JEFFREY SIMPSON

Canada's Juggernaut: The Future of Health Care

Canadians love their health-care system, and are fiercely protective of it – but in many ways we are fooling ourselves. We tell ourselves that Canadian Medicare is a Cadillac, when in reality it is more of a rusting Chevy Cavalier; we tell our politicians that they cut services at their peril, just as passionately as we tell them they had better not impose new fees or taxes to fund those services. With each passing year, our stubborn refusal to look at the true costs of health care brings us closer to disaster. In many ways, our devotion to our health-care system is understandable, noble, and very Canadian – but it is also profoundly unhealthy, and we are running out of time to face reality.

CANADIANS are wedded more tightly to their health-care system, Medicare, than to any other public program. Poll after poll, over long periods of time, has underscored health care as the number one issue for Canadians. So cherished is Medicare that it has become a national icon politicians dare not question or even touch.

Outside Quebec, where language and culture define the distinctiveness of society, health care reflects Canadian values and differentiates us from Americans. Nowhere else in the world does public health care play such a defining role. Elsewhere, the health-care system is just that – a system, a program, a policy – whereas in Canada, especially outside Quebec, it is all these things and a great deal more.

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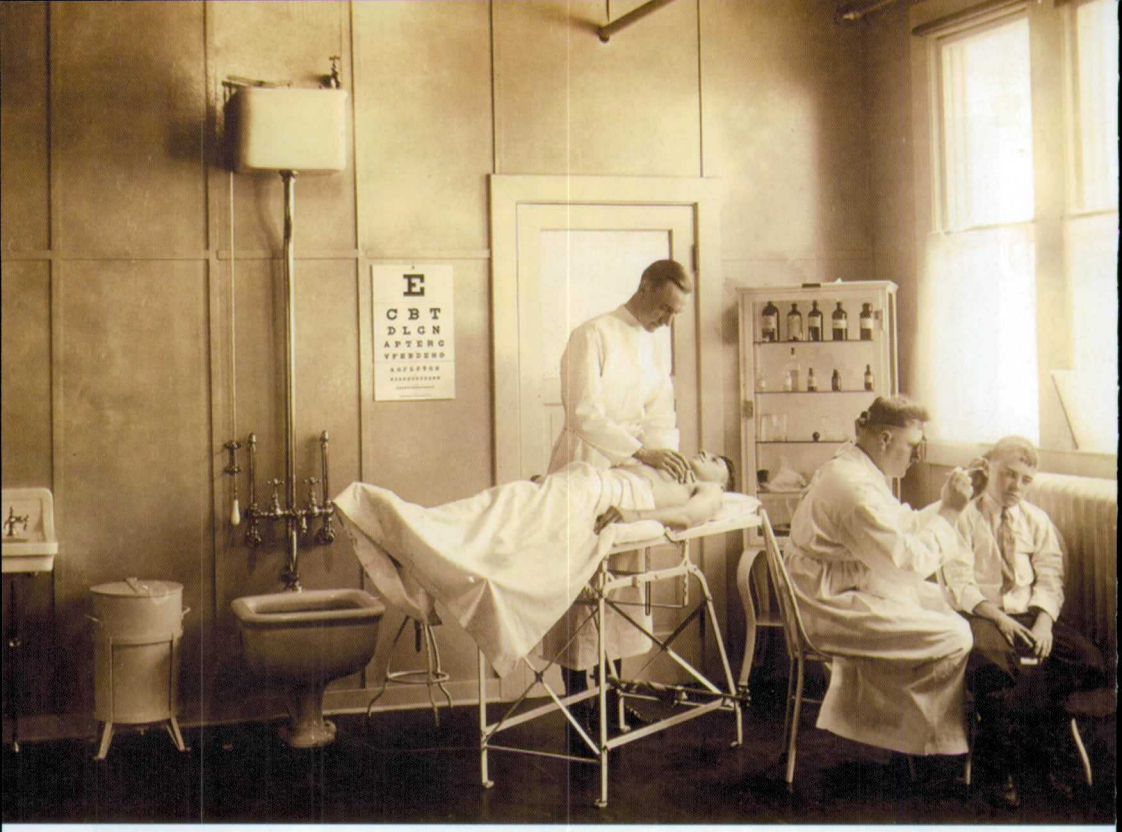
Like patent medicine addicts in days gone by, Canadians continue to drink the elixir, and to convince themselves that everything will be all right.



PUBLIC policies can be attacked and changed without people getting too nervous or upset. Icons, however, have existential qualities that make them almost immune from assault. To attack an icon is to attack something essential, definitional, and deeply fundamental. In Canada, it can even be considered unpatriotic to question the essentials of Medicare. When anyone wants to start a debate about the fundamentals of Medicare, or ask the more modest but essential question about whether the system can be sustained, the speaker is quite likely to be accused of wanting US-style private health care. As former Prime Minister Jean Chrétien liked to quip, "down there, they check your wallet before your pulse." End of discussion.

Politicians are therefore very frightened to speak frankly about Medicare. Yet across the country, almost every elected official and senior civil servant knows privately that health care as now organized and financed cannot be sustained. They have looked at the costs of the system versus their governments' ability to keep paying for it at current levels of taxation. They understand that health care is eating

their budgets alive, taking an increasing share of spending each year. They know other government programs are suffering as more money gets shovelled into health care. They appreciate that health-care budgets have been rising, are rising, and will continue to rise faster than the rate of inflation adjusted for population growth, their own revenues, transfers from Ottawa, or spending on any other program. They are fully aware that whereas health care today consumes 41–45 percent of provincial budgets, if no change is made to the spending trajectory of heath care, in two decades the share will be 55–65 percent. But they are afraid that if they address publicly these private concerns, let alone try to do anything serious to address those concerns, they risk political trouble, and perhaps defeat.

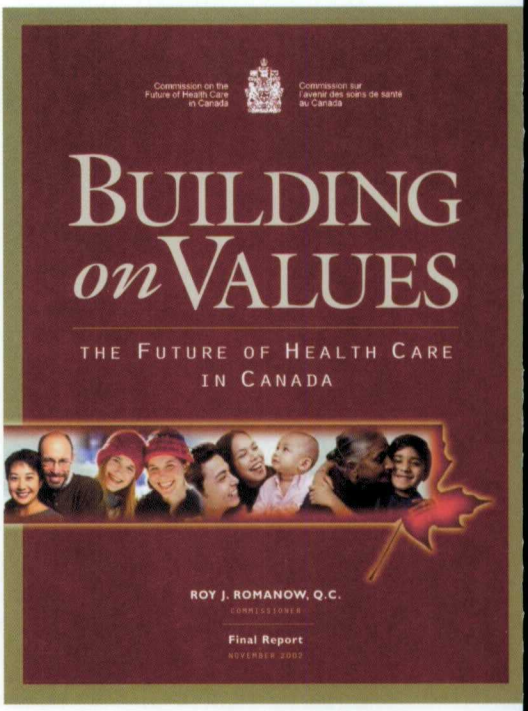
Here and there these days, the spending pressure is so great that a few politicians timidly are starting to offer warnings. Said British Columbia's finance minister in his last budget: "If health care continues to grow at the current pace, it will increasingly crowd out spending in other areas." Said the Ontario finance minister: "So the question now facing us is: How do we fund the best health care without compromising our investments in schools, helping the vulnerable or protecting the environment?" Said the Quebec minister: "Accounting for 31 percent of program spending in 1980, health-care spending now represents 45 percent. If nothing is done to change this dynamic, spending could represent two thirds of program expenses in twenty years."

It is one thing for finance ministers to offer occasional warnings and frame questions; it is quite another for governments to launch a serious and sustained debate with citizens to awaken them to the problem and to ask them to choose among hard, even unpalatable, options to save Medicare – at current tax rates and without gutting other programs. Unless a debate of this kind is opened, Canadians will sleepwalk towards even harder decisions.

Canadians carry on their love affair with Medicare, only vaguely, if at all, aware that public health care cannot continue as organized and financed, completely unaware of what Medicare is doing to public finances, resistant to paying higher taxes to support it, opposed to any limitations to its reach, and demanding even more from it, worried that somehow it won't be there for them if needed, alarmed that any change might lead down the slippery slope towards two-tier US-style health care, defending the icon against any politician who would suggest that maybe, just maybe, we should re-examine what we are doing.

NO issue has spawned more studies, reports, and commissions than health care. The latest was led by former Saskatchewan Premier Roy Romanow in 2002. That report is as good a marker as any to judge where we have been, and what Canadians feel about their system.

Romanow held public hearings, heard from many Canadians, and wrote that Medicare reflected Canadian "values." He put his descriptive abilities into overdrive in describing Medicare as a "right of citizenship," "the Canadian way," a "moral enterprise," a "public trust," a "defining aspect of our citizenship," an "expression of social cohesion."



One might have thought that after such an exhaustive list of descriptions, Romanow would have run out of rhetorical steam. But, no, he went biblical, proposing that Medicare become a "Covenant" with the Canadian people, replete with a written charter outlining the precepts of the "Covenant" in order to "reaffirm our collective vision for the future of health-care in Canada." Even the most ardent defenders of Medicare thought the "covenant" idea over-the-top, and it was never acted upon.

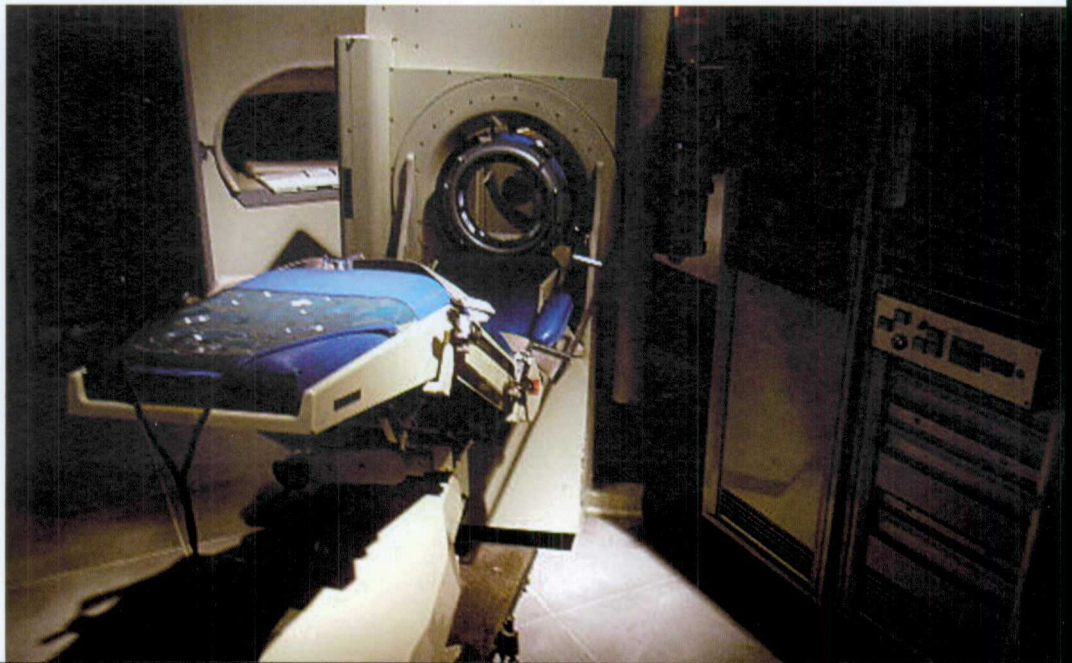
Much else was acted upon, and Medicare today is living in the shadow of the Romanow recommendations. Romanow said bluntly, "the system needs more money." It needed a minimum threshold for federal transfers to the provinces. The extra money, he explained, was required to "buy change." Indeed, if one central refrain ran through his recommendations it was that the delivery of health care needed to change, and that additional money would ease the transition to these changes. These included "better management practices," more focus on prevention of illness, and "more agile and collaborative institutions." A few recommendations for change were specific; most were vague, as the ones just cited.

Prime Minister Paul Martin and the provincial premiers heeded Romanow's call for more money. They filled the $6 billion that Romanow said the system needed in extra federal cash. They signed a deal worth $41 billion for health care from Ottawa over a decade – indexed at 6 percent a year! That agreement will end in 2013–2014, and the federal Conservative government has already pledged not to reduce the amount flowing to the provinces in the next deal. However, the federal government enjoyed a larger surplus when the deal was signed in 2004; it will be in a deficit when the new deal is negotiated. Today's promises notwithstanding, it is hard to imagine Ottawa coughing up such a generous arrangement next time.

Indexing transfers to 6 percent yearly sounds generous, and it is. No other government program enjoys that kind of indexing. And yet, all the 6 percent helps to do is keep the system afloat, since provincial health-care spending keeps rising in the 5–7 percent range.

Canada spends a shade under 12 percent of its gross national product on health care, compared to about 7 percent when Medicare went into full operation in the early 1970s. That 12 percent share is among the very highest in the OECD among countries with largely public systems. (The United States spends more than 17 percent, but the majority of this money is spent in the private system, whereas 70 cents of every dollar spent in Canada will pass through Medicare.) For three years – 1993 to 1997 – health-care spending flattened out, as Ottawa successfully wrestled with its deficit. Since then, spending has grown on average 4.7 percent yearly, before inflation.

Why did spending grow so rapidly? Aging was a small factor, although it will become a bigger one in decades to come. The population grew,



and there was inflation. But by far the biggest reason was increased use of medical services, especially pharmaceuticals, and pay increases that outstripped the rate of inflation for those who work in the system. Seventy percent of a hospital's costs are for wages, salaries, and benefits. If they rise faster than inflation, the budgetary pressure will be intense. If physicians, whose remuneration accounts for about 13 percent of health-care spending, get increases well above inflation, as they did, that too adds to budgetary pressures. In a system where no one has to pay to see a doctor or visit a hospital, there is no constraint at all on demand. Nothing is more controversial in a system based on a strong equity principle than charging for access to the system, as is done, it should be said, in almost every other advanced industrial democracy, Britain being another exception.

The results of these spending pressures are apparent in every provincial budget. Consider Ontario and Alberta.

In Ontario, health-care expenditures rose by 8 percent in 2002–2003 and by 12.1 percent in 2003–2004. The government then announced that it would bring further yearly increases down to 2.8 percent. What happened? Here are the numbers: 2005–2006, 8.5 percent increase; 2006–2007, 9.5 percent; 2007–2008, 6.8 percent; 2009–2010, 6.4 percent. In the 2010 budget, Premier Dalton McGuinty promised to lower the rate of increase to 3 percent in the next three years. Who was he kidding? Twenty years ago, 32 percent of the Ontario budget went to health-care; today it's 46 percent.

Now look at Alberta. In 1993–1994, Alberta spent about 26 percent of its budget on health care and a similar share on education. In 2012–2013, it is estimated that health will take 42 percent and education 26 percent. By definition, too, all other parts of the Alberta budget will get less as a share of the total: environment, roads, justice, welfare, tourism, culture, municipal affairs, etc. In recent years, 2007–2008 to 2010–2011, total spending by the Alberta government grew by 13 percent, but health soared by 21 percent. If the trend of the last two decades is maintained, in 20 years something in the range of 57 to 58 percent of the Alberta budget will be for health.

Consider British Columbia. Its 2010 budget offered a three-year projection in which overall spending would rise by $1.3 billion, but the health budget would go up $1.4 billion, which meant cuts almost everywhere else to make room for health care.

The pattern is similar across the country. Health care grows far, far faster than any other part of the provincial budgets. Other programs

are being systematically squeezed. Provinces such as Ontario that originally launched lotteries and gaming establishments to provide money for culture and recreation now put almost all of these revenues into health care, so that gambling provides a part of the revenues to support Medicare.

WHAT is to be done, especially since it's hard to imagine Ottawa's very generous transfers to the provinces can be increased further, given the country's post-recession debt and deficit challenges? The one answer that will not suffice is to do nothing, or to nibble at the edges of the problem, which would be the politically safe approach but merely delay decisions, thereby making later choices harder.

Six broad choices lie before the public – but citizens are only vaguely aware of these choices because politicians are too scared to spell them out.

1 Governments could keep health-care spending on its current track, do nothing else, and incur more debt.

2 Governments could raise more revenues, and direct the monies into health care. Among the revenue sources could be: user fees, health-care premiums where none exist or higher premiums where they do. Special health taxes. Higher income tax or GST, with all additional money devoted to health care.

3 Cut spending on other programs, which is what governments have been doing by stealth. Governments could get out of providing certain non-health services. Or, they could keep spending on some non-health programs by raising money from users, as in higher university fees, road tolls, green taxes.

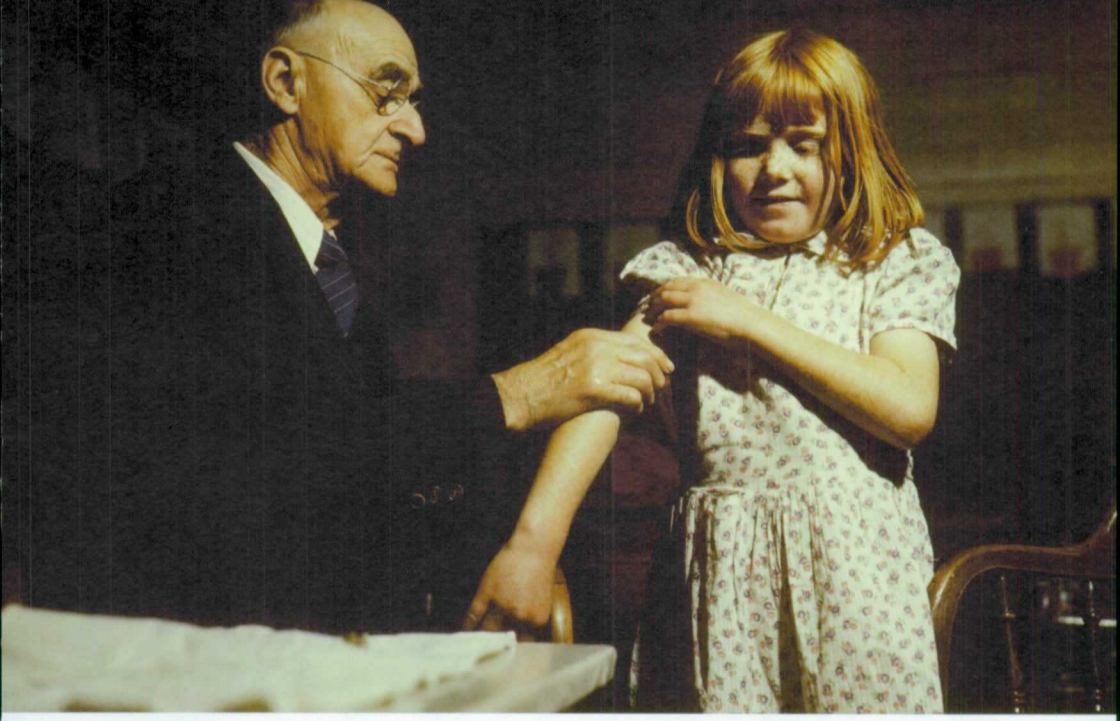
4 Governments could continue trying to rationalize the health delivery system and seek efficiency gains.

5 Governments could change the system by allowing more private delivery of health-care services, or private delivery of publicly financed services, as is done in almost every other country with a public system.

6 Governments should promote healthy lifestyles and wellness.

To repeat: doing nothing is not an option, because the do-nothing option does not make the existing system better, and drains money from all other government programs. A few years ago, for the first time, Canadian governments spent more money on health care than on all levels of education, and the trends continue. Is this really what Canadians want when every study demonstrates that future prosperity depends, more than anything else, on a well-educated population?

When participants in focus groups confront the options above, they invariably pick number 4, efficiency gains. The public thinks widespread inefficiencies plague the system, a response developed through the tyranny of the anecdote. Of course, there are many ways to improve delivery, although they are often much easier said than done, given the incredible complexities in the health-care system and the multiplicity of entrenched interest groups. Greater efficiency, yes. The solution to the spending dilemma, absolutely not.



The next preferred option, 6, is to improve people's health, a worthy objective not easily achieved. Better health for citizens is a long, slow business. It definitely brings dividends in slightly easing spending burdens, but not for many years and not by much.

So we are left with the other options – the ones people either do not want to hear about, or are largely against. Polling data repeatedly show people do not want to pay higher taxes, and certainly do not want to pay from their own pockets to access the system, as in user fees. Indeed, the Quebec government proposed user fees tied to income, with no fees at all for low-income citizens, but withdrew the idea after the finance minister said the "Quebec political culture" was not ready for this initiative.

Similarly, citizens do not favour the public system dropping any services. Some provinces have done this to save money, as in Ontario where chiropractic services, physiotherapy, and optometry were all delisted in an attempt to save money. Nor, of course, does the public want less money spent on other programs to make more room for the health-care juggernaut.

No new taxes. No new fees. No fewer services, indeed more if possible. No cuts elsewhere. All the serious options – the ones Romanow didn't mention, and politicians are reluctant to outline – have been pushed off the table by a public that simply does not understand what is happening and fears that change will hurt them or turn the system towards US-style medicine.

THAT Canada is unique in the Western world in the way it organizes health care is not known to the public. That our system is regularly rated at nothing more than average in international comparisons is not understood by a public constantly told that Canadian health care is the best. We have a Chevy of a system by international standards, but the public thinks we have a Cadillac. That we are sliding inexorably towards distended provincial budgets is also largely unknown. That we cannot go on like this has occurred to very few citizens. That we have to make hard choices is something no politician wants to address.

We remain wedded to our icon, blindly.