

THE “OTHER” HEALTH SYSTEM: REFLECTIONS ON THE DARK SIDE OF THE MOON OF HEALTH AND HEALTH CARE IN CANADA

Hugh Scott



During the last decade, public discourse over the state of our health system has been alarming and calls for reforming what was described as an unsustainable situation have been frequent. In this article Hugh Scott, former executive director of the McGill University Health Centre, takes issue with this and argues that the situation is less catastrophic and more manageable than is often assumed. While annual health expenditures increased by \$50 billion between 1993 and 2003, much of this increase is due to private spending. And more than half of this increase was spent on non-medicare components of health care expenditures. Governments, he concludes, are not at the mercy of unfathomable forces that would require greater reliance on private financing.

Depuis dix ans, le discours public sur notre système de santé est à la fois alarmant et ponctué de fréquents appels au redressement d'une situation devenue intenable. Mais selon Hugh Scott, ex-directeur du Centre universitaire de santé McGill, la situation est moins catastrophique et plus simple à gérer qu'il n'y paraît. Les dépenses de santé annuelles ont effectivement augmenté de 50 milliards de dollars de 1993 à 2003, mais une grande partie de cette augmentation est attribuable à des dépenses privées et plus de la moitié a servi au financement de composantes extérieures au régime d'assurance-maladie. Les gouvernements, conclut l'auteur, ne sont pas à la merci de forces insondables qui lui dicteraient d'accroître le financement privé des soins de santé.

“Health services: Feed the monster.”

“The health system put in place 30 years ago is no longer viable.”

“Medicare costs threaten education.”

These are but a small selection of recent headlines and comments concerning Canada's health system. It makes for discouraging reading, especially for someone who has spent a career as a physician and most recently as the senior administrator of a large, merged academic health centre, as I have. The image presented is one of helplessness on the part of both citizens and governments in the face of an irresistible juggernaut. There are few if any policy options available, as the forces of demography and technology are beyond our control. One has the sense that something treasured is not only inevitably going to be lost, but will also in the process drag down with it other social goods. The call for reform is incessant; the remedies proposed usually involve radical, destructive

restructuring and the search for new sources of revenue somewhere in the private domain.

This is frightening and upsetting. It provokes resentment and even overt hostility. Fortunately, on examination, this alarmist tone is totally unjustified. “Facts” are often presented in distorted, even self-serving ways. The reality is that governments are very much in control and have made and are constantly making hundreds of choices and policy decisions that deserve to be examined and evaluated calmly. The different jurisdictions in Canada face very different challenges, and each can learn from the experience of the others. In the end there are of course problems and no single, simplistic silver bullet such as privatization is the solution. Instead the entire health system, not just selected portions of it, must be constantly scrutinized to identify the areas that need attention. Continuous sequential experimentation, innovation and evaluation will provide the required improvements, not wrenching revolution. Such an approach will not only preserve our system, but ensure that it evolves as circumstances dictate.

In what follows I will attempt to set the record straight in a number of areas to begin the process of shining a light on what is often described as the “dark side of the moon” of health care, to demonstrate a few examples of intriguing differences between provinces and to highlight at least one alternative

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explanation for the so-called “crowding out” of other programs by health care.

It is often said that health care expenditures are rising significantly faster than the gross domestic product (GDP) and that it is thus by definition unsustainable. Yet, strangely, it is rare to see any two commentaries agree on a reasonable projection of the rate of increase in the future or even the historical experience. One reason is that the projections are easily distorted depending on the years upon which a trend is based on. Recent experience must be approached with particular caution as the last decade has seen periods of recession, dramatic economic growth, major health and other government program restraint as well as times of apparent affluence. Table 1 examines this question from a ten-year perspective, 2003 as compared with 1993.

Over that period of time, total annual health expenditures in Canada increased by almost \$50 billion, to \$121.4 billion from \$71.5 billion. This is the “monster” mentioned above. What is less well recognized is that over the same period the GDP grew by \$485.8 billion (from \$727.2 billion to \$1213 billion). In percentage terms, health expenditures increased by 69.8 percent while GDP grew by 66.8 percent.

That is in the aggregate. However, growth in the major categories of health expenditure was far from uni-

form. Indeed to use the term “medicare” as a synonym for health expenditures or even for public health expenditures is extremely misleading. In his 2003 article for the Centre for Health Services and Policy Research, Robert Evans popularized the notion that “medicare” should be reserved for

the two major founding programs of medicare which came into being subsequent to the Hall Commission report in the 1960s, that is, hospital services and physician services. Indeed they are what most people think of when they hear the terms “health services,” and it is their potential loss or decreased availability that causes most public concern.

There was a major decline in the relative costs of both categories over the decade, from a combined total of 5.11 percent to 4.29 percent of GDP. While a decline of 0.82 percent may seem marginal, on a base of \$1213 billion it is almost \$10 billion, and thus not trivial! It is also difficult to see what is unsustainable about medicare funding as viewed from this perspective. Indeed, if one goes right back to 1975, the comparable figure for medicare was 4.20 percent of GDP. Despite the massive technological and demographic changes that have occurred in the interval, hospitals and physicians have adjusted.

Until now we have been discussing total health expenditures. Yet one might argue that of most concern are public sector expenditures, more specifically, those of provincial and territorial governments. Tables 2 and 3 provide some insight into that question.

It is evident that only the privately funded sector increased its proportion of expenditures relative to the GDP. Both the provincial/territorial governments and the overall public sector decreased.

The net result was that provincial and territorial government health expenditures as a proportion of total health expenditures declined to 63.9 percent from 67.8 percent. As will be discussed later, while this was marginally a result of off-loading to the other sectors, it was largely because those expenditure categories paid predominately through private sources increased more than did those paid through provincial/territorial government sources.

Four categories — hospitals, physicians, public health, and administration and other — are overwhelmingly in the public sector; other professions and more recently prepayment administration are predominately in the private sector; all others are mixed (table 3). There was marked stability over the decade except for further shifts to the private sector of other professions and prepayment administration.

At least two conclusions may be suggested. First the ideological “public/private” debate is a very artificial one. Over 30 percent of health care expenses are already paid through private sources, and this appears to be increasing. Second there already appears to be some tendency for certain provincial/territorial government programs to

TABLE 1. TOTAL HEALTH EXPENDITURE, CANADA, PERCENTAGE OF GROSS NATIONAL PRODUCT

Category	1993	2003
Hospitals	3.67	3.00
Other institutions	0.93	0.95
Physicians	1.44	1.29
Other professionals	1.06	1.19
Prescription drugs	0.91	1.32
Other drugs	0.35	0.30
Capital	0.28	0.46
Public health & admin.	0.45	0.65
Prepayment admin.	0.19	0.25
Health research	0.11	0.15
Other	0.43	0.43
Total	9.82	9.99

Source: Canadian Institute for Health Information, *National Health Expenditure Trends — 1975-2003*. Calculations by author.

transfer certain expenditures to other sectors either explicitly or through a process of delisting. Simultaneously other public sector programs (federal, municipal and social security) are assuming an ever increasing role which now exceeds \$7.3 billion annually.

While the potentially useful distinction between medicare and health care expenditures is important in itself, there is further insight to be gained by examining individually the non-medicare components of health care expenditure. These make up the "dark side of the moon" in the ongoing debate. While examining the question, one should ask in every instance whether such popular solutions as primary care reform, regionalization, altered remuneration schemes for physicians and an increased role for the private sector can be expected to restrain expenditures. By the same token, are the allegedly irresistible forces such as demography and technological change to blame for increasing expenditures? Table 4 provides an initial perspective.

The most widely reported figure is that over the decade in question health care expenditures in Canada increased by almost \$50 billion. This is a startling, headline-attracting number. It is this number that is alleged to demonstrate unsustainability.

But all categories have contributed to that figure to markedly varying degrees. Indeed traditional medicare (hospitals and physicians) make up less than 30 percent of the 49.9 billion increase. In addition to medicare, increasing public attention is being paid to expenses related to prescription drugs. This is certainly justified, especially as these increased by almost the same amount as did all hospital costs combined. But even with prescription drugs added to the medicare components, less than 50 percent of increased expenditures can be accounted for. Indeed had all health care expenditures risen by the same percentage as these three categories combined (55.2 percent), and thus distinctly less than the rate of growth in the GDP (66.8 percent), one can spec-

TABLE 2. TOTAL HEALTH EXPENDITURE, CANADA, SOURCE OF FUNDS

Source	1993		2003	
	(\$ millions)	% GDP	(\$ millions)	% GDP
Private	19,578	2.69	36,609	3.02
Provincial and territorial	48,573	6.68	77,500	6.39
Public	51,980	7.15	84,822	6.99
Total	71,557	9.84	121,431	10.01
GDP	727,184	100.0	1,212,965	100.0

TABLE 3. TOTAL HEALTH EXPENDITURE SOURCE OF FUNDING, PUBLIC VERSUS PRIVATE (\$ MILLIONS)

Category	1993			2003		
	Public	Private	% Public	Public	Private	% Public
Hospitals	24,070	2,670	90.0	33,475	2,917	92.0
Other institutions	4,784	2,013	70.4	8,401	3,156	72.7
Physicians	10,402	97	99.1	15,475	165	98.9
Other professionals ¹	1,125	6,610	14.5	1,216	13,216	8.7
Prescription drugs	3,045	3,559	46.1	7,551	8,457	47.2
Non-prescription drugs	0	2,579	0.0	0	3,611	0.0
Capital	1,650	367	81.8	4,412	1,215	78.4
Public health and admin.	3,238	0	100.0	7,919	0	100.0
Prepayment admin.	349	1,060	24.8	490	2,5598	15.9
Health research	520	275	65.6	1,213	662	64.7
Other	2,801	351	88.9	4,626	611	88.3
Total	51,980	19,578	72.6	84,822	36,609	69.9

¹ Other professions include dental services, eye care and other professions.

TABLE 4. TOTAL HEALTH EXPENDITURE BY USE OF FUNDS, CANADA (\$ MILLIONS)

Category	1993	2003	Increase	Increase (%)	Share of increase (%)
Hospitals	26,739.5	36,392.0	9,652.5	36.1	19.4
Other institutions	6,796.3	11,557.7	4,761.4	70.0	9.5
Physicians	10,498.9	15,640.2	5,141.3	49.0	10.3
Professional dental	4,926.9	9,031.5	4,104.6	83.3	8.2
Professional vision	1,587.0	3,109.0	1,522.0	95.9	3.1
Other professional	1,220.4	2,336.3	1,115.9	91.4	2.2
Prescription drugs	6,603.5	16,008.0	9,404.5	142.4	18.9
Non-prescription drugs	2,576.0	3,611.1	1,035.1	40.2	2.1
Capital	2,016.9	5,626.7	3,609.8	179.0	7.2
Public health and admin.	3,238.0	7,918.7	4,680.7	144.6	9.4
Prepayment admin.	1,408.9	3,088.8	1,679.9	119.2	3.4
Health research	792.9	1,874.2	1,081.3	136.4	2.2
Other	3,151.9	5,236.7	2,084.8	66.1	4.2
Total	71,557.2	121,430.8	49,873.6	69.7	100.0
GDP (\$ million)	727,184	1,212,965	485,781	66.8	100.0

Source for tables 2, 3 and 4: Canadian Institute for Health Information, *National Health Expenditure Trends - 1975-2003*. Calculations by author.

ulate that the “sustainability” debate would be distinctly less impassioned.

The remaining 51.4 percent or \$25.7 billion is rarely if ever discussed. Indeed, there appears to be as little known about this as about the dark side of the moon. Yet logically, if restraint is required, it is only reasonable that all categories of expenditure must be explored, especially those

ing in the medical sector, the deterioration in facilities and equipment was evident, and the scarcity of such modern technology as magnetic resonance imaging (MRI) and positron emission tomography (PET) scanners has been a concern to professionals and public alike. Over the five years from 1998 to 2003, the situation changed dramatically with significant support from all

have gained national prominence, there is no reason to absolve this category from receiving the same surveillance as all other government programs. Moreover it is entirely within the public domain. It accounts for more spending than do prescription drugs in the public sector, and over the decade it increased at the same rate as prescription drugs, well beyond that of the GDP.

An indeterminate but significant amount of this spending was to make up for inadequate depreciation allowances over many years as well as technological innovation. While further expenditures at the current levels will undoubtedly be required for the foreseeable future, there is no reason to suggest that the exponential increases of recent years will continue or be required. This is very much within the control of governments.

where the greatest increases have occurred. These categories are considered individually below.

Other institutions: This category relates to residential care types of facilities of all kinds where beneficiaries live more or less permanently. Expenditures increased marginally more than the GDP over the decade. With the continued aging of the population, further increases are likely, although enhanced home care should blunt this tendency. Also, it is reasonable to at least question whether responses to normal aging should be categorized as “health care” in the first place. It is also an area where there is already a significant private presence, so this need not conceptually make markedly increased demands on the public sector.

Non-prescription drugs: This is entirely a charge on the private system. While it represents an activity of \$3.6 billion, it does not appear to be a challenge to the public system.

Capital: The increase in this category was the highest in terms of rate of increase (179 percent). It is also striking that in terms of both private and public expenditure, this has largely occurred in the period since 1998. Prior to that time, expenditures had been essentially stagnant for over a decade. Certainly, for those of us work-

levels of government as well as such “private” sources as hospital foundations. An indeterminate but significant amount of this spending was to make up for inadequate depreciation allowances over many years as well as technological innovation. While further expenditures at the current levels will undoubtedly be required for the foreseeable future, there is no reason to suggest that the exponential increases of recent years will continue or be required. This is very much within the control of governments.

Public health and administration: This data goes against conventional wisdom in that this area has been sadly neglected. For instance, I once heard an exasperated health economist proclaim that “There is no point putting more money into health care, the doctors will just soak it all up.” Yet over the decade the percentage increase in this category was the second highest of all the categories (144.6 percent) and by almost as much as the increase in physician payments, in absolute dollars. One reason for this is that in the early 1990s, when medicare expenditures were being severely constrained, no such restrictions were evident in expenditures in public health and administration. While issues such as SARS and water supply contamination

Prepayment administration: One of the very clear advantages of the single payer system for both the payer and the providers is its simplicity and therefore low cost as compared with multiple payers. Indeed American colleagues are envious of the low (almost non-existent) costs in Canada for billing, collections and advertising.

This is changing, as can be seen over the decade concerned. Expenditures in this sector have more than doubled and now exceed \$3 billion annually. This, as would be expected, is largely a concern for the private sector. Over the decade, expenditures in the public sector increased by 40 percent, in the private sector by 145 percent. This should provide a note of caution to those who would advocate a greater role for the private sector in personal health care. Any such increases will inevitably be met by demands for increased insurance benefits. Yet in recent years (largely driven by prescription drug costs and other professional services), many such benefit plans have doubled their premiums so that employers have noted that their contributions have increased from 3 percent of payroll to 6 percent on average. Further, a recent survey reports that most Canadian employees would choose retaining their plan over salary increases of up to \$8,000. Thus, those who advocate increased private health care to permit a corporate tax cut should reflect on what this would mean to employers premiums generally and to costs of prepayment administration specifically.

Health research: This is not a category for which there is any lobby to constrain costs. (Nonetheless, it is

interesting that some still argue that Canada should devote at least 1 percent of total health care expenditures to health research. That level was first achieved in 1985 and more recently has stabilized at 1.5 percent!) Both the public and private sectors have increased their commitment over the decade by approximately the same proportion for a combined total of 136 percent. Future increases are therefore entirely controllable by governments and donors. They are in no way unsustainable.

Other. This is never a satisfactory category. It is the ultimate dark area. However, it has been increasing at essentially the same rate as the GDP (66.1 percent), in both public and private expenditures. Nonetheless, it does account for over \$5 billion in expenditures and should not be ignored. It is a mixed bag of items such as home care, medical transportation, hearing aids and other appliances, training of health workers, voluntary health associations and occupational health. There is no reason to anticipate marked increase in expenditures unless it is for home care. As noted earlier, this should offset some of the potential spending growth in "other institutions." It also is well within the control of governments.

If in the aggregate the situation for Canada appears less catastrophic and more manageable than is often supposed, this should not be construed to imply that there are not significant problems in individual provinces. Their experiences and challenges over the decade were very different. Two crucial ingredients impacted very differently on different provinces: the growth in population and the growth in GDP, both overall and per capita. One has a direct impact on the volume of health services required, the other an indirect impact in terms of revenues available. It might be expected that increases in expenditure over time would reflect increases in population, collective wealth and some irreducible minimum due to evolution in health technology and practice. As there were such great differences in population growth (from +18 percent in Alberta to -10 in

Newfoundland), table 5 presents both expenses and GDP on a per capita basis.

There were significant differences in both initial expenditures, increases over the decade and most recent per capita expenditures. The relative level of expenditure between provinces changed considerably over the decade. Table 6 demonstrates quite remarkable differences in the two major components of medicare — hospitals and physicians.

In the case of hospitals, Newfoundland spends 56 percent more per capita than does Ontario, while in the case of physicians, British Columbia spends 81 percent more per capita than does Prince Edward Island.

Thus it does appear that while health care expenditures are driven by certain irresistible forces common to all systems, there remain major variations determined by local conditions such as policies, the results of collective bargaining and local traditions. Clearly there are options that are being exercised, and it is probable that a major role is played by factors that have nothing to do with health care. There is a potential for benchmarking and significant savings in certain instances to ensure sustainability.

The final frequently raised argument to suggest that public health care is not sustainable is exemplified

TABLE 5. TOTAL PROVINCIAL HEALTH SPENDING, PER CAPITA (\$), AND GDP GROWTH, 1993-2003

Province	1993	2003	Difference	Increase (%)	GDP growth (%)
NL	2,085	3,839	1,759	84.4	108.8
PEI	2,359	3,909	1,550	65.7	51.7
NS	2,192	3,721	1,529	69.9	54.7
NB	2,322	3,715	1,393	60.0	52.0
Que.	2,362	3,715	1,115	47.2	50.5
Ont.	2,632	3,945	1,313	49.9	49.3
Man.	2,460	4,220	1,760	71.5	51.1
Sask.	2,286	3,877	1,591	69.6	61.7
Alta.	2,444	4,010	1,566	64.1	66.2
BC	2,606	3,919	1,313	50.4	30.0
Canada	2,495	3,839	1,344	53.9	51.3

Source: Canadian Institute for Health Information, *National Health Expenditure Trends — 1975-2003*. Calculations by author.

TABLE 6. TOTAL HOSPITAL AND PHYSICIAN EXPENDITURES, PER CAPITA, CANADA (\$)

Province	Hospitals		Physicians	
	1993	2003	1993	2003
NL	869	1,473	228	388
PEI	811	1,197	239	324
NS	808	1,092	272	443
NB	826	1,188	262	460
Que.	891	1,133	300	386
Ont.	792	944	429	517
Man.	857	1,089	256	507
Sask.	682	994	250	461
Alta.	846	1,089	345	450
BC	737	1,009	397	588
Canada	819	1,042	357	480

Source: Canadian Institute for Health Information, *National Health Expenditure Trends — 1975-2003*. Calculations by author.

by the earlier quote to the effect that health spending threatens education. It is alleged that total health expenditures will soon consume more than 50 percent of provincial program spending. What is the reality? The basis for this concern is presented in table 7.

While the average health expenditures as proportion of program spending is still a long way from 50 percent, a rise to 38.1 percent from 32.6 percent in a decade cannot be ignored. However, it is important to consider that proportions may be changed in several ways. Table 8 is revealing in this respect.

This table demonstrates the dramat-

TABLE 7. TOTAL PROVINCIAL/TERRITORIAL HEALTH EXPENDITURES AS A PROPORTION OF PROGRAMS SPENDING

Province	1993	2003
NL	28.0	37.7
PEI	27.4	35.0
NS	30.8	40.1
NB	30.2	35.0
Que.	29.3	31.1
Ont.	36.0	43.2
Man.	34.6	42.2
Sask.	34.1	38.5
Alta.	30.6	39.0
BC	33.8	39.9
Canada	32.6	38.1

Source: Canadian Institute for Health Information, *National Health Expenditure Trends — 1975-2003*. Calculations by author.

TABLE 8. TOTAL PROVINCIAL/TERRITORIAL GOVERNMENT HEALTH AND ALL PROGRAM SPENDING (% PROVINCIAL GDP)

Province	1993		2003	
	Health	All programs	Health	All programs
NL	9.0	31.1	8.1	20.9
PEI	8.3	34.4	8.9	24.5
NS	7.2	22.4	7.7	18.1
NB	7.9	26.0	8.0	21.9
Que.	7.3	24.5	6.6	20.0
Ont.	6.3	17.5	5.8	12.4
Man.	7.6	22.3	8.4	18.6
Sask.	6.7	22.0	6.9	17.3
Alta.	5.5	17.3	5.2	12.9
BC	6.8	20.3	7.9	19.3
Canada	6.7	20.4	6.4	15.9

Source: Canadian Institute for Health Information, *National Health Expenditure Trends — 1975-2003*. Calculations by author.

ic differences in the roles that government programs (including health) play in the economies of the different provinces. Some have decreased their health spending as percent of GDP; others have increased it, with a combined overall reduction to 6.4 percent from 6.7 percent of GDP. However, they have all significantly decreased total program spending (including health) to 15.9 percent from 20.4 percent of GDP, on average. This has undoubtedly been motivated to achieve budgetary equilibrium, but also to provide the possibility of tax relief. Thus an argument can be made that health care is not crowding out other programs; instead, it is not experiencing the same degree of cutbacks. It is deficit elimination and tax cuts that are crowding out new initiatives. The changing proportion of provincial program spending allocated to health has more to do with total program spending than it does with health expenditures.

Clearly health expenditures are the result of a complex interplay of numerous factors and forces. Canada has not one, but a variety of health care systems, all dependent upon both public and private funding, yet consistent with the *Canada Health Act*. Such a mixed system is found in all countries. And the proportion of public and private funds is very similar to countries such as

Australia and some Western European countries. What is unique to Canada is the concentration by sectors such that hospitals and physicians are overwhelmingly public while other professionals, and to a large degree drugs, are private.

Clear, also, is that governments are not at the mercy of unfathomable, uncontrollable forces; they are making choices. There are undoubtedly multiple opportunities in all categories to better control expenditures. But there is no evidence of current or impending financial unsustainability requiring greater reliance on private financing. However, there is a real potential for increased private sector involvement to increase expenditures not directly related to medicare.

Looking to the future, the argument is made that the current public/private shares should change to take pressure off the public system and public finances. Yet, as can be seen, the medicare system has adapted through significant productivity enhancements to accommodate very important technologic and demographic changes of the past decade within the same funding parameters, as defined as a proportion of GDP. There is no reason to suggest that this will not continue. Some would argue that the current concerns over waiting lists demonstrate that the public system "cannot cope." It is necessary to remember that a decade ago the concern was the reverse. There was alleged to be "over-servicing." This led to major cutbacks in hospitals (such that expenditures declined for several years) and to decreases in health professional enrolment opportunities. These policies were successful. Too successful. Many waiting lists are as much due to personnel shortages as to funding. To develop private facilities would only make things worse, as the pool of health professionals is fixed. Fortunately, schools enrolments have increased markedly across Canada, so that by 2011, when the first baby boomers turn 65, waiting lists will be a thing of the past.

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