

Canadian Doctors for Medicare

Neat, Plausible, and Wrong: The Myth of Health Care Unsustainability February 2011



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The “Sustainability” Myth

The assertion that Medicare is “unsustainable” has been repeated so many times¹ that in some circles it has become accepted as indisputable fact. Critics² of Medicare assert that the cost of our public health care system is growing at an alarming pace. They are joined by provincial Premiers who are concerned that health care is taking up an increasing proportion of provincial budgets.³ They claim that the cost of health care is rising faster than the pace of inflation and taking up an increasing share of provincial budgets. Extrapolations of future costs, based on these trends, lead to alarming assertions that health care could consume 70% of provincial tax dollars by 2022⁴ and 80% of provincial budgets by 2030⁵. Critics warn that the depth of the crisis will inevitably increase, with a tidal wave of health care demand sweeping across the nation as baby boomers become seniors and overwhelm the system. With this supposed crisis looming, provinces have been forced, say critics, to reduce commitments to education⁶ and municipalities⁷.

These fears consistently lead to the claim that the only “adult” response is to break with what has for many decades been a fundamental priority in Canadian political life: the preservation of universal, publicly funded health care. Pundits claim that governments must “relinquish their monopoly over the market for medical insurance ... raising funds from the private sector through private insurance, co-payments for publicly insured medical services, and deductibles linked to utilization”.⁸ In short, critics assert there is no way forward but a repeal of the legislation that preserves our health care system – the Canada Health Act.

Without such changes, critics tell us that governments will need to ration health care by increasing wait times and barriers, and by cutting quality, to make ends meet until they finally face “the facts”.⁹

While this argument is sufficiently compelling to have won it widespread repetition in newspaper reports and public commentary, it is not substantiated by the available evidence. In fact, it flies directly in the face of most reliable data on health care. As the flurry of media coverage and public debate accelerates around this cavalcade of inaccurate platitudes, it is hard not to be reminded of what H.L. Mencken warned many years ago, “There is always an easy solution to every human problem – neat, plausible, and wrong.”¹⁰

The Facts:

Medicare and public health care expenditures are not growing rapidly. Any crisis in health care funding has nothing to do with Medicare. The costs of Medicare – medically necessary hospital and physician services – are not growing significantly and can easily be sustained.

¹“Why we’re paying more for health care and getting less”, *National Post*, August 16, 2010

² Brett Skinner & Mark Rovere, “An unsustainable system: Why we are paying more and getting less”, *Fraser Forum*, February 2008

³ Speech from the Throne, Ontario, 2010

⁴ *ibid*

⁵ “Charting A Path To Sustainable Health Care In Ontario” *TD Economics Special Reports*, May 27, 2010

⁶ Mark Rovere, “The unsustainable growth of government health care spending” *Fraser Forum*, May 2010

⁷ “Cuckoo in the nest”, *Globe and Mail*, November 12, 2010

⁸ “Tax hikes not answer to soaring health care”, *Winnipeg Free Press*, August 30, 2010

⁹ Brett Skinner & Mark Rovere, “An unsustainable system: Why we are paying more and getting less”, *Fraser Forum*, February 2008

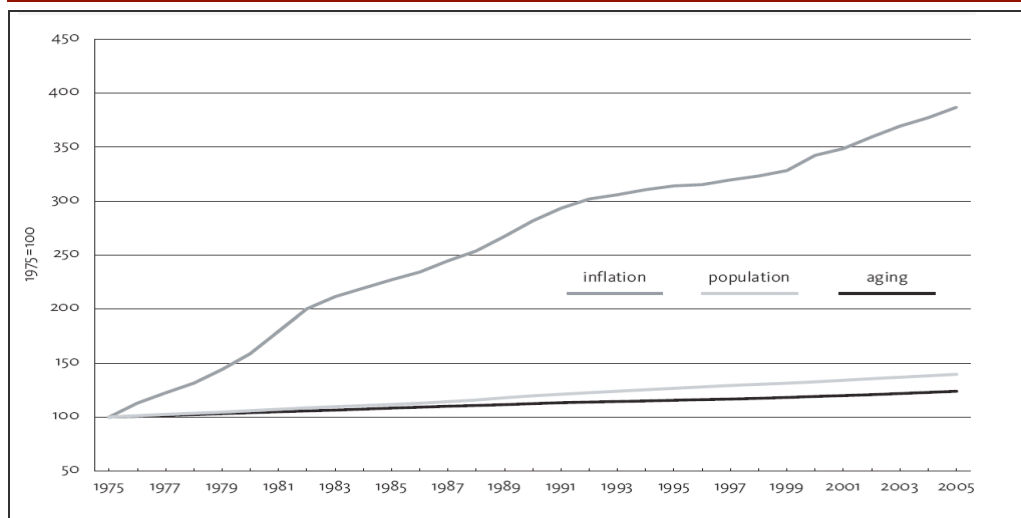
¹⁰ H.L. Menkin, “The Divine Afflatus”, *New York Evening Mail*, November 16, 1917

Over the last 35 years, Medicare costs have remained remarkably stable at 4 to 5% of Canada's gross domestic product (GDP).¹¹ In 2009, for example, Medicare costs were 4.25% of GDP, up only 0.62% from the 1981 level of 3.63% and down 0.58% from the 1992 level of 4.83%.¹² Governments have actively worked to contain Medicare costs by finding efficiencies. Hospitals in particular, have become much more efficient. Hospital admissions are shorter, more services are delivered on an outpatient basis, and less chronic care is provided in hospitals. These efforts by the public sector to hold the line on costs have been largely successful.

Total government health care spending, which includes costs that are not part of Medicare, such as public health, publicly funded dental care and prescription drugs, have risen faster than Medicare spending alone so that total public spending on health care has increased from about 5% of GDP in 1980 to about 7% in 2009.¹³ But still, this hardly reflects spending that should be considered "unsustainable."

It is also inaccurate to suggest that the aging population is responsible for out of control health care costs. While costs do increase as the population ages, the pace of change is more modest than most people expect. Certainly, about 10.4% more Canadians will be seniors when the baby boomers reach retirement age, but it will take more than 25 years to reach that mark, and the number of seniors will increase by less than 0.5% each year. As a result, if aging were the only factor, health care costs would increase at a rate of only about 1% per year.¹⁴ This increase is approximately equal to the cost imposed by population growth. The cost of aging on health care spending is well below the costs imposed by inflation, which runs at about 2.5% per year and far below the increase in pharmaceutical costs, now estimated at 7.3% per year.¹⁵

Comparison of cost drivers, 1975-2006



Source: *How Sustainable is Medicare? A Closer Look at Aging, Technology and Other Cost Drivers in Canada's Health Care System*
By Marc Lee, CCCPS

¹¹ Mackenzie, H & M. Rachlis, *The Sustainability of Medicare*, CFNU, August 2010

¹² Evans, Robert G, *Economic Myths and Political Realities: The Inequality Agenda and the Sustainability of Medicare*, Centre for Health Services and Policy Research, University of British Columbia, July 2007

¹³ *ibid*

¹⁴ Mackenzie, H & M. Rachlis, *The Sustainability of Medicare*, CFNU, August 2010

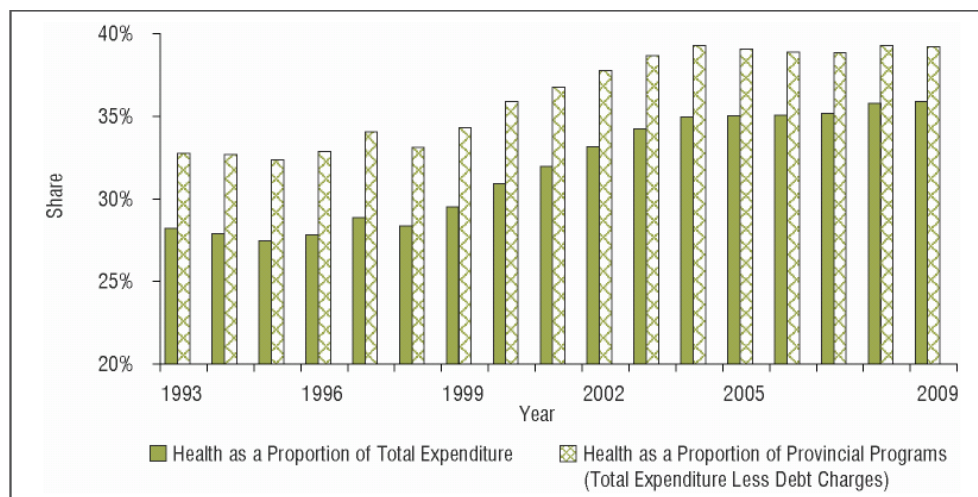
¹⁵ Canadian Institute for Health Information, *Drug Expenditure in Canada, 1985 to 2006*, (Ottawa, Ont.: CIHI, 2007)

Provincial Budgets

None of this is meant to imply that health care is not making up an increasing portion of provincial budgets. It clearly is. The change in the share of provincial budgets however, is not primarily due to increased health care spending. It is the result of decreases in other provincial spending to accommodate political decisions to cut taxes.

Overall, public sector spending on health care rose from just under 28.2% of all provincial government spending to almost 35.9% between 1993 and 2009.¹⁶ That 0.5% annual increase should raise some concerns to anyone who looks at it in isolation, but is of less concern when dissected in greater detail.

Provincial/Territorial Government Health Expenditure as a Proportion of Total Provincial/Territorial Government Expenditure and Programs, Canada, 1993 to 2009



Note

FMS data is estimated for 2009.

Sources

National Health Expenditure Database, Canadian Institute for Health Information; Financial Management System, Statistics Canada.

First, virtually all of that growth occurred prior to 2005. Health care's share of provincial budgets rose less than 1% in the next half decade, between 2005 and 2010.¹⁷

Second, almost all of the growth in health care's share of provincial budgets can be attributed to the simple arithmetic of an essentially constant numerator and a decreasing denominator. Deep cuts in federal transfers to the provinces in the mid-1990s were compounded by provincial tax cutting policies in the latter part of the decade, causing significant reductions in total provincial budgets. Provincial revenues have fallen almost \$30 billion since 1997, causing decreases in other government program spending through cuts to education, social services, and municipalities.¹⁸

¹⁶ Canadian Institute for Health Information, *National Health Expenditure Trends, 1975 to 2010*, (Ottawa, Ont.: CIHI, 2010)

¹⁷ Canadian Institute for Health Information, *National Health Expenditure Trends, 1975 to 2010*, (Ottawa, Ont.: CIHI, 2010)

¹⁸ Mackenzie, H & M. Rachlis, *The Sustainability of Medicare*, CFNU, August 2010

But it is tax cuts that have “crowded out” these priorities, not Medicare. Medicare spending has remained stable for more than three decades. That stability, in an environment of shrinking budgets, means Medicare inescapably makes up a larger share of that smaller total budget, but Medicare costs are not the part of the equation that is changing at an alarming pace. If the “runaway” growth of Medicare’s share of provincial spending is of genuine concern to provinces, they could simply address the real cause of that development by choosing not to reduce their total tax revenues each year.

Which Costs Are Rising?

While the cost of Medicare has not grown as a percent of GDP over the last 35 years, there have been significant increases in total health care system costs over the same period, and those increases have accelerated in the last decade. Overall health spending in Canada has risen from about 7% of GDP in 1975 to about 10.7% in 2008.¹⁹ In 2010, health care spending was estimated to be about 12% of GDP.²⁰

If Medicare costs are stable, and public sector costs are rising slowly, why are total health care costs increasing rapidly? The real cost driver is precisely the thing that critics of Medicare tout as the solution: private health care.

Currently 30% of all health spending is in the private sector, up from 24% in 1975.²¹ That growth is a result of significant increases in costs in the private health care sector, including out-of-pocket spending and the costs of private insurance. Pharmaceuticals and private prescription drug insurance are the most significant driver of these costs, followed by dental care and private dental insurance.²²

The overall cost of care has been driven most significantly by the rising cost of pharmaceuticals. In fact, the rising share of privately financed health care would be much more modest were it not for the impact of pharmaceutical costs. Canada’s drug costs are higher than the per capita costs of all Organisation for Economic Co-operation and Development (OECD) countries with the exception of the United States and Switzerland, and 30% higher than the OECD average.²³ Drug costs overall rose from \$4 billion in 1985 to an estimated \$26.5 billion in 2007.²⁴ During that time, Canadian drug prices rose an average of 9.2%²⁵, far faster than in any other OECD country²⁶.

Addressing Rising Health Costs

Canadians long ago decided that we value a system where access to health care is based on need, not wealth. We have reaffirmed that position in public opinion poll after public opinion poll. Abandoning our publicly funded system would undermine the economic efficiencies of our provincial single-payer systems, threatening our ability to get care based on our health needs rather than on our financial positions.

¹⁹ National Health Expenditure Trends, 1975 to 2010, Canadian Institute for Health Information (Ottawa, Ont.: CIHI, 2010)

²⁰ National Health Expenditure Trends, 1975 to 2010, Canadian Institute for Health Information (Ottawa, Ont.: CIHI, 2010)

²¹ National Health Expenditure Trends, 1975 to 2009, Canadian Institute for Health Information (Ottawa, Ont.: CIHI, 2009)

²² National Health Expenditure Trends, 1975 to 2010, Canadian Institute for Health Information (Ottawa, Ont.: CIHI, 2010)

²³ Gagnon, M-A and G. Hebert, The Economic Case for Universal Pharmacare, CCPA/IRIS, September 2010

²⁴ Canadian Institute for Health Information, *Drug Expenditure in Canada, 1985 to 2006*, (Ottawa: CIHI, 2007)

²⁵ Canadian Institute for Health Information, *Drug Expenditure in Canada, 1985 to 2006*, (Ottawa: CIHI, 2007)

²⁶ Gagnon, M-A and G. Hebert, The Economic Case for Universal Pharmacare, CCPA/IRIS, September 2010

The Private Funding Option

Those “concerned about sustainability” recommend breaking the “monopoly” Medicare has on insuring medically necessary hospital and physician services and allowing private health insurance for these services. But increased private financing offers no relief to Canadians concerned about the rising costs of health care. The private insurance market, if anything, makes the system less sustainable, as well as less equitable.

Canada’s private insurance system has seen some sharp increases in costs. Private health insurance spending has grown rapidly since the late 1980s, rising from \$139 per capita in 1988 to \$591 per capita in 2007.²⁷ Even adjusted for inflation, (giving a per capita constant dollar cost of \$377) this represents an impressive 369% increase, outpacing almost all other categories of health care.²⁸ It is hard to see how this increasingly costly system can be expected to reduce cost in health care overall.

Competing private sector insurance providers have not been able to achieve the same efficiencies as the public insurance system because they are burdened by the inefficiencies of redundant administrative infrastructure, lack of coordination, fragmented purchasing power, personnel costs and corporate profit.²⁹ In other countries, experiments with private health insurance have not produced measurable savings to the public purse and in fact have coincided with increasing public costs for health care.³⁰

Even if the inefficiency of private sector health insurance were ignored, few gains can be anticipated by expanding this sector. Expanding the role of the private insurance sector would shift costs from tax funded public insurers to private insurers, but Canadians will still pay for those costs through private rather than public means. Unfortunately, private insurance models weigh more heavily on those with the least ability to pay, as insurance premiums are not proportional to incomes the way taxes are.

Even more alarming is the potential for runaway cost increases similar to those seen in the United States, where private sector health insurance costs have increased especially rapidly, driven by inflated executive compensation policies and staggering administrative costs. A rapidly growing Canadian health insurance sector could prove to be an irresistible attraction to the large American firms who have shown a remarkable capacity to use their influence to minimize regulation and grow at the expense of the public interest, despite clear cost inefficiencies.

More Effective Options Within Medicare

Still, rising costs are understandably of concern to Canadians. Whether we pay for health care through public taxation, through private insurance, or through direct out-of-pocket spending on drugs and health services, those costs are still all borne by individual Canadians in the end. The question is whether or not they are borne in a way that is equitable.

Sound public policy dictates that we recognize the growing cost burden on Canadians, and, though those costs are largely in the private health care sector, that we find strategies for addressing cost while continuing to improve quality and access for all Canadians.

²⁷ National Health Expenditure Trends, 1975 to 2009, Canadian Institute for Health Information (Ottawa, Ont.: CIHI, 2009)

²⁸ Inflation factors from the Bank of Canada applied to National Health Expenditure Trends 1975 to 2009, Canadian Institute for Health Information (Ottawa, Ont.: CIHI, 2009)

²⁹ Gagnon, M-A and G. Hebert, *The Economic Case for Universal Pharmacare*, CCPA/IRIS, September 2010

³⁰ Dhalla, I. Private health insurance: An international overview and consideration for Canada. *Healthcare Quarterly*, 10(4), 89-95. 2007

There are many opportunities to do so.

a) Curb the growth of pharmaceutical costs

Growing pharmaceutical costs in both the public and private sector need to be better managed. Canada could achieve a more cost efficient system by addressing some easily identified dysfunctions in the system.

Regulating the prices of prescription drugs more effectively is one such opportunity. Canada's drug costs are higher than almost any in the world. The system used for setting drug prices in Canada pegs our costs to some of the highest spending countries in the OECD. Setting prescription drug prices based on comparisons to the average prices in the OECD, instead of using only a few, high cost comparators would also lower drug costs by \$1.43 billion nationally.³¹

Policy makers can also institute more effective assessment systems to identify the best and most cost effective drugs. This has been done in British Columbia through the *Therapeutics Initiative* that for many years has evaluated new drugs and determined which ones are appropriate and effective for particular uses. This could reduce drug costs nationally by an estimated 8%.^{32 33}

Too little public sector intervention, rather than too much, is responsible for some of the rising costs of pharmaceuticals. Premiums for private drug insurance plans rose 15% per year between 2003 and 2005, almost double the increase in drug costs.³⁴ These rising private drug insurance costs are, in part, due to perverse incentives that encourage the overuse of more expensive brand name drugs and patented medicines where less expensive and equally effective options are readily available. These incentives also discourage cost containment and allow private drug insurance plans to pay on average 7-10% more for generic and patented medications respectively, than the public sector insurance plans.³⁵ The rising costs are also due in part to the fact that private sector drug plans impose unnecessary administrative costs on the health care system. As a proportion of total health care spending, the cost of administration in Canada's public sector drug plans is approximately 1.3%, as compared to private sector plans which consume 13.2%.³⁶ The relative efficiency of single-payer health care financing, whether for medical care or pharmacare, is well documented internationally, and benefiting from that efficiency would certainly play a role in reversing the rise in costs that the growth of private drug plans has caused.³⁷

Finally, private drug insurance plans also receive annual tax subsidies of about \$933 million, as part of the much larger multi-billion dollar tax deductions for all private, employer funded health insurance as a whole, subsidizing a relatively inefficient system and driving up the costs of public sector care in the process.³⁸

³¹ Gagnon, M-A and G. Hebert, *The Economic Case for Universal Pharmacare*, CCPA/IRIS, September 2010

³² Gagnon, M-A and G. Hebert, *The Economic Case for Universal Pharmacare*, CCPA/IRIS, September 2010

³³ Unfortunately, pressure from the Pharmaceutical industry in BC has recently caused the Ministry of Health to eliminate the TI, replacing it with an industry controlled Drug Benefit Council that includes four separate points of engagement for the pharmaceutical industry.

³⁴ Gagnon, M-A and G. Hebert, *The Economic Case for Universal Pharmacare*, CCPA/IRIS, September 2010

³⁵ Gagnon, M-A and G. Hebert, *The Economic Case for Universal Pharmacare*, CCPA/IRIS, September 2010

³⁶ Gagnon, M-A and G. Hebert, *The Economic Case for Universal Pharmacare*, CCPA/IRIS, September 2010

³⁷ Evans, Robert G, *Economic Myths and Political Realities: The Inequality Agenda and the Sustainability of Medicare*, Centre for Health Services and Policy Research, University of British Columbia, July 2007

Woolhandler, S., D.U. Himmelstein, and J.P. Lewontin "Administrative Costs in U.S. Hospitals" *New England Journal of Medicine*, Vol. 329, no. 6 (August 5, 1993)
Mossialos, E., A. Dixon, A. J. Figueras, and J. Kutzin (Ed.) *Funding Health Care: Options for Europe* in European Observatory on Health Care Systems Series, Open University Press. (2002)

³⁸ Gagnon, M-A and G. Hebert, *The Economic Case for Universal Pharmacare*, CCPA/IRIS, September 2010

b) Ensure more appropriate use of resources

The cost of pharmaceuticals is not only driven by policies of insurance companies and government pricing policies. Though Canada's drug costs are high regardless of the rate of use, Canadians are using more medicines than before. In 2009 Canadian doctors wrote 80% more prescriptions than they did only a decade earlier.³⁹ Some of that increase is justified by an aging population, the development of new medications, and an increase in the number and duration of chronic diseases. However, some of it occurred independent of shifting disease patterns or population demographics. Providing more guidelines and information to doctors, and setting clearer government policies on the use of prescriptions were identified by the Health Council of Canada as useful tools in managing the unnecessary growth in pharmaceutical use.⁴⁰

Similarly, growth in the use of diagnostic imaging, such as CT and MRI scans, have put cost pressures on the system. In fact the number of CT scans grew 58% between 2003 and 2009 and the number of MRIs grew by 100% over the same period. While greater access to diagnostic tools is undoubtedly a boon, as many as 30% of imaging studies are inappropriate or contribute no useful information. Other estimates put the number as high as 50%.⁴¹

The Health Council of Canada suggests clinical practice guidelines and more effective rules for ensuring the appropriateness of tests and prescriptions would be an effective remedy for overuse, again indicating that more coordinated management may be more useful to reducing costs.

c) Continue to make the delivery of Medicare services more efficient

Opportunities abound for continued improvement of our health care system. Financial pressures and other challenges that confront our health care system are often used as an argument against a single, public health care system. Such changes are, for the reasons reviewed above, unlikely to produce the desired outcome. More fruitful are the many opportunities to improve our Medicare system by drawing on its strengths and building the changes that advance it. To name but a few, such reforms include: greater emphasis on primary prevention and health promotion; integrated patient-centred primary care by multi-disciplinary teams; enhanced scope of practice for allied health professionals; shared care with increased coordination between family doctors and specialists; national pharmacare including national procurement processes; better uptake of evidence-based guidelines for diagnosis and treatment; stronger patient safety protections; and deployment of the long-awaited electronic health record.

These health care innovations could provide many of the improvements critics of Medicare call for without the adverse impacts on access to necessary care, and without the risk of higher costs and inequities more privatization brings.

The Role of the Public Sector in Financing Increased Medicare Costs

Combined, these savings noted above are significant, but many of them are achievable only through establishing greater regulation of the system, for example, through the creation of a national pharmacare program. Studies show this could save Canadians between \$4 and \$10 billion depending on the models used, but those savings require significant public investment.⁴² Strategically increasing the public sector's health care spending can reduce the overall cost of

³⁹ Health Council of Canada, *Decisions, Decisions: Family Doctors as Gatekeepers to Prescription Drugs and Diagnostic Imaging in Canada*, September, 2010

⁴⁰ Health Council of Canada, *Decisions, Decisions: Family Doctors as Gatekeepers to Prescription Drugs and Diagnostic Imaging in Canada*, September, 2010

⁴¹ Health Council of Canada, *Decisions, Decisions: Family Doctors as Gatekeepers to Prescription Drugs and Diagnostic Imaging in Canada*, September, 2010

⁴² Gagnon, M-A and G. Hebert, *The Economic Case for Universal Pharmacare*, CCPA/IRIS, September, 2010



health care by shifting away from less efficient privately funded health care services, providing a net gain to Canadians.

The process of increasing public sector spending is not, however, without challenges. The debate about how the public might spend more, but smarter, has been on the minds of health care policy researchers for some time, focusing on a small number of possible models including direct taxation, tied taxes, and social insurance. Selecting a viable model will involve balancing political and practical issues with an analysis of the economic and health impacts of various approaches. There is little doubt that addressing the current rise in health care costs, though predominately driven by the private sector will require public sector investment, and models that support that capacity will require our attention in the very near future.

Health System Transformation

Given the irrefutable evidence, one would be justified in asking why the sustainability issue has been raised as a criticism of Medicare in the first place. With Medicare costs stable, why challenge a system that is working? While assessing the motives behind arguments is more art than science, many of those concerned about the sustainability of health care, most notably the Fraser Institute, are also staunch ideological proponents of market-driven solutions to whatever ails us. Their proposal to increase private, for-profit delivery of health care, coupled with private financing, makes it easy to see that the goal of this debate about sustainability is not so much to save our health care system, but to radically transform it.

This is lamentable, because there is a real, “adult conversation” yet to be had around health care reform. Before declaring a crisis and calling for privatization of health care, there is a wide array of reforms that can make far better use of the resources we currently put into the public health care system. Indeed, not only can these reforms make our system more efficient, they can also lead to improved health and well being at the same time.

Reforms, such as the ones outlined in this paper, would foster healthy partnerships between physicians, other health practitioners, public policy decision-makers and the public, regardless of their political outlooks, focused not on rehashing the public/private debate that Canadians have settled countless times, but on improving the public health care system. The distraction caused by recycling the old debates has taken up far too much of our policy efforts. It’s time we got down to the real process of improving health care.