

HEALTH CARE: FUNDING, FACTS AND FUTURE

Glenda Yeates

"Canada's health system has become a vital part of our economy," writes Glenda Yeates, president of the Canadian Institute for Health Information (CIHI). "One-tenth of our economic output — \$148 billion — goes to health care." Even adjusted for inflation, health care spending has increased by more than 1000 percent in the last 30 years. Only the United States and Switzerland, among OECD countries, spend a larger percentage of GDP than Canada does on health care. While Americans most frequently cite the cost of health insurance as a barrier to treatment, 32 percent of Canadians cite waiting times within the universally insured system. The Canadian clientele is growing with the greying of the boomers, as well as living longer. "It remains true," she writes, "that health care needs usually grow as people get older."

Notre système de santé est devenu un élément vital de l'économie canadienne, écrit Glenda Yeates, présidente de l'Institut canadien d'information sur la santé. Nous y consacrons en effet le dixième de notre production économique, soit 148 milliards de dollars. Même en dollars constants, les dépenses en santé ont augmenté de plus de 1000 p. cent depuis 30 ans. Parmi les pays de l'OCDE, seuls les États-Unis et la Suisse dépensent en santé une part plus importante de leur PIB que le Canada. Et si la majorité des Américains invoquent le coût de l'assurance-maladie comme obstacle à la prestation de services médicaux, 32 p. 100 des Canadiens citent les temps d'attente de leur système universel. Les usagers canadiens se multiplient au gré du vieillissement des baby-boomers, tout en vivant de plus en plus longtemps, rappelle l'auteure.



Sparking heated debates in living rooms, boardrooms and budget lock-ups, little generates more controversy than questions about what health care we want and need, what we can afford and who should pay. Some say that we should spend more, while others say we are spending in the wrong places. Some believe that we need to invest more in health promotion and disease prevention; others argue that long-term sustainability is best achieved in other ways.

Answers to these questions are, at the same time, intensely personal and deeply rooted in societal values. They force us to consider our views about what affects health, who is responsible for improving health, how to ensure appropriate access to care and whether we are receiving value for health dollars spent. As Canadians — individually and collectively — ponder what the right mix of health services should be tomorrow, it helps to consider where we are today.

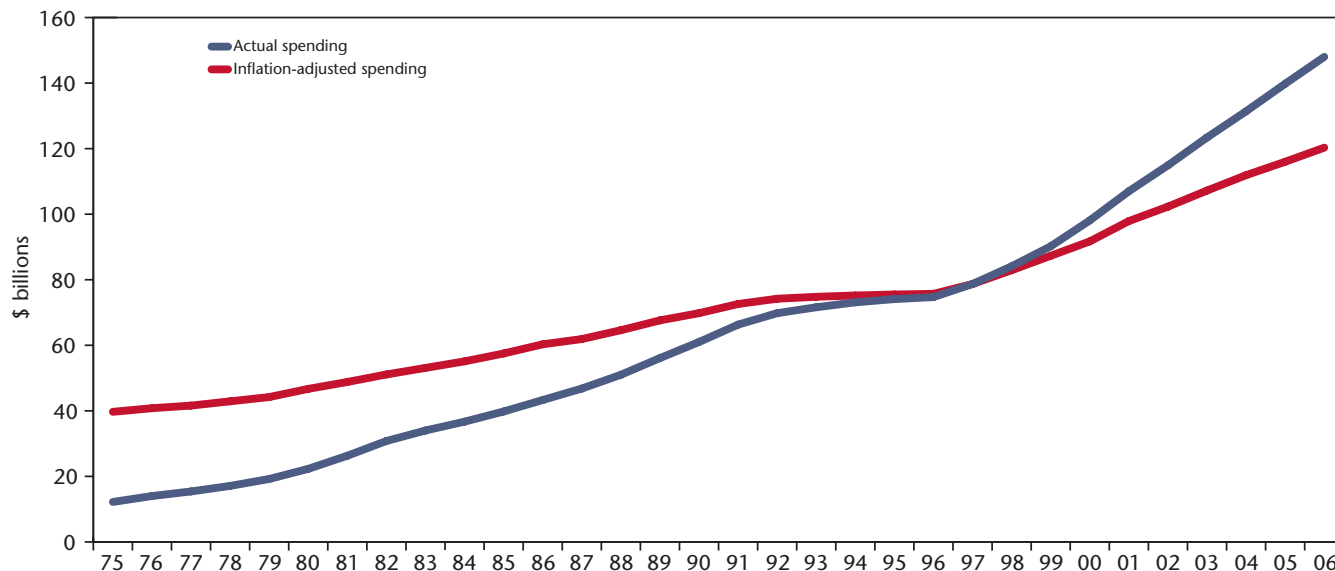
Canada's health system has become a vital and complex part of our economy. One-tenth of our economic output — \$148 billion — goes to health care (see figure 1). As a share of GDP, costs rose sharply in the early 1980s, and then again in the early 1990s, when the economy slowed. Following a

dip in the mid-1990s, health spending is once again growing faster than the economy as a whole. Health spending has been rising in other countries too, albeit with somewhat different growth patterns. The result: Canada spends more on health services per capita than most, but by no means all, OECD countries. For example, we spend less than the United States and Switzerland, more than Denmark or Spain.

In the 20 years since the *Canada Health Act* was passed, the combined public and private health care bill more than tripled. What drove the growth? Together, population growth and inflation accounted for over half of the increase (59 percent). More public and private sector spending per person explains the rest of the overall increase in health spending (25 percent and 16 percent respectively). This partly reflects the cost of additional care, such as higher rates of hip and knee replacements or more CT scans, offset by any service reductions or efficiencies. But new types of care (e.g., vaccines against the chicken pox or new drug therapies) also play a role.

Private sector financing, primarily through health insurance and out-of-pocket payments, accounts for between

FIGURE 1. TOTAL PUBLIC AND PRIVATE HEALTH CARE SPENDING (\$ BILLIONS)



Source: Canadian Institute for Health Information.
 Note: Data for 2005 and 2006 are forecasts.

one-fifth and one-third of health expenditures in most OECD countries (see figure 2). At 30 percent in 2004, Canada falls within this range. Canada’s private share of health spending is similar to Spain’s and Australia’s, but higher than in the United Kingdom, France, Germany and Sweden. The exception is the United States, with a 55 percent private share. That said, the United States spends more per person on health care through public programs than Canada (and almost all other countries).

Even countries that spend about the same amount on health care often finance these costs very differently. For example, Canada funds hospital and physician services almost entirely through taxes, an arrangement that differs from those of some other countries. On the other hand, Canada’s public share of drugs and dental care costs is much lower than many European countries’. These variations have sparked several studies — and even more debates — about the effect of different financing arrangements on cost structures and trends.

Differences in health spending are just one of the reasons why health care is sure to come up when you ask what makes Canada different from the United

States. Often, questions are raised about differences in access to care. Interestingly, Canadians and insured Americans are about equally likely to report unmet needs for health care in the past year. One in ten adults on both sides of the border did so in 2002-03, according to a joint survey by Statistics Canada and the National Center for Health Statistics of the US Centers for Disease Control and Prevention. (Uninsured Americans are much more likely to report unmet needs for health care.)

Leading reasons for access problems do diverge, however. In the United States, cost was the most common barrier, cited by just over half of those with unmet needs. In Canada, 32 percent of those with access difficulties named waiting for care as a barrier. While we don’t yet have a comprehensive, comparable picture of wait times, the data that exist suggest that waits vary widely across the country and for different types of patients. Some patients are immediately whisked through the emergency department; others wait several hours before being seen. Large variations in waits also exist for MRI and CT scans, specialist visits, elective and emergency surgery, and rehabilitation.

In other areas, health systems in Canada and the United States share sim-

ilar challenges when compared with those of other countries. For example, the Commonwealth Fund recently surveyed primary care doctors in both countries, as well as in Australia, Germany, New Zealand, the Netherlands and the United Kingdom. North American physicians were less likely than others to say that their practice offers after-hours care, to receive alerts about potential problems with drug doses or interactions, and to send patients routine reminders about the preventive or follow-up care they need.

Canadians are living longer than ever before. Our life expectancy is one of the best in the world — more than 80 years in 2004. That’s up from 60 years in the 1920s and 70 years in the 1950s. As well, older adults can, on average, look forward to more years with a higher quality of life. However, not all Canadians enjoy equally good health. There is a more than 10-year gap in life expectancy between provinces and territories — and between health regions within some provinces. In large part, these differences reflect the fact that patterns of health and disease are largely a consequence of how we learn, live, work and play.

A number of factors — many outside of the health system — have driven recent improvements in health status, but it remains true that health care needs usually grow as people get older. A young population would, all else being equal, have fewer health needs and lower health care costs than one with older residents. Some groups have used this fact to project what would happen in the future if patterns of care stayed the same but the population aged. These studies typically project large increases in spending.

Is this trend inevitable? A typical 70-year-old today receives very different health care than his or her counterpart did a generation ago. Our choices, as individuals and as a society, affect the demand for health services, as well as health care use and costs. So do innovations and other shifts in health services and their delivery. For example, research

suggests that changes in the types and quantity of care received have had more impact on increases in health spending than population aging in recent years.

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Studies from Canada and around the world have found that changes in how often people in specific age groups are hospitalized (and in the nature of their care during their stay) have been more important than overall population aging in explaining changes in hospital use.

From gene therapy to laser eye surgery, innovations are transforming

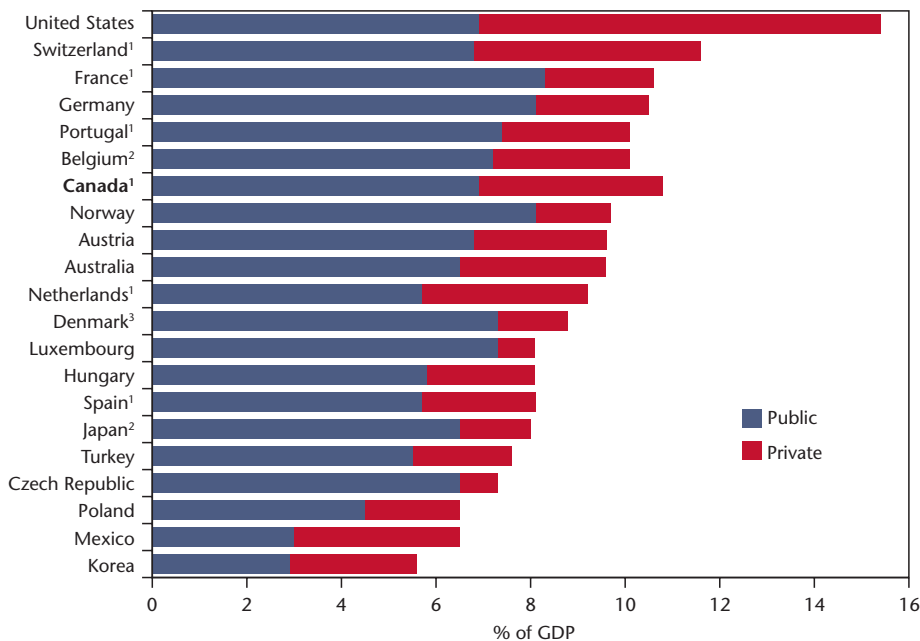
health care. Options now exist to care for once untreatable conditions and same-day clinics now perform surgery that used to require several days in

hospital. Use of some services is growing rapidly. For example, the number of MRI scans grew by 13 percent between 2003 and 2005. The number of knee replacements, hip replacements and cataract surgeries rose by more than 10 percent last year, even after adjusting for population growth and aging.

Other therapies have fallen out of use. Sometimes the change is dramatic, as when drugs are taken off the market for safety reasons. In other cases, practice patterns evolve over time. For instance, about one in four Canadian babies born today are delivered by Caesarean section, up from under one in six babies in the late 1970s. Changes in birthing practices clearly have important implications for mothers, their babies and their care providers. They may also affect health expenditures since hospitals typically spend over 60 percent more to care for a mother who has a Caesarean section birth than they do for someone who has a vaginal delivery.

Health services are also being delivered differently than in the past. For example, family doctors are less likely to perform surgery or deliver babies than historically. Younger and older physicians also tend to have different work and practice styles. The same is true for other professions, something that will continue to affect the health system as large numbers of baby boomers head toward retirement.

FIGURE 2. PUBLIC AND PRIVATE HEALTH SPENDING AS A PERCENTAGE OF GDP IN 2004



Source: Organization for Economic Co-operation and Development, Health Data.

¹ Estimate

² Data for 2003

³ Data for 2002

Many of the same trends apply across the country, but local practice patterns also diverge. There are significant differences in what health services are provided, how they are delivered and who pays. For example, some regions have C-section rates below 15 percent but others have rates that are more than double this level. Likewise, the latest data show at least a twofold difference in rates of exposure to second-hand smoke, low birth weight, surgery and hospitalization due to injury from region to region. There are also important variations in patient outcomes, such as a patient's odds of surviving a heart attack or stroke. Even after differences in age, sex and other illnesses are taken into account, death rates in some large health regions are more than double those in others. The same is true for your chances of

an unplanned readmission to hospital after being discharged.

There has been much debate about the sustainability of the health care system but, as these examples demonstrate, the issues are far from simple. Canada's health systems are founded in, but have diverged in important ways from, those that existed when medicare was introduced. Based on recent history, it's fair to assume that evolution will continue, albeit not always in predictable ways. Shifts in population demographics, factors that affect health, disease rates, patient and public preferences, health human resources, technology and practice patterns are just a few of the trends that will affect tomorrow's health systems.

As these and other trends interact, what will the result be? Forecasting the future is never easy, particularly since

projections depend so critically on assumptions about how health systems will — or won't — evolve. Nevertheless, a thoughtful look at Canada's recent experience, as well as that of other countries, can provide a solid foundation on which to base our thinking about sustainability and other questions — and the many decisions and policies that follow.

Glenda Yeates is the president and chief executive officer of the Canadian Institute for Health Information (CIHI). She is the former deputy minister of health in Saskatchewan, and also held senior posts in the Saskatchewan Departments of Finance and Social Services. CIHI is an independent, not-for-profit organization that provides data and analysis on Canada's health system and the health of Canadians. www.cihi.ca



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