Fraser Alert

January 2007

Market solutions to public policy problems

Long-term or Short-term, Public Health Insurance is Not Sustainable: *A Reply to CUPE About Health Spending Trends in Canada*

Since 2004, The Fraser Institute has annually published a measurement of the financial sustainability of public health insurance in Canada called *Paying More, Getting Less* (Skinner 2004, 2005; Skinner and Rovere, 2006). Using publicly available data, the study observes the most recent five-year trend in average annual growth rates for government health expenditures and total revenue from all sources in each of the provinces and projects this trend forward into the future without any adjustments for the expected aging of the population. The analysis essentially says that if governments continue with the policy status quo, the future will look similar to the observed trend—or worse.

The analysis observes that government health expenditures have over time consumed an increasing share of total revenues in every province. It predicts that if trends continue, that government health expenditures will continue to consume increasing shares of revenue, crowding out spending on other public priorities and eventually

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Main Conclusions

- **Long-term and medium-term average annual growth rates are similar to short-term average annual growth rates for government health expenditure**
- **Government health expenditure has grown faster on average than our ability to pay for it for a long time**
- **Solutions include: user fees for publicly funded health care; legalizing private insurance for medically necessary health care; and using competition between private (non-profit and for-profit) and public providers for the delivery of publicly funded health care**

bankrupting the provinces altogether. Based on this analysis, the study recommends major reforms to the structure of health care financing that include the introduction of user fees for publicly insured services; allowing parallel private health insurance options for all medically necessary services; and competition between private (non-profit and for-profit) health care providers and public sector health care providers.

The Canadian Union of Public Employees (CUPE) has since published a critique of the analysis (CUPE 2006a). The CUPE critique makes the following claim to criticize The Fraser Institute study:

> There is no doubt that provincial health care costs have increased at a significant pace in the past five and ten years: increasing by an average of about 7% in the past ten years. If these rates of increase stay higher than revenue growth or GDP growth over the long-term, then they are of course unsustainable. But the last five to ten years have not been typical.

This *Alert* will demonstrate that CUPE's claims are either non-factual or an incomplete representation of the facts. The data presented in this short study are only drawn from readily accessible and publicly available data sources in order to make it easy for readers to replicate the analysis for themselves and verify its accuracy.

Public health insurance is near a financial tipping point

Fraser Institute research (Skinner and Rovere, 2006) indicates that we cannot pay for the kind of modern health system we all want from public funds alone. We are near the limit of what taxpayers can afford and are facing significant trade-offs including reduced access to the latest medical care—worse than the lack of access already seen in Canada today—and proportionally less spending on other public priorities. Private funding sources are necessary to keep up with the demand for medical care and to more efficiently allocate health expenditures.

We are near the limit of what taxpayers can afford and are facing significant trade-offs including reduced access to the latest medical care—worse than the lack of access already seen in Canada today—and proportionally less spending on other public priorities.

Data on the most recent five-year trends show that government spending on health in every province continues to grow faster, on average, than total revenues from all sources—including federal transfers. Health care is taking up an increasing share of provincial revenue over time, leaving proportionally less money for everything else. Government health spending in six of the ten provinces is on pace to consume more than half of total revenue by the year 2020, two thirds by the year 2035, and all of provincial revenue by 2050.

And this analysis is generous. Projections of future revenue growth are actually overestimated because in many provinces recent growth in revenue is a result of increasing tax burdens. Rising tax burdens are not sustainable unless people want slower economic growth and lower standards of living over time. Also, in some provinces there has been a temporary boost to the growth in resource-based revenue from spiking oil prices that is already fading. Finally, the study's projections of government health spending do not take into account the added pressures from an ageing population that will further accelerate the growth of provincial health spending.

Since 2000, at least five provincial government studies, in addition to a federal Senate report, have concluded that government health spending is unsustainable at current growth rates (Clair, 2000; Fyke, 2001; Mazankowski, 2001; Kirby, 2002; Menard, 2005; Taylor, 2006). The most recent and urgent warning has come from BC's Finance Minister Carole Taylor, whose

analysts have estimated that government health spending could consume 71 percent of the provincial budget by 2017. Even Janice MacKinnon, the former finance minister in Roy Romanow's NDP government in Saskatchewan, warned in a privately published study in 2004 that health spending was growing faster than the ability of governments to pay for it (MacKinnon, 2004).

Fact: Short-term trends mirror long-term trends

The heart of CUPE's criticism of this research is that short-term trends cannot be projected as a reasonable expectation of the future because they are not reflective of long-term trends. But, the evidence shows that long-term and short-term trends are in fact similar.

In order for government health spending to be financially sustainable, provincial governments must be able to pay the costs from current revenues over the long run. Deficits and debt are not sustainable financing approaches by definition. Therefore, The Fraser Institute's *Paying More, Getting Less* analyzes publicly available data from Statistics Canada's Financial Management System (Statistics Canada, 2006a) that allows a comparison between revenues (TREV) and government health expenditures (GHEX) in each of the provinces. The FMS data standardizes provincial accounting for revenue and expenditures, making provincial finances comparable.

The data presented in table 1 clearly show that either over the 10-year period between 1996/97 and 2005/06, or over the 5-year period between 2001/02 to 2005/06, provincial government health expenditure has grown at a faster annual rate than total provincial revenue from all sources in every province. The singular notable exceptions were Newfoundland and Nova Scotia. Newfoundland's one-year revenue increase in 2005/06 was nearly 56 percent and Nova Scotia's almost 15 percent. This was due to the one-time boost to provincial revenue from the new start of offshore oil production that raised the revenue base, but will not have the same effect on future growth rates because such expansions are not likely be repeated in future years. Both provinces were also beneficiaries of a special deal with the federal government regarding equalization transfers that gave a one-time boost to their revenue bases in 2005/06 that are also not likely to be repeated in future years (Skinner and Rovere, 2006). Therefore, the data presented in table 1 calculates the average growth rates for Newfoundland and Nova Scotia based on the previous 9-year trend as a more realistic expectation of future growth.

In order to look at the long term trend, another source of data must be used because FMS data do not cover the entire period since Medicare's introduction in 1971.

Table 1: 10-Year and 5-Year Average Annual Growth in Provincial Government Health Expenditure (GHEX) and Provincial Total Revenue (TREV)

10-year Average Annual Growth in GHEX and TREV, by Province, 1996/97 to 2005/06			5-year Average Annual Growth in GHEX and TREV, by Province, 2001/02 to 2005/06		
Province	**GHEX**	**TREV**	**Province**	**GHEX**	**TREV**
AB	10.4	9.3	AB	11.4	5.6
BC	6.4	3.8	BC	6.7	4.2
MB	6.5	3.4	MB	6.9	2.8
NB	5.4	3.1	NB	6.4	4.1
NF	7.4	2.0*	NF	6.5	4.1*
NS	6.5	5.1	NS	7.0	6.5*
ON	5.9	4.7	ON	6.6	4.5
PE	7.6	3.8	PE	7.9	3.6
QC	6.1	4.7	QC	5.2	4.0
SK	7.5	4.4	SK	8.7	3.4
Consolidated AVG	7.0	4.4	Consolidated AVG	7.3	4.3

*NF and NS are shown with 9-year averages (1996/97 to 2004/05) for reasons stated in the text.
Source: Statistics Canada, Financial Management System (2006a). Calculations by author.

Table 2: Long-term Annual Growth In National Gross Domestic Product (GDP) and National Government Health Expenditure (GHEX), Canada, 1975 to 2005

Year	GDP (Current Millions $)	Annual % Change	GDP (1992 Constant Millions $)	Annual % Change	GHEX (in Millions Current $)	Annual % Change	GHEX (in Millions Constant 1992 $)	Annual % Change	CPI 1992 = 100
1975	173,621	—	503,249	—	9,300	—	26,957	—	34.5
1976	199,994	15.2%	539,067	7.1%	10,817	16.3%	29,157	8.2%	37.1
1977	220,973	10.5%	552,433	2.5%	11,845	9.5%	29,612	1.6%	40
1978	244,877	10.8%	561,644	1.7%	13,041	10.1%	29,909	1.0%	43.6
1979	279,577	14.2%	587,347	4.6%	14,552	11.6%	30,572	2.2%	47.6
1980	314,390	12.5%	599,981	2.2%	16,842	15.7%	32,141	5.1%	52.4
1981	360,471	14.7%	612,005	2.0%	19,943	18.4%	33,858	5.3%	58.9
1982	379,859	5.4%	581,714	-4.9%	23,447	17.6%	35,906	6.0%	65.3
1983	411,386	8.3%	595,349	2.3%	26,080	11.2%	37,742	5.1%	69.1
1984	449,582	9.3%	623,553	4.7%	27,957	7.2%	38,775	2.7%	72.1
1985	485,714	8.0%	647,619	3.9%	30,095	7.6%	40,127	3.5%	75
1986	512,541	5.5%	656,262	1.3%	32,529	8.1%	41,650	3.8%	78.1
1987	558,949	9.1%	685,827	4.5%	35,055	7.8%	43,012	3.3%	81.5
1988	613,094	9.7%	722,988	5.4%	38,163	8.9%	45,003	4.6%	84.8
1989	657,728	7.3%	739,020	2.2%	41,911	9.8%	47,091	4.6%	89
1990	679,921	3.4%	728,747	-1.4%	45,446	8.4%	48,709	3.4%	93.3
1991	685,367	0.8%	695,804	-4.5%	49,382	8.7%	50,134	2.9%	98.5
1992	700,480	2.2%	700,480	0.7%	51,694	4.7%	51,694	3.1%	100
1993	727,184	3.8%	714,326	2.0%	51,980	0.6%	51,061	-1.2%	101.8
1994	770,873	6.0%	755,758	5.8%	52,599	1.2%	51,567	1.0%	102
1995	810,426	5.1%	777,760	2.9%	52,791	0.4%	50,663	-1.8%	104.2
1996	836,864	3.3%	790,240	1.6%	52,877	0.2%	49,931	-1.4%	105.9
1997	882,733	5.5%	820,384	3.8%	55,002	4.0%	51,117	2.4%	107.6
1998	914,973	3.7%	842,517	2.7%	59,028	7.3%	54,354	6.3%	108.6
1999	982,441	7.4%	889,087	5.5%	63,056	6.8%	57,064	5.0%	110.5
2000	1,076,577	9.6%	948,526	6.7%	68,995	9.4%	60,789	6.5%	113.5
2001	1,108,048	2.9%	951,931	0.4%	74,658	8.2%	64,139	5.5%	116.4
2002	1,152,905	4.0%	968,828	1.8%	79,782	6.9%	67,044	4.5%	119
2003	1,213,408	5.2%	992,157	2.4%	86,267	8.1%	70,537	5.2%	122.3
2004	1,290,788	6.4%	1,035,945	4.4%	92,054	6.7%	73,880	4.7%	124.6
2005	1,371,425	6.2%	1,077,317	4.0%	98,795	7.3%	77,608	5.0%	127.3
AVG		7.2%		2.6%		8.3%		3.6%	

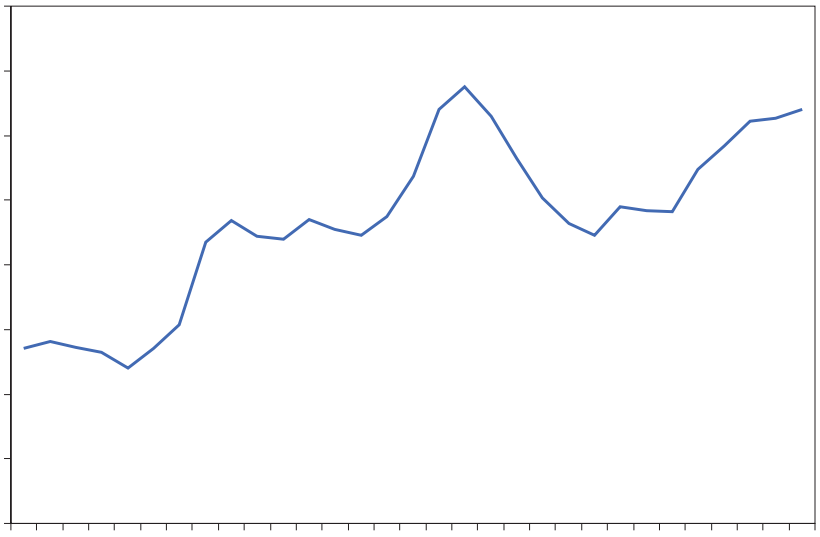
Source: [CPI] Statistics Canada (2006b), CANSIM, table 326-0002 and catalogue nos. 62-001-X, 62-010-X, and 62-557-X (last modified January 18, 2006); [GDP] Statistics Canada (2006c), table 380-0017—Gross Domestic Product (GDP), expenditure-based, annual (dollars x 1,000,000); [PHEX] CIHI (2005a), table B.3.1: Public Sector Health Expenditure, by Province/ Territory and Canada, 1975 to 2005—Current Dollars; and calculations by author.

Only the most recent 10 years of FMS data are posted online and data is not available at all before the fiscal year ending in 1989. Thus, this Alert compares data from the Canadian Institute for Health Information (CIHI) for national government health expenditures with Statistics Canada data for growth in national gross domestic product (GDP) over the 31-year period 1975 to 2005 (see table 2).

By 1971, public health insurance was uniformly implemented across the provinces so this dataset covers virtually the entire history of medicare's national expenditure growth relative to national GDP growth.

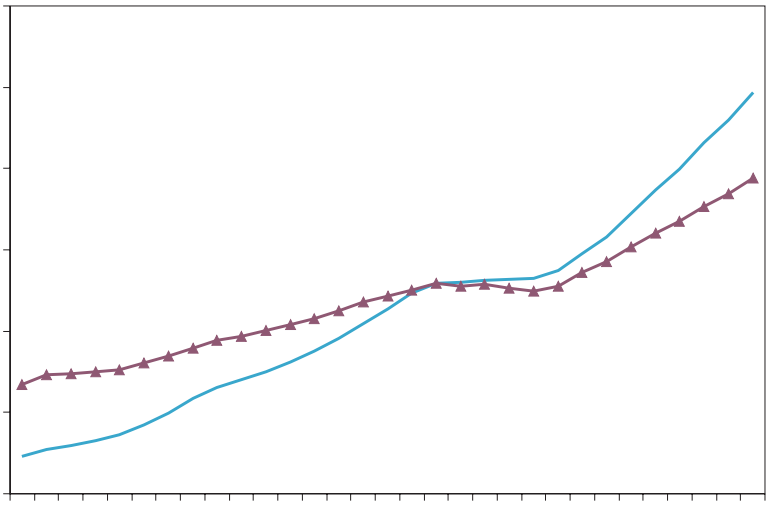
Because there is no data readily accessible for provincial total revenue over this 31-year period, national government health expenditures are compared to national GDP, with GDP serving as a proxy for expectations about future revenues in considering the issue of sustainability. Ultimately, all government revenue can only be taken from income; and over the long run, revenue cannot grow faster than GDP without taxes eventually consuming 100 percent of income and reducing economic growth along the way. Therefore, as the basis of future expectations, it is assumed that revenues cannot grow faster than GDP over the long run. In order to select a reasonable assumption about relative future growth rates (all else staying the same), it is sufficient to show that if government health expenditures have actually grown faster than GDP since 1975, and thus can be expected to grow faster than GDP in the future (all else staying the same), that into the

Figure 1: National Government Health Expenditure as a Percentage of National GDP, Canada, 1975 to 2005.



Sources: [GDP] Statistics Canada (2006c), table 380-0017—Gross Domestic Product (GDP), expenditure-based, annual (dollars x 1,000,000); [PHEX] CIHI (2005a), table B.3.1: Public Sector Health Expenditure, by Province/ Territory and Canada, 1975 to 2005—Current Dollars; and calculations by author.

Figure 2: Nominal and Real (Inflation Adjusted) National Government Health Expenditures, Canada, 1975 to 2005.



Sources: [CPI] Statistics Canada (2006b), CANSIM, table 326-0002 and catalogue nos. 62-001-X, 62-010-X, and 62-557-X (last modified: 2006-01-18); CIHI (2005a), table B.3.1: Public Sector Health Expenditure, by Province/Territory and Canada, 1975 to 2005—Current Dollars.

future government health expenditures will therefore grow faster than revenue, as in fact the FMS data show they have done over the last 10 years.

Table 2 displays the nominal and real (inflation adjusted) figures for national GDP and government health expenditures between 1975 and 2005, as well as the corresponding annual growth rates. The data clearly show that government health expenditures in Canada have grown at a faster average annual pace than GDP for the entire 31-year period for which data is available, a period that spans virtually the entire history of medicare in Canada.

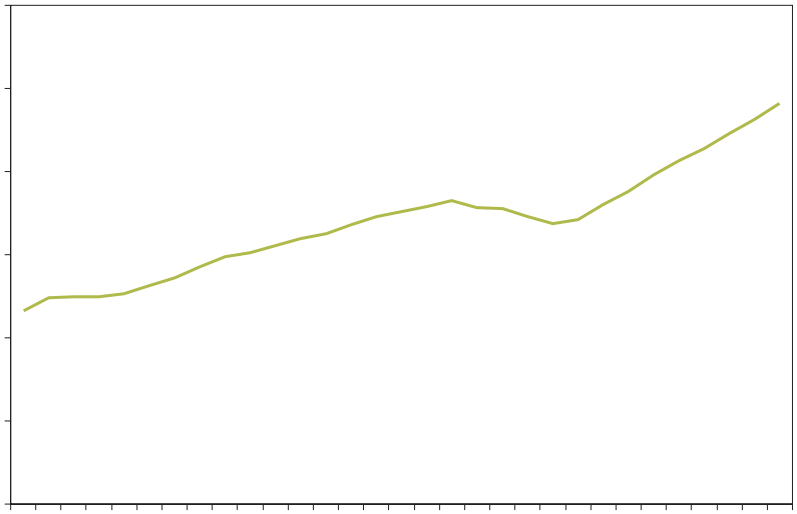
The fact that government health expenditure has consistently grown faster than GDP in Canada is also reflected in figure 1, which shows that government health expenditure has consumed an increasing share of GDP over the entire period.

It is also important to point out that government health expenditures have grown in absolute terms over the entire 31-year period, whether in nominal or real (inflation adjusted) terms. Figure 2 compares the nominal and real growth in government health spending in Canada between 1975 and 2005.

Government health expenditures have also grown, even after adjusting for Canada's population growth since 1975. Figure 3 shows real national per capita (per person or population adjusted) government spending on health care in Canada between 1975 and 2005.

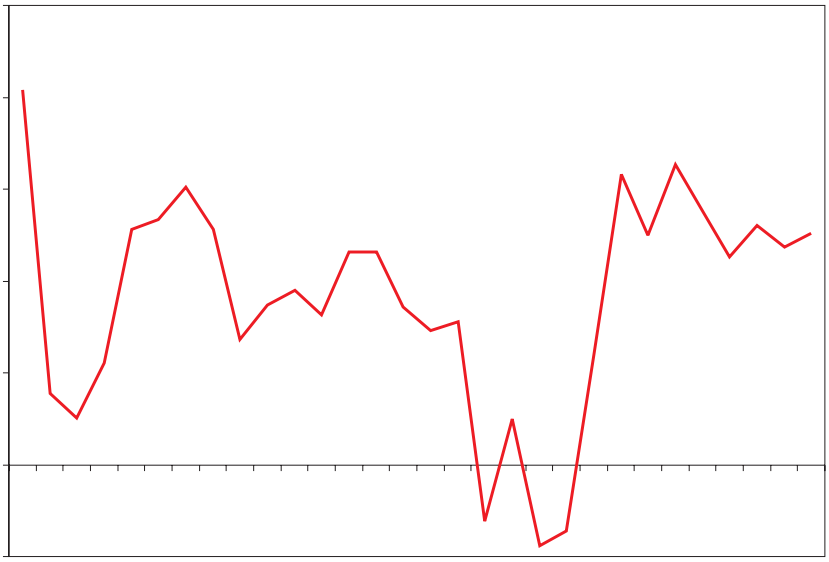
The 6-year period between 1992 and 1997 stands out as an aberration in the overall growth trend for government health expenditures

Figure 3: Real Per Capita National Government Health Expenditures, Canada, 1975 to 2005, ($1992).



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

Figure 4: Annual Percentage Change in Real (Inflation Adjusted) National Government Health Expenditures (GHEX), Canada, 1975 to 2005



Sources: [CPI] Statistics Canada (2006b), CANSIM, table 326-0002 and catalogue nos. 62-001-X, 62-010-X, and 62-557-X (last modified: 2006-01-18); CIHI (2005a), table B.3.1: Public Sector Health Expenditure, by Province/ Territory and Canada, 1975 to 2005—Current Dollars; and calculations by author.

over the 31 years for which data is available. As figure 4 shows, during this time the growth rate in government health expenditure slowed. Figures 2 and 3 show that national government health expenditures and per capita government health expenditures actually declined in absolute terms for a few years. But this 6-year period was abnormal relative to the overall 31-year trend. Following this short period, growth rates in government health expenditures quickly returned to historical rates.

Conclusion

The data presented in this *Alert* clearly show that the CUPE criticism is not valid. Long-term trends are virtually the same as short-term trends. Whether looked at over the most recent 5-year, 10-year, or 31-year trends, government health expenditures are growing faster than our ability to pay for them. Therefore, government health expenditures are, by definition, not sustainable.

The problem is the design of public health insurance. Medicare is a government-run health insurance monopoly that is not accountable to the patients it abandons, and is barely accountable to taxpayers.

The prescription for reform is to introduce the kinds of policies increasingly being used in other countries to deal with similar financial sustainability 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;

The prescription for reform is to introduce the kinds of policies increasingly being used in other countries to deal with similar financial sustainability problems in their public health care programs ...

- 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, without practice restrictions; and
- Permitting private sector (both for-profit and non-profit) health providers to compete with the government sector for the delivery of publicly insured health services.

It is this last suggestion that most likely explains why CUPE criticized *Paying More, Getting Less*. CUPE members currently enjoy the protection of a system, which is in essence based on a publicly funded monopoly over the provision of support services in hospitals. As a labour union representing hospital workers, CUPE doesn't seem to want to compete with private sector organizations—even if such competition would produce higher value for money spent on health care. While CUPE claims that government sector delivery is more efficient than private sector delivery (CUPE 2006b), it is apparently unwilling to test that claim in a competitive environment with the private sector.

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