current "pay more, get less" approach to health policy, we recommend that governments do the following:

1. encourage the efficient use of health care by requiring patients to make co-payments for any publicly funded medical goods and services they use;

2. relieve cost pressures facing the public health-insurance system by legalizing the right of patients to pay privately (private insurance or out of pocket) for all types of medical goods and services, including hospitals and physician services, as is currently allowed for access to medicines;

3 allow health providers to receive reimbursement for their services from any insurer whether government or private;

4 shift the burden of medical price inflation onto the private sector by allowing providers to charge patients fees additional to the government health-insurance reimbursement level;

5 create incentives for cost and quality improvements by permitting both for-profit and non-profit health providers to compete for the delivery of publicly insured health services.

Introduction

This is The Fraser Institute's fourth annual report on the financial sustainability of health spending by provincial governments in Canada. The report uses a moving-trend analysis to measure sustainability. The trend is derived from the average, annual growth rates for total provincial government health expenditures (GHEX) and total available provincial government revenue from all sources (TAREV) over the most recent ten-year period. [1] Government spending on health care is deemed unsustainable when it grows faster on average than revenue over the trend period. Future growth in government health spending and revenue had been projected on the basis of the trend to estimate the urgency of the sustainability problem.

The report also examines the long-term feasibility of attempts by provincial governments to deal with the unsustainable growth in health spending through increased tax burdens and centrally planned rationing. The analysis partially exposes the degree to which Canadians are paying more for government health insurance over the trend period and getting less.

Policy environment

The annual growth of government spending on health care is partially affected by the structure of medical and drug insurance in Canada. [2] Canada's current approach to health policy is unique among the advanced countries of the world. Generally

[1] This is a change from the methodology used in previous reports. Critics argued that our previous five-year analysis was not a long-enough trend in health spending or revenue upon which to build assumptions about future growth rates when projecting sustainability. We still maintain that five years is an appropriate reflection of the effect of the policy decisions of current (or recent) governments on the growth in provincial health spending. However, we agree that five years is too short to capture the full effect of recent changes in the tax structure. Changes in tax policy have a delayed impact on the growth of GDP, which in turn affects the growth of the revenue base over a time horizon that might not be fully captured in the five-year trend. On balance, we decided it was important to accommodate the concerns of those who think that ten-year trends are a better way to capture the impact of policy decisions on available revenue in the provinces.

[2] The structure and availability of health insurance, growth of GDP, the growth and aging of the population, changing demands for health care, and the introduction of new treatments and technologies all contribute to the growth of health spending in general, regardless of whether the private sector or the public sector finances it. However, unsustainable growth in health spending is short-lived in the private sector once the insured decide that the price of financing health spending through premiums is too high. When expenditures grow faster than revenue, private-sector insurers make immediate adjustments to prevent insolvency and ensure the financial viability of the insurance plan. Private-sector insurers also cannot make unpopular

speaking, since the late 1960s the private sector has effectively been prohibited from providing insurance for medically necessary health care in Canada. Instead, each province has established its own government-run monopoly over the market for medical insurance (for, e.g., hospital, clinical, and physician services). The provincial medical insurance monopolies also insulate consumers from the cost of medical care because they provide coverage without user-based premiums, co-payments, or deductibles. In addition, private-sector health-care providers are prohibited from competing for the delivery of publicly insured medical services. Each province also has separate, publicly-funded drug programs that occupy and encroach upon large shares of the market for drug insurance.

reductions to the scope of insured benefits in order to contain costs without risking the loss of clients. By contrast, under publicly funded health insurance, most of the population actually pays a price for health insurance that is disproportionately low. The cost of financing health spending is redistributed through taxes and is disproportionately high for a relative minority of the population. Governments can therefore allow costs to rise unchecked without risking immediate political consequences. Under a public health-insurance monopoly, governments can also get away with reductions in the scope of publicly insured benefits because there are no other insurance options available.

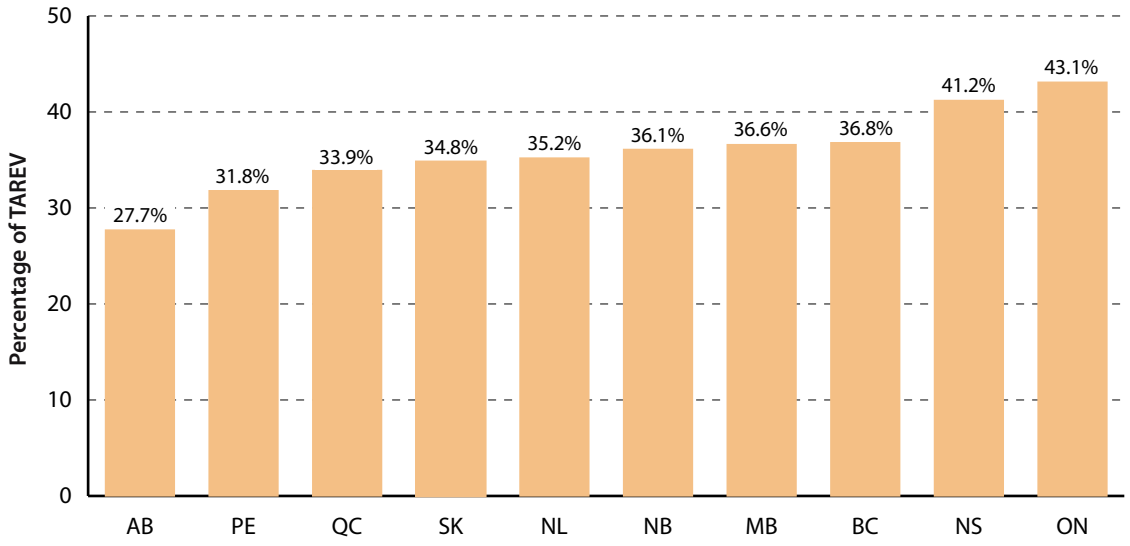
Findings

Current health spending as a percentage of available revenue

The first finding of this report is that government health spending currently consumes a large percentage of total available revenues in each of the provinces. The most recent data [Figure 1] shows that in 2006/07 government health expenditures (GHEX) accounted for 43.1% of total available revenue (TAREV) **[3]** in Ontario, the largest percentage among all ten provinces. At the other end of the scale, GHEX consumed 27.7% of TAREV in Alberta.

[3] Total Available Revenue (TAREV) is total revenue from all sources, including federal transfers, minus debt charges. Debt charges are removed because they represent fixed financial obligations of the provinces and cannot be spent on programs or other responsibilities of government. Debt charges are distinct from debt repayment. Debt repayment is a policy choice, whereas debt charges are not. This is a change from the methodology used in previous reports.

Figure 1: Percentage of total available revenue (TAREV) consumed by government health expenditures (GHEX), 2006/07, by province



Note: To make Quebec comparable to other provinces, the extra tax room ceded to the province by the federal government for policy areas that are under federal jurisdiction in other provinces has been removed from the calculation of TAREV.

Sources: Statistics Canada, 2007; calculations by authors.

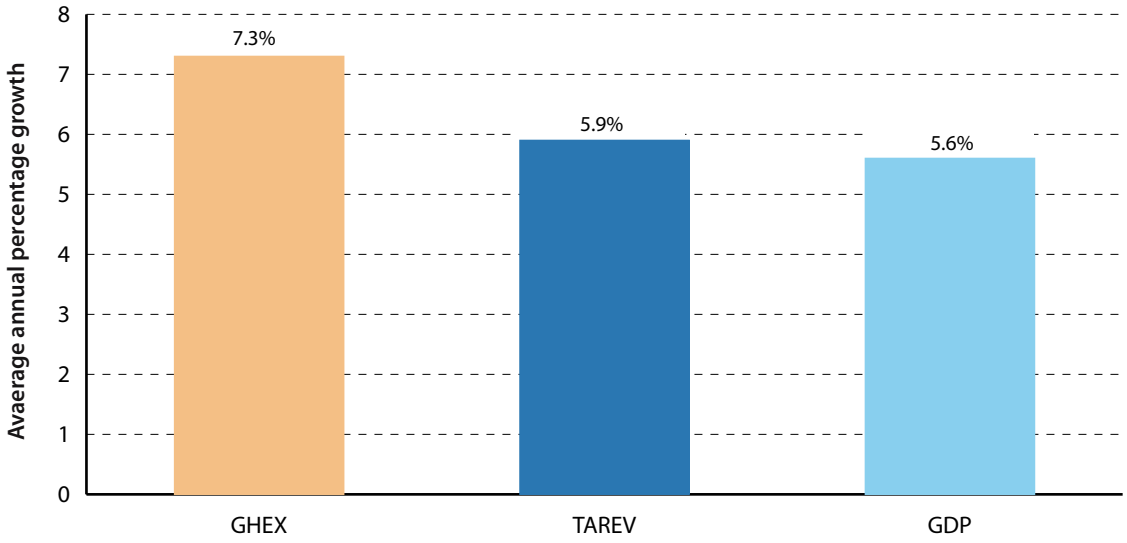
National trend

The most recent national trend for the sustainability of provincial government health spending is shown in Figure 2. National ten-year average, annual growth rates are the average of the ten-year average annual growth rates that occurred for each province. Figure 2 compares the average annual rates of growth in provincial government health expenditures (GHEX), total available provincial revenue (TAREV), and provincial gross domestic product (GDP) as a consolidated average across all ten provinces.

Data for GHEX and TAREV were obtained from Statistics Canada's Financial Management System, which uses fiscal years ending March 31 for its accounting periods. Data for GDP were obtained from the general databases of Statistics Canada, which uses calendar years ending December 31 for its accounting. The most recent ten-year period for GHEX and TAREV therefore covers the years 1997/98 to 2006/07. The most recent ten-year period for GDP covers the years 1997 to 2006.

Figure 2 shows that, averaged across all provinces, government health spending has grown at a faster average annual pace than revenue over the last ten years. Health spending has also grown faster than the economy (GDP) over this period. Therefore, on average provincial government spending on health care has been growing faster than our ability to pay for it through public means alone without counter-balancing reductions of spending on all other responsibilities of government.

Figure 2: National average of ten-year provincial annual percentage growth rates for government health expenditure (GHEX) and total available revenue (TAREV), 1997/98 to 2006/07; and gross domestic product (GDP), 1997 to 2006



Note: To make Quebec comparable to other provinces, the extra tax room ceded to the province by the federal government for policy areas that are under federal jurisdiction in other provinces has been removed from the calculation of TAREV. TAREV growth rates for Newfoundland & Labrador and Nova Scotia has been adjusted to remove the one-year increase in revenue from the Atlantic Accord.

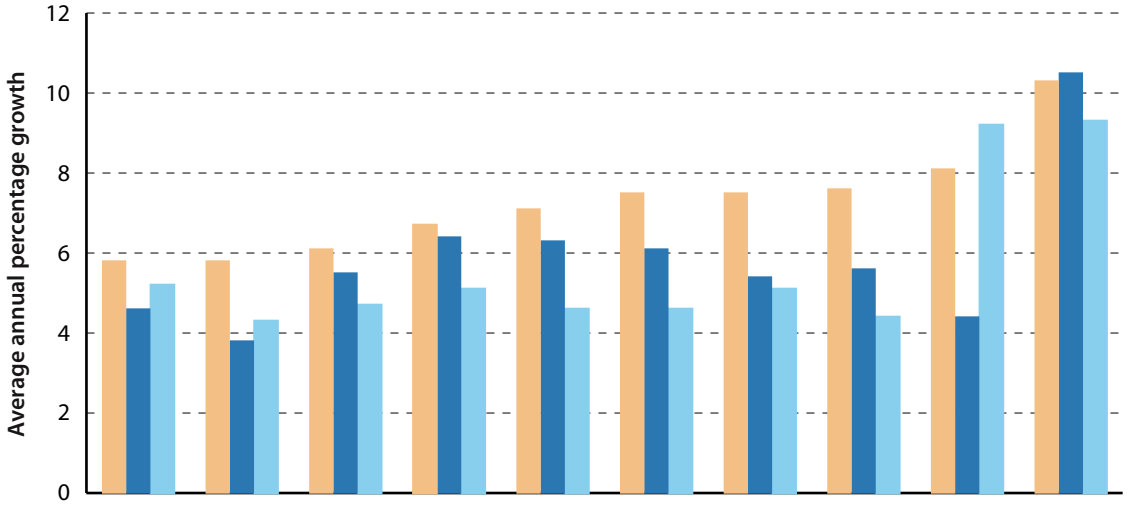
Sources: Statistics Canada, 2007a and 2007b; calculations by authors.

Provincial trends

The severity of the unsustainable rate of growth in spending on health care varies significantly from province to province. Figure 3 compares the average annual percentage growth in GHEX, TAREV, and GDP in each province over the ten-year trend period. [4] The provinces are ranked according to the slowest to the fastest average annual rate of growth in GHEX over the trend period. Over the last ten years, the fastest average annual rate of growth for GHEX occurred in Alberta (10.3%). British Columbia and New Brunswick had the slowest average annual rates of growth for GHEX (5.8%). The fastest average annual growth of TAREV over the trend period was in the province of Alberta (10.5%). TAREV grew slowest in New Brunswick over the period (3.8% annually on average).

[4] Unfortunately, the ten-year average annual rates of growth calculated are vulnerable to the effects of revisions to earlier published data that Statistics Canada routinely completes each year. Statistics Canada recently made accounting changes to their FMS data that substantially altered the previously published figures from which growth rates were calculated between years.

Figure 3: Average annual percentage growth rates for government health expenditure (GHEX) and total available revenue (TAREV), 1997/98 to 2006/07; and gross domestic product (GDP), 1997 to 2006; by province



	BC	NB	MB	ON	QC	SK	NS	PE	NL	AB
GHEX	5.8%	5.8%	6.1%	6.7%	7.1%	7.5%	7.5%	7.6%	8.1%	10.3%
TAREV	4.6%	3.8%	5.5%	6.4%	6.3%	6.1%	5.4%	5.6%	4.4%	10.5%
GDP	5.2%	4.3%	4.7%	5.1%	4.6%	4.6%	5.1%	4.4%	9.2%	9.3%

Note: To make Quebec comparable to other provinces, the extra tax room ceded to the province by the federal government for policy areas that are under federal jurisdiction in other provinces has been removed from the calculation of TAREV. TAREV growth rates for Newfoundland & Labrador and Nova Scotia has been adjusted to remove the one year increase in revenue from the Atlantic Accord.

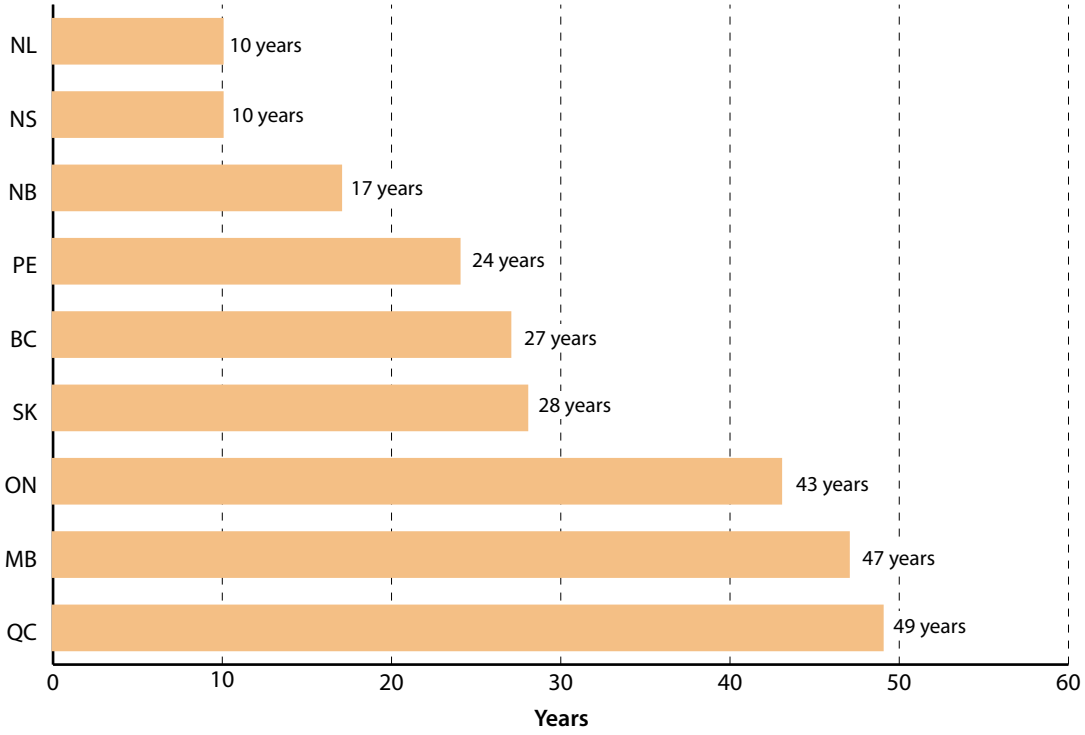
Sources: Statistics Canada, 2007a and 2007b; calculations by authors.

Most importantly, in nine of ten provinces government health spending has grown faster on average than revenue over the last ten years. The only exception was the province of Alberta, which kept the pace of growth in health spending just slightly below the growth of revenue over the trend period. The gap between the average annual growth rates for GHEX and TAREV was widest in Newfoundland & Labrador, where GHEX outpaced TAREV by 3.7 percentage points annually on average between 1997/98 and 2006/07.

Projections

Figure 4 shows the number of years it will take before government health spending consumes half of total available revenue in each of the ten provinces based on a projection of the most recent ten-year trend for growth rates in GHEX and TAREV. These ranks are

Figure 4: Number of years until government health expenditures (GHEX) consume 50% of total available revenue (TAREV), 2007 forward, by province



Notes: To make Quebec comparable to other provinces, the extra tax room ceded to the province by the federal government for policy areas that are under federal jurisdiction in other provinces has been removed from the calculation of TAREV. TAREV growth rates for Newfoundland & Labrador and Nova Scotia has been adjusted to remove the one year increase in revenue from the Atlantic Accord. Alberta is excluded from this figure because GHEX is growing slower than TAREV in the province.

Sources: Statistics Canada, 2007a; calculations by authors.

not comparable with those in previous reports because the current analysis is based on a change in methodology, including the adoption of a ten-year trend period and a new calculation of total available revenue explained earlier.

Among the provinces, Newfoundland & Labrador and Nova Scotia are facing the most urgent sustainability problem. Growth in government spending on health care in both provinces is on pace to consume half of all provincial revenues as early as 2017, reaching 60% by 2022 in Newfoundland & Labrador and 2026 in Nova Scotia.

No adjustment for aging population

The analysis presented in this publication is cautious. The projections on government spending on health care do not account for the expected acceleration in demand that will accompany the aging of the population. Data on provincial health spending by age from the Canadian Institute for Health Information shows that, across all ages, average per-capita provincial/territorial health spending in Canada was about $2,630 in 2004, while spending for those aged 65 to 74 was about $5,865, for those aged 75 to 84 was roughly $10,342, and on those 85 years of age and older was $19,418 [CIHI, 2006]. It is well known that the proportion of the population that is older than 65 years will increase in coming years as the numerically populous generation born just after World War 2 approaches retirement. Because of this demographic trend, if there are no significant changes made to the structure of health-care financing in Canada, government health expenditures will probably grow much faster than observed over the trend periods presented here.

Paying more

Differences among provincial rates of revenue growth suggest that the high growth rates observed for total available revenue (TAREV) in some provinces over the trend period are being driven by economic growth that is partially linked to the inflation of energy prices. GDP growth in some provinces can also be explained by earlier tax-reduction policies. In other provinces, revenue growth has been temporarily accelerated by unsustainable and counter-productive recent increases in the tax burden that will only reduce GDP growth, and thus revenue growth, in the future. As the ten-year trend period moves forward in future reports, the effect of changes in tax policies and economic circumstances will be reflected in the average, annual growth rates.

Inflation in energy prices

In some provinces, recent revenue growth has been caused, to some extent, by escalating energy prices that have boosted the rate of growth in GDP and expanded the tax base. Alberta, British Columbia, Saskatchewan, and Newfoundland & Labrador are the provinces most affected by the inflation in energy prices over the last five years. However, it is uncertain that the economic conditions driving increases in energy prices will persist in the future, making it unclear whether recent growth rates for GDP and revenue will continue. Unless high energy prices continue indefinitely, the unusually high rates of growth in GDP seen over the last five years will likely return to lower historical norms. Also, only British Columbia, Alberta, Saskatchewan, Newfoundland & Labrador, and, to some degree, Nova Scotia have significant energy resources to rely on. Moreover, despite the growth in GDP and revenue associated with high energy prices, government health spending is still growing faster than revenue in all of these provinces except Alberta.

Increasing tax burdens

In some provinces, growth rates for revenue have been temporarily accelerated by recent increases to the tax burden. Ontario, for instance, introduced an income surtax (called a "health premium" by the province) in 2004 to pay for health care. The measure added about $2.5 billion to the revenue base of the province and temporarily increased the growth rate of TAREV in the process. However, previous research has demonstrated that the province cannot expect to increase revenue growth by the same rate each year through such measures [Skinner, 2004]. Increasing the tax burden is not a sustainable way to grow revenues over the long run. Increasing tax burdens reduce the growth of GDP and the potential tax base in future years [Clemens, Veldhuis and Palacios,

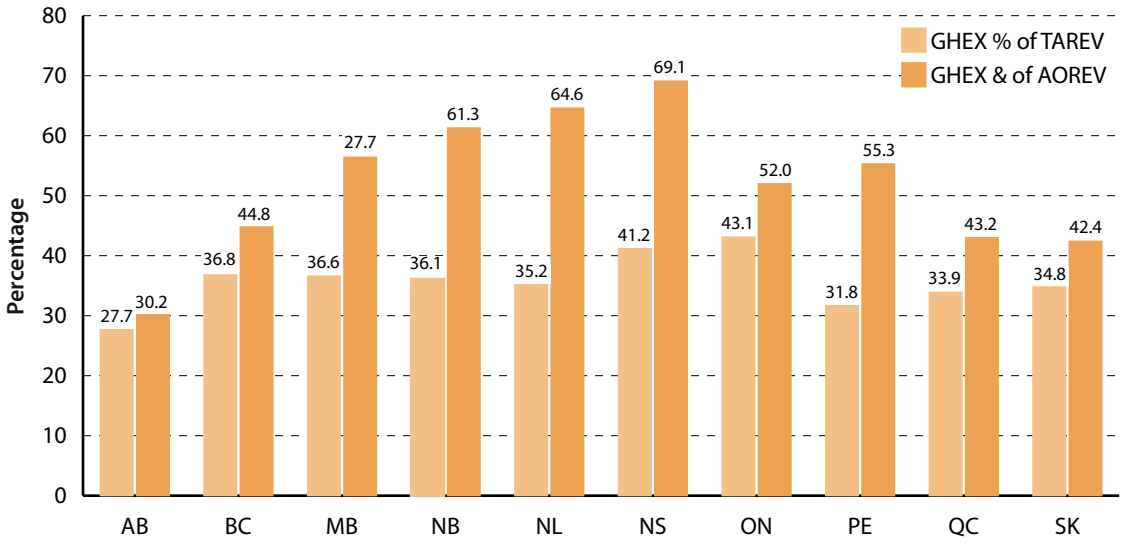
2007; Karabegović, Veldhuis, Clemens, and Godin, 2004]. Slower economic growth caused by increasing tax burdens can also raise the risk of job losses and increase demands for more government spending on things like employment insurance and social assistance, further straining revenues.

Over the long run, the only sustainable fiscal strategy for increasing government revenue faster is to reduce the tax burden (especially on capital investment and returns) in order to accelerate economic growth. [Clemens, Veldhuis and Palacios, 2007; Karabegović, Veldhuis, Clemens, and Godin, 2004]. This causes the tax base to grow along with the economy as the growth of GDP expands the tax base by increasing the amount of wealth available to be taxed. The growth of government revenue is then driven by general economic growth without the damaging, long-term effects of an increasing tax burden.

Inter-provincial subsidies

Revenues available to some provinces for health spending are obtained at the expense of other provinces. Figure 5 shows that, once federal transfers are excluded, the percentage of available own-source revenue consumed by health spending is much higher in some provinces. The growth rates for government health spending in Manitoba, New Brunswick, Newfoundland & Labrador, Nova Scotia, and Prince Edward Island are subsidized by federal transfers to a much higher degree than rates in other provinces.

Figure 5: Government health expenditure (GHEX) as a percentage of total available revenue (TAREV) and available own-source revenue (AOREV), 2006/07, by province



Note: To make Quebec comparable to other provinces, the extra tax room ceded to the province by the federal government for policy areas that are under federal jurisdiction in other provinces has been removed from the calculation of TAREV.

Sources: Statistics Canada, 2007a; calculations by authors.

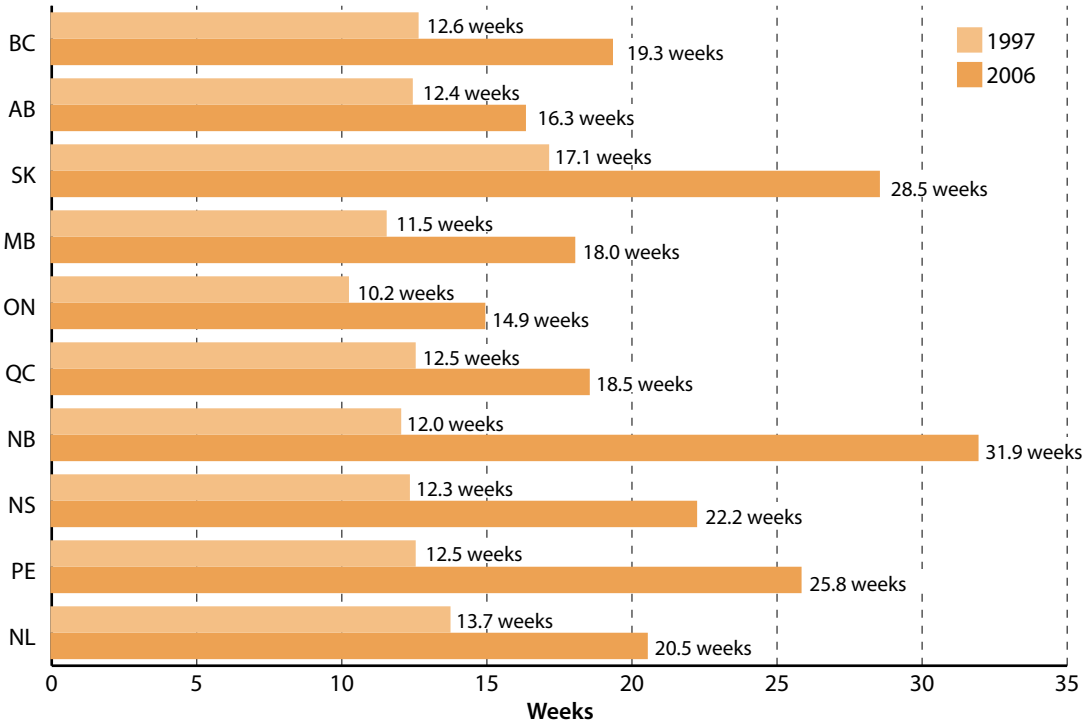
Getting less

All provinces continue to use rationing in an effort to contain the growth in government health spending. Governments ration health care with policies that reduce the effective supply of health professionals [Esmail, 2006], reduce the availability of advanced medical equipment [Esmail and Walker, 2006], and restrict the scope of coverage for new medicines under public drug insurance plans [Skinner, Rovere and Glen, 2007]. Such rationing drives up waits for specialist medical care and inhibits access to new drugs.

Rationing access to publicly insured health care

Figure 6 shows the only available, nationally comparable, evidence on wait times for specialist medical services in Canada. The results are averaged across 12 medically necessary specialties. The data indicate that the average, median, total wait between an appointment with a family doctor and the final receipt of specialist treatment has grown significantly in all provinces over the trend period. These waits can be considered severe as they are nearly twice as long, on average, as the wait physicians consider clinically reasonable for patients [Esmail, Walker & Wrona, 2006].

Figure 6: Median wait times (weeks) from referral by GP to specialist treatment, 1997 and 2006, by province

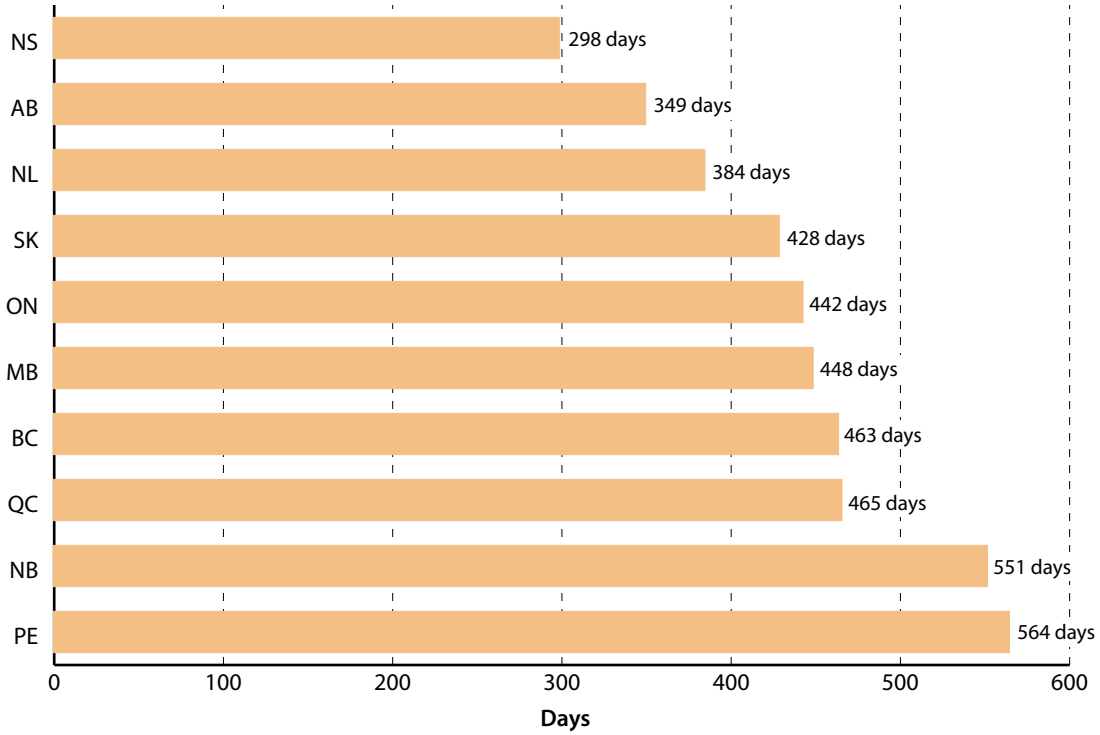


Source: Esmail, Walker & Wrona, 2006.

Similarly, delays and denials for the reimbursement of new medicines under public drug programs in Canada are also evident [Skinner, Rovere and Glen, 2007]. Figure 7 shows the average wait for each of the provinces to approve the public reimbursement of new medicines that were certified by Health Canada as safe and effective in the years 2004 and 2005. Data on waits for reimbursement under public drug plans was not available on a comparable basis over the entire trend period. Future annual updates to the data presented in figure 7 will allow us to assess trends in the severity of government rationing and its impact on access to new medicines. The most recent analysis found that for new drugs submitted for approval by manufacturers in the two-year period covering 2004 and 2005, the average wait for reimbursement in the provinces was just over 439 days. In other words, patients who are dependent on public drug benefits or who need drugs that are delivered only through hospital settings are waiting on average more than a year after Health Canada has certified a new drug as safe and effective before the provinces finally cover it under public drug plans.

There are also a significant number of drugs that are approved by Health Canada as safe and effective but which are never declared eligible for public reimbursement by

Figure 7: Average wait (in days) for approval of public drug plan reimbursement after safety certification by Health Canada for new medicines submitted to the National Common Drug Review, 2004 to 2005, by province

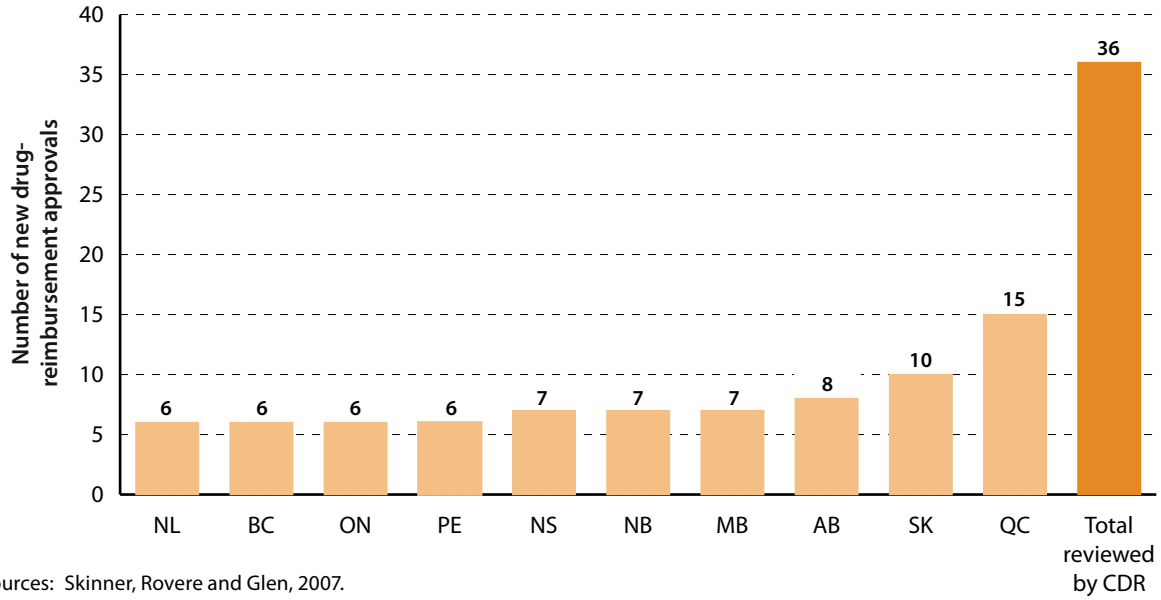


Sources: Skinner, Rovere and Glen, 2007.

the provinces. Figure 8 shows the number of drugs approved by each of the provinces among the new drugs submitted in 2004 and 2005. In total, 36 drugs were submitted for reimbursement approval during this period. Therefore, on average, fewer than 22% of the new drugs submitted for reimbursement approval in 2004/05 were finally accepted for reimbursement by the provinces.

None of these government efforts at rationing have made the growth of government spending on health care sustainable. Despite being slowed by the continued rationing of publicly insured medical goods and services over the trend period, government spending on health care has still grown faster on average than revenue in nine of ten provinces over the last ten years.

Figure 8: Number of approvals of public drug plan reimbursements for new medicines reviewed by the national Common Drug Review, 2004 to 2005, by province



Sources: Skinner, Rovere and Glen, 2007.

Conclusion & recommendations

Based on the data and analysis in this report, we conclude that public health insurance, as it is currently structured in Canada, tends to produce rates of growth in health spending that are not financially sustainable through public means alone. This is occurring while governments are restricting and reducing the scope of benefits covered under publicly funded health insurance. As an alternative to the current "pay more, get less" approach to health policy, we recommend that governments do the following:

1. encourage the efficient use of health care by requiring patients to make co-payments for any publicly funded medical goods and services they use;

2. relieve cost pressures facing the public health-insurance system by legalizing the right of patients to pay privately (private insurance or out of pocket) for all types of medical goods and services, including hospitals and physician services, as is currently allowed for access to medicines;

3. allow health providers to receive reimbursement for their services from any insurer whether government or private;

4. shift the burden of medical price inflation onto the private sector by allowing providers to charge patients fees additional to the government health-insurance reimbursement level;

5. create incentives for cost and quality improvements by permitting both for-profit and non-profit health providers to compete for the delivery of publicly insured health services.

Other warnings

A growing number of researchers, including government analysts, have come to the conclusion that the current, annual growth of government spending on health care in Canada is not financially sustainable. The list includes the following (in chronological order from the most recent).

Taylor, C. (2006). "Economic and Fiscal Update: First Quarterly Report." PowerPoint presentation (September 15). Ministry of Finance.

Organisation for Economic Co-operation and Development (2006). *Rising Health Costs Put Pressure on Public Finances, Finds OECD.* OECD online. <http://www.oecd.org/document/37/0,3343,en_2649_201185_36986213_1_1_1_1,00.html>.

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.

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Esmail, Nadeem (2004). "Hitting the Health Care Wall." *Fraser Forum* (July): 28–29.

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Data

For this study, all data for government health expenditures and for total revenues are taken from Statistics Canada's Financial Management System (FMS). FMS data is comparable across provinces because of the application of standardized accounting. FMS data are also updated annually, retroactively adjusted for complete reporting, and provide detailed breakdowns that allow the separation of government spending on health care from private and other sources. [5] All figures in this study are reported in current (or nominal) dollar terms.

The data on government spending on health care used in this study include only the expenditures of the provinces. All federal and territorial government spending on health care is excluded. All private spending on health care is also excluded. The revenue data include all revenue regardless of source (e.g., federal transfers). Total Available Revenue (TAREV) is calculated by counting total revenue from all sources minus debt charges. Debt charges are removed because they represent fixed financial obligations of the provinces and cannot be spent on programs or other responsibilities of government. Debt charges are distinct from debt repayment. Debt repayment is a policy choice, whereas debt charges are not. In order to make Quebec comparable to other provinces, the extra tax room ceded to the province by the federal government for policy areas that are under federal jurisdiction in other provinces has been removed from the calculation of TAREV.

Growth rates for TAREV for Newfoundland & Labrador and Nova Scotia have been adjusted to remove the one-year increase in revenue from the Atlantic Accord. This was done because the revenue boost from the Atlantic Accord was a one-time event that will not be repeated in the future and expectations about future revenue growth cannot be based on a trend that includes such a one-year effect.

[5] Data definitions available at Statistics Canada, 2006.

Method

For the analysis in this study, the ratio of government spending on health care (GHEX) to total available revenue (TAREV) is used because it is better than other measures of sustainability such as the ratio of health spending to total programs spending. The ratio of government spending on health care to total available revenue measures the ability of government to pay from current available revenues, thus directly satisfying the definition of long-run sustainability and immediately exposing any attempt to use deficits to finance government health spending. We use a moving-trend analysis to measure sustainability over the most recent ten-year period.

The ratio of government health spending to revenue also explicitly illustrates the tax implications of unchecked high rates of growth for government health spending. If government health spending is to be kept at a stable percentage of revenue, then revenue must grow at least as fast as public health spending. When the economy is expanding rapidly, revenue often grows fast enough to keep up with the growth in government health spending. But when the economy grows at historically normal or slower rates, health spending usually outpaces revenue, increasing the possibility that future tax rates will rise, new taxes will be introduced, or spending on other government responsibilities will be reduced.

The ratio of health spending to revenue also makes trade-offs with competing government spending clear: if government 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 government 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 government health spending at a stable percentage of programs spending, thus creating the illusion of sustainability.

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