

# REFORM, RE-FORM, AND REACTION IN THE CANADIAN HEALTH CARE SYSTEM\*

**Robert G. Evans\*\***

## **Reform or Re-form?**

The word “reform” carries the implication of improvement, of making some organization or institution better. Literally, though, it means simply to “re-form” or to change the shape or structure of something. Whether the result will be better or worse, and particularly for whom, is left open. Calling a proposal a reform is “persuasive definition,” inviting a presumption of improvement that may or may not be justified.

There is certainly room for improvement in Canadian health care, as in every other system in the real world. Proposals for reform might focus on improving the efficiency or effectiveness of the care provided, or the timeliness and responsiveness of provision. They might address the very large variations in clinical practice, apparently unrelated to patients’ needs, or the discrepancies between actual practice and the research evidence on appropriate care, or the prescribing of new, costly drugs that often offer no benefit over older, off-patent alternatives, or the effects of professional “turf protection” on access and costs.

But they do not. The most widely and loudly promulgated proposals for “reform,” at least in the broader public and political arena, focus on rearranging payment processes so as to transfer costs from the healthy and wealthy to the unhealthy and unwealthy, while improving access for the wealthy and unhealthy, and increasing income opportunities for strategically placed providers.

This agenda is advanced under a claim that the present universal publicly financed system is fiscally “unsustainable,” so that major change – and in

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particular a shift toward more private financing – is inevitable (“Resistance is useless”). This claim flies in the face of all the available evidence; its purpose is merely to provide spurious justification for shifting the distribution of burdens and benefits among the population.<sup>1</sup> (Various subsidiary claims that shifts toward more private financing will improve system performance are equally specious.)

## The Financial Architecture of Health Care Systems

Figure 1 provides a simplified schematic of the basic accounting structure of health care systems. The financing and funding mechanisms, and the effects of specific re-forms, can all be represented within this framework. The solid lines show the flow of funds from the residents who pay for the system, through the various financial institutions that collect those funds, and on to the various organizations that are paid for providing health care goods and services. From these, and this is very important to grasp, the funds ALL flow back to various members of the population who work in, supply, own, or invest in these organizations.<sup>2</sup> Every dollar raised is a dollar spent, and becomes a dollar of someone’s income, closing the circle.

Beneath this financial framework are represented (dashed lines) the flows of the fundamental resources of human time, effort, skills and knowledge that are used, along with equipment and drugs, by the organizations that produce the health care goods and services received by persons. Financial arrangements support these “real” production processes, and powerfully shape them for good or ill. But in the final analysis dollars don’t care. Our health needs are met by skilled people, adequately supported with appropriate equipment, supplies and drugs.

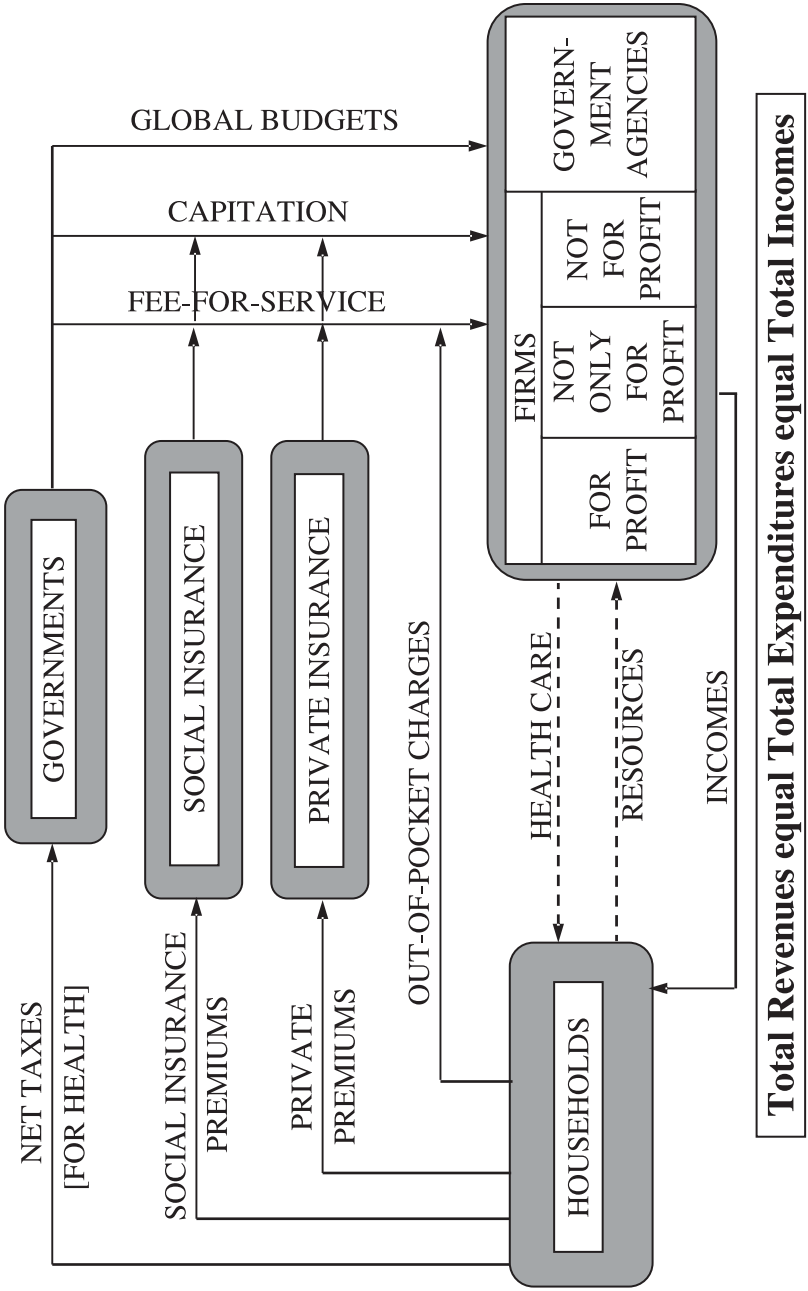
Figure 1 correspondingly places at its core this relationship, between the flesh-and-blood people supporting and served by a health care system (the box at lower left), and the various types of institutions – hospitals, medical and dental practices, pharmacies and drug and equipment manufacturers, public health agencies, etc. – that provide health care (the various boxes at lower right). These “firms” convert the resources contributed by the mem-

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1 “Unsustainability” is a peculiarly Canadian concern. Other OECD countries have similar expenditure levels and trends, but do not raise this issue. See Steven Lewis, “Can a Learning-Disabled Country Learn Healthcare Lessons from Abroad?” (2007) 3 *Healthcare Policy* 19.

2 The foreign sector is here compressed into one large person.

**Figure 1**  
**The Health Care Financing Identity**



bers of the population into the health care goods and services used by that population.

Most of the figure, however, is taken up with the flows of financial resources – dollars – around the outside of these core activities. This corresponds to the primary emphasis of so many of the public debates over reform. There are good reasons for this, in terms of the conflicting economic interests involved, but they have little to do with improving the health care system itself.

The members of the population provide the financing for their health care system through four main channels, the pipes at upper left. Most of the money (even in the United States) flows through public channels, either tax-financed programs or – as in Germany, France, and the Netherlands – social insurance systems. World-wide, the public sector financed fifty-five percent of health spending in 2003.<sup>3</sup> In high income countries (GDP per capita > \$15,000 USD) this share rises to seventy percent.

Direct payment by users finances nearly a quarter of world health spending. Private health insurance is largely an American phenomenon, financing only about six percent of health spending outside the United States. But both American health spending and American reliance on private insurance are so extraordinarily high relative to every other country that including the United States raises the world share of private coverage to nearly twenty percent of total expenditures.<sup>4</sup>

Where private insurance does exist, moreover, it is typically either heavily subsidized by governments or provided with special regulatory protection or encouragement (or both). In the United States (and in Canada), “tax-expenditure” subsidies account for roughly one-third of the financing provided through private insurers.<sup>5</sup> These complexities could be included in Figure 1 without conceptual difficulty, but would add considerable clutter.

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3 See World Health Organization, *The World Health Report 2006: Working Together for Health* (Geneva: World Health Organization, 2006).

4 In some countries – Canada and the United States, for example – a substantial majority of the population has some level of private insurance. But this coverage meets a relatively small share of total health care costs. Private insurers, quite understandably, do not insure the greatest needs.

5 Employers purchasing health insurance for their employees can deduct the cost from their taxable income. But this coverage is not taxable in the hands of employees.

Funds then flow to the different institutions providing health care through a variety of different payment mechanisms. The simplest is fees per unit of service – virtually all user payment takes this form, as does public payment for physicians or pharmaceuticals in Canada. Current proposals for “payment for performance” – actually payment for activity, not results – seek to expand this form of reimbursement. At the other end of the scale is the allocation of defined budgets, as for public health agencies or in Canada for hospitals. In between are various forms of payment by treated case, as in the American Medicare Prospective Payment System for hospitals, or by capitation – a fixed amount of payment for each person on a roster or in a defined geographic area.

How the financing is raised will affect the range of funding choices available – governments may choose among the full range of funding mechanisms, while user payment is pretty much restricted to fee per unit of service. Private insurers can (but rarely do) employ capitation payments.

These funds then flow to various forms of provider organizations, with different ownership and corresponding motivations. At one end of the spectrum are the purely for-profit firms such as pharmaceutical and equipment manufacturers, responsible to (and only to) their shareholders for maximizing “shareholder value” – i.e. profit. At the other are public agencies budgeted by and under the administrative control of governments or other public institutions. In between are the not-for-profit firms – most hospitals – and the “not-only-for-profit” firms such as medical and dental practices.

These two types differ in that the NFP firm has no residual claimant to any surplus of revenue over expenditure – no person is legally entitled to pocket it as income. A medical practice, by contrast, has a well-defined owner or owners, for whom any surplus is personal income. But the professional organization has to, or at least is supposed to, place the interests of patients above, or at least on a par with, the maximization of profit. The extraordinary regulatory protections that such firms receive against the rigours of the competitive marketplace are typically justified as permitting the protection of patients’ interests.

The behaviour of these different provider organizations is significantly influenced by the interactions between their varying objectives and the economic incentives embodied in the funding structure. While the motivations of providers (outside the for-profit sector) are various and complex, and for most (their perceptions of) the needs of patients play a dominant role, it is well-established that modifications in the funding structure result in changes in the patterns of care provided – quite independently of patient needs and therapeutic possibilities and often without the awareness of providers themselves.

## The Axes of Conflicting Interests

Perhaps the most important feature of Figure 1, however, is that as noted above all the funds that flow to the organizations providing health care flow back out again. They emerge eventually as the incomes of persons – total expenditures on health care will and must, by an iron law of accounting, equal total incomes earned.

Most of the population will contribute much more to financing health care than they earn from its provision; some will earn much more than they contribute. But every dollar of expenditure is a dollar of someone's income, and it is this, not the objective facts of epidemiology and therapeutic technology, that makes cost containment and evidence-based "reform" such a seemingly intractable political problem. Cost containment is equivalent to containment of someone's income aspirations, regardless of whether the services they provide are of critical importance to the health of patients, or relatively ineffective, or even downright harmful.

Conflicts of interests and objectives within the population served are thus fundamental and unavoidable in all health care systems. No amount of "reform" can make them go away. These conflicts are aligned along three principal axes:

### Who Pays?

(What share of the total cost of the health care system is borne by which members of the population?)

### Who Gets?

(Who receives the goods and services produced by the health care system, and on what terms – timeliness, priority? Is allocation determined by need or by ability and willingness to pay?)

### Who Gets Paid?

(How much is paid to the providers of care, for doing what, and how is the total divided up among the different providers?)

Who Pays? Is primarily determined by the share of total financing that flows through each of the pipes on the upper left of Figure 1. Tax financing distributes the burden of payment roughly in proportion to income, or at least to tax liability. User payment distributes it according to health status, or at least use of care. The eternal arguments over user fees are rooted in this simple fact: tax finance places heavier burdens on the healthy and wealthy, user fees on the unhealthy and unwealthy.

Much econo-fog has been generated by claims that when individuals pay their own bills they somehow become able to decide which services are medically necessary and which are superfluous, and will choose accordingly. Apart from being *prima facie* absurd and in conflict with everyday experience this proposition is comprehensively rejected by the research evidence. But it remains a powerful rhetorical tool in the struggle over Who Pays.<sup>6</sup>

Private insurance is somewhat more complex. Private coverage does serve to pool care costs, transferring burdens from the sick to the well, or at least from users to non-users. But it has two important features relative to public financing.

First, private premiums are not linked to incomes so that, unlike taxation, wealthier people do not pay more. Insofar as wealthier people also tend on average to be healthier, a competitive market will offer them lower premiums. The substitution of private insurance for taxation thus redistributes the cost burden from higher- to lower-income people. (Expansion of public financing, of course, does the reverse).

Second, competitive insurance markets force insurers to become increasingly sophisticated in partitioning the covered population into higher and lower risk categories. Premiums thus become increasingly differentiated according to risk status – those at greater risk pay more. Moreover the most reliable measure of today's risk is yesterday's experience (most illness is chronic) so yesterday's use becomes today's higher premiums. These two processes considerably reduce the extent to which private insurance can pool the costs of the healthy and the unhealthy. In a fragmented and competitive insurance market, the distribution of cost burden across income classes looks the same as it does with user payment – heavier burdens on high users with lower incomes.

People with higher incomes, and their representatives, accordingly tend to favour the extension of private insurance, and resist, for example, the introduction of universal Pharmacare. A tax-financed Pharmacare system has the potential to mitigate considerably the escalation of drug costs, but

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6 There is also a certain school of economists who believe that people should pay for their own care "just because," regardless of the implications for their health or the inequity of the resulting burdens. They allege that this view arises from economic theory, but that is false and indeed logically impossible. It is in fact a rather idiosyncratic ethical position that has very little broader resonance.

the healthy and wealthy would indeed pay a larger share of its costs through higher taxations.

The alignment of interests along the Who Gets? axis is equally straightforward. Can you, or can you not, buy your way to the front of any queues? If your needs are light but your purse is heavy, and particularly when demands are perceived to outrun resources, the attractiveness of private payment is obvious. And if private payment can be supported by private insurance, which is always more available to the wealthy and relatively healthy, the structure of interests is even more obvious. Still better if, as with present private insurance in Canada, a large part of the cost is subsidized by the general taxpayer.

But behind the conflicting interests of payers and users are the very powerful interests of providers – Who Gets Paid? And how much? When better-off patients can buy their way up the queue, it is physicians or owners of private clinics (often the same people) who collect their money. Expanded private payment permits those able to control and charge for access to raise their prices and incomes.

Pricing freedom also lies behind the bitter opposition of brand-name pharmaceutical manufacturers to universal Pharmacare. Insofar as a universal public plan would greatly strengthen the bargaining power of the public purchaser, it would result in lower prices, revenues, and profits for drug manufacturers. In a fragmented financing system, purchasers' negotiating power is minimized – in a self-paying market it is zero – and manufacturers can price to maximize profits. They do.

Claims that increased private payment will improve access to the public system are economic nonsense. When practitioners can work simultaneously in the public and in the private systems, and/or can extra-bill some of their patients, they will focus their attention on the more remunerative patients. Public patients go to the back of the queue. None of this is hypothetical: the “wallet biopsy” has been a feature of the British National Health Service throughout its existence. People, even doctors, respond to economic incentives.

The Canadian Medical Association, perfectly consistently, now advocates a two-tier system of payment in which physicians can work in both tiers. Their surrounding publicity insists that this is purely motivated by the good of patients, and has nothing to do with the economic interests of doctors. But as a former president of the CMA, Dr. Victor Dirnfeld, wrote: “At CMA, defending and promoting the interest of Canada's doctors is central to our mission. Advancing the medical community's financial interests is an

important element of that commitment.”<sup>7</sup> The CMA’s advocacy position is about money, pure and simple.

As for private insurance, it is well-documented, in North America at least, that the administrative overheads associated with this form of financing are much greater than in a purely public system. These include, but go well beyond, the administrative costs embedded in private premiums. Efforts by insurers to limit their own liabilities can set up an “administrative arms race” between insurers and providers, imposing much larger costs on hospitals and medical practices that are then passed forward in higher fees and prices. In the United States these extra bureaucratic costs are now in the hundreds of billions of dollars.<sup>8</sup> Every dollar of these costs is someone’s income, but none of them pay for health care. These multi-billions do, however, finance very effective campaigns against public health insurance in the United States.

Any actual or proposed shift in the financial structure of a health care system, and the corresponding shifts along the three axes of conflicting interests, can be represented in the framework in Figure 1. We offer three Canadian examples. The first, British Columbia’s Fair Pharmacare program, is a textbook case of a purely redistributive policy, a shift in Who Pays? The second, the possible impact on Who Gets Paid? of the recently expressed interest of the Canadian Competition Bureau in the market for generic drugs, is also purely redistributive. The third, the public or private funding of private clinics and short-term hospitals, is more complex and has implications across Figure 1 and along all three axes of conflict.

### **Cost Shifting: B.C.’s Fair Pharmacare Program**

Fair Pharmacare was explicitly redistributive in its objectives. As everywhere in Canada, pharmaceuticals in B.C. are financed through a mix of public insurance, private insurance and out-of-pocket payment. Historically, the public program paid the drug ingredient costs for all seniors. A so-called “universal” program covered the rest of the population, but with a sufficiently high deductible as to exclude most people from any public benefits.<sup>9</sup>

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7 Victor Dirnfeld, “A Message from the President of the Canadian Medical Association”, (1997-98) archived with the author.

8 Steffie Woolhandler, Terry Campbell & David U. Himmelstein, “Costs of Health Care Administration in the United States and Canada” (2003) 349 *New Eng. J. Med.* 768.

9 Insured persons or families were required to pay all their own costs up to a

The current Fair Pharmacare program, by contrast, makes no age distinctions. Instead it is means-tested, with proportionately greater public subsidies to those at lower incomes. Above a ceiling income, public support ceases entirely. On the surface, this does indeed appear to be a more equitable way of using public money, shifting the public subsidies from the wealthy elderly to the unwealthy non-elderly. But this is not the whole story.

The new program was a response to a very substantial cut in the provincial government's support for Pharmacare, driven by provincial tax policy. Virtually the first official act of the Liberal government elected in 2001 was a major cut in income tax rates. Finance Canada estimates that this lowered provincial revenues by about \$2 billion. Together with an unexpected economic slow-down, this pushed the province from a surplus of \$1.5 billion in 2000/01 to a deficit of \$2.7 billion in 2002/03.

The new government promised to balance the budget before the next election. They did, primarily by cutting spending programs across all government departments. Pharmacare was required to find \$90 million; the only way to do this was to transfer more of the costs onto users in the form of higher deductibles and larger coinsurance rates. Higher income seniors now pay more for their drugs, but there has been, on average, no net gain for lower-income groups.

The combination of tax cuts and expenditure cuts increased the flow through the two lower pipes on the upper left of Figure 1 and reduced the flow through the top pipe. Part of the expenditure burden was thus shifted from taxpayers to drug users.

The tax cut, however, was strongly tilted in favour of higher income earners – they received the bulk of the foregone revenue. What high income British Columbians may have lost in drug subsidies was more than made up for in reduced taxes. Fair Pharmacare transferred a significant cost burden from the healthy to the sick; the tax cut that motivated – forced – it also actually lowered the total burden – drug costs plus associated taxes – on the highest income groups. The healthy and wealthy gained; the unhealthy and unwealthy lost.

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certain level – the “deductible” – in any year. Only expenditures beyond this level were insured, and then only partially. A “coinsurance rate” required individual payment of a proportion of expenditures above this level. These features are common in private insurance plans, but not in public health insurance programs.

In engineering this redistribution the provincial government was very concerned to avoid the Quebec experience, and attendant bad publicity. In Quebec, mentally ill people responded to increased user charges by “going off their meds,” coming into emergency wards, and adding to hospital costs. On the evidence so far, it appears that the Fair Pharmacare structure has avoided this outcome. The new higher but income-related user charges seem to have confounded right and left alike, neither saving money by discouraging unnecessary use, nor threatening health by discouraging necessary use. They just changed Who Pays?

There is, however, a longer-run question. British Columbia’s Pharmacare program has been relatively successful in using the purchasing power of government as “prudent purchaser” to negotiate lower prices from manufacturers. By lowering government’s share of costs, Fair Pharmacare reduces both government’s bargaining power and the incentive to use it. Moreover, since the previously insured elderly were grandfathered in, the share of expenditures covered by Pharmacare will decline over time. The longer-run effect is quite likely to be more rapid escalation of pharmaceutical prices and profits. Canadian drug users, insurers and governments will pay more, to the benefit of shareholders in and out of Canada.

### **Cost Reduction? Retail Pricing of Generic Drugs**

The recent interest of the Canadian Competition Bureau in generic drug markets turns that coin over. The Bureau notes that although generic drug manufacturing in Canada is intensely price-competitive, this competition is not reflected in lower retail prices. Rather, manufacturers pay large rebates to pharmacies – as much as 40% off wholesale prices – to have their products stocked. These rebates – prima facie evidence of a failure of retail price competition – are pocketed by the pharmacy’s owners.

This lack of competition is also reflected in comparisons of drug prices in Canada and in New Zealand. New Zealand’s PHARMAC program, requiring manufacturers to supply drugs on competitive tender, has been outstandingly successful in holding down that country’s drug costs. But remarkably, the ratio of generic prices in New Zealand to those in Canada is even lower than the ratio for patented drugs. Since generic drugs are commodities, readily traded internationally, the only possible explanation is that Canadian retail pharmacies have successfully blocked retail price competition and captured for themselves the gains from competition among generic manufacturers.

If the Canadian Competition Bureau were able to generate retail price competition for generic drugs, the resulting fall in prices would reduce the

flow through each of the pipes at upper left in Figure 1. There would be savings for patients, insurance buyers and governments, and corresponding income losses for the individual or corporate owners of pharmacies.

### **Private Clinics: For Productivity or Profit?**

For at least forty years, it has been known that much of the care of hospital inpatients could be provided as well or better in day surgery or other short-stay facilities. But the pace of change has been glacial. The hospital budget cuts in the early 1990s greatly speeded the process, by reducing inpatient capacity and forcing change in hospitals.<sup>10</sup> But they also resulted in longer waiting lists for certain elective surgeries. Surgeons frustrated by the limited operating time available in the public system began to look for, or establish, alternative private facilities.

Private delivery need not imply private payment. If Medicare pays clinic fees as well as surgeons' fees, there is no change in the mix of financing sources in Figure 1. As surgical workload is shifted from inpatient to dedicated short-stay facilities, there should be some reduction in average costs per patient. In the (likely) case that hospital budgets are not reduced, then at least overall surgical capacity is expanded at lower cost than building – and staffing – more inpatient beds.

So far, so good. But on the right-hand side private clinics introduce two very significant changes. First, unlike hospitals, private clinics have well-defined residual claimants. Corporate owners will be strictly for-profit. And second, again unlike hospitals, they are reimbursed by fee-for-service rather than by global budgets. These two changes create very different economic incentives.

The most obvious incentive is for “cherry-picking” or “cream-skimming.” Patients are far from homogenous in their needs. Patient age, physical condition, and especially co-morbidities can make a major difference to the costs and back-up requirements for care. Surgeons who have an equity interest in a private clinic as well as admitting privileges in the public system have a direct economic interest in referring the “cheap and cheerful” cases to their

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10 The pharmaceutical industry in particular has had considerable success with the claim that the reduction in inpatient use resulted from the availability of new, more effective, but more expensive drugs. There is some truth to this, but very little. Unfortunately powerful marketing, including pseudo-research, tends to trump historical reality.

private clinics, while admitting the more complex and costly cases to the public hospitals.

But so they should. The hospital is exactly where the more difficult and complex cases belong. A problem arises only insofar as private clinics are able to negotiate facility fees that do not accurately reflect the less complex work they are taking on. Ideally, private clinic fees would be discounted from average inpatient costs to match their less difficult caseload. But if clinics are overpaid (relative to hospitals) for the work they do, then unless the total flow of financing is expanded to cover what are, in effect, higher prices paid in the private sector, the inpatient system may be starved for funds.<sup>11</sup> In negotiating facility fees, however the informational advantages are likely to be on the side of the private clinics, particularly when their surgeon owners work on both sides of the fence.

There are further problems if surgeons working in both systems are able, directly or indirectly, to extra-bill their private patients. This creates an obvious and readily understandable economic incentive both to steer patients to their private clinics and to devote more time and effort to those patients. More timely access to elective surgery becomes based, in part, on willingness and ability to pay. This has been a perennial problem in the British National Health Service; to claim that it would not arise in Canada is either naive or disingenuous.

Even if overt extra-billing in the private sector can be suppressed – despite the formidable problems of information and motivation – indirect extra-billing can occur through the marketing of “value-added” services not reimbursed through the public payment system. The sale of foldable intra-ocular replacement lenses by ophthalmologists is a classic example.

In provinces where Medicare pays only for the rigid lenses, ophthalmologists can and do charge several hundred dollars for a bit of foldable plastic costing less than \$25 wholesale, and pocket the difference. There is no clear evidence of therapeutic superiority – if there were, the foldable lenses should be covered by the public system. But patients have no way of knowing this.

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11 They may also be starved for staff. Cheap and cheerful cases make a much more pleasant working environment, giving private clinics a significant recruitment advantage. This advantage is even stronger if successful cherry-picking permits the private clinics to offer better wages or other benefits.

This example illustrates the general incentive problem. The term “not-only-for-profit” reflects the mixed objectives of the professional provider, seeking both the patient’s health and his own economic well-being. The incentives to over-treatment embodied in the fee-for-service system, memorably described by Shaw a century ago, have been noted for millennia. Each professional must reconcile these incentives with his or her own ethical standards. But the evidence is quite clear that, when the incentives and the motivations change, so does (average) provider behaviour. Substituting private fee-for-service clinics for hospitals increases the weight of economic motivations in this balance.

### **“Unsustainability”: Myth and Motive**

Tracing the effects of particular re-forms through the framework in Figure 1 permits one to draw inferences about the underlying motives of their advocates, on the principle that “a man must be presumed to will the consequences of his own acts.” But as noted above, there has for a number of years been a more general campaign for major re-structuring of the Canadian health care system, promoted by loud and persistent claims that the universal public system is fiscally “unsustainable” and must inevitably collapse. This theme was sounded most strongly by the Government of British Columbia, when the “Conversation on Health” was launched in late 2006 with a blaze of misleading statistics and absurd projections presumably designed to stampede the B.C. population into accepting the Premier’s privatization agenda. (It seems to have failed in this respect at least.)

The policy responses to this claimed “unsustainability” are both to increase the proportion of private financing – out-of-pocket or private insurance – and to increase the extent of private for-profit delivery of services. This would mean moving left-ward across the boxes at the lower right of Figure 1, as well as downward across the pipes at upper left. Increased private delivery would also involve a shift in the mix of funding mechanisms at upper right toward more fee-for-service, with all the well-known strengths and weaknesses of that form of funding.

It is interesting to note, however, that this agenda has been promoted in Canada along with claims that the overall health care system, or at least the Medicare component, is underfunded and needs more resources – i.e. money. More private payment is required because governments simply cannot afford to provide the resources necessary to meet the health needs of Canadians. Claims by right-wing economists that user payment would actually lower overall health care costs, and even lead to more appropriate choices of

care by “informed consumers,” have received little or no attention. The coalition for privatization relies heavily on providers of care, for whom health expenditures are incomes. The objective is to shift more money into health care, but at the expense of users, not taxpayers, so as to distribute more of the burden farther down the income spectrum.

Figure 2 shows the ratio of national government debt to GDP for the major industrialized countries.<sup>12</sup> Canada is now in the strongest fiscal position in the G-7. Despite major tax cuts, the national debt has fallen from 70.7% of national income in 1995 to 26.6% in 2006, and the trend remains strongly downward.<sup>13</sup> There is no shortage of public money.

But health care is primarily financed by provincial governments, and here the rhetoric has for many years been that uncontrollable health spending has been taking up an ever larger share of provincial government expenditures and crowding out other important public programs. This claim has in fact some truth, but a truth more deceptive than an outright lie.

Figure 3 shows what we may call the “Klein line,” after former Premier Ralph Klein of Alberta. Measured on the right-hand scale, total spending on health care by all provincial governments rose from 34.9% of total program spending in 1995/96 to 42.2% in 2003/04. By itself, this would seem strong evidence of the crowding out of other programs – an unsustainable trend.

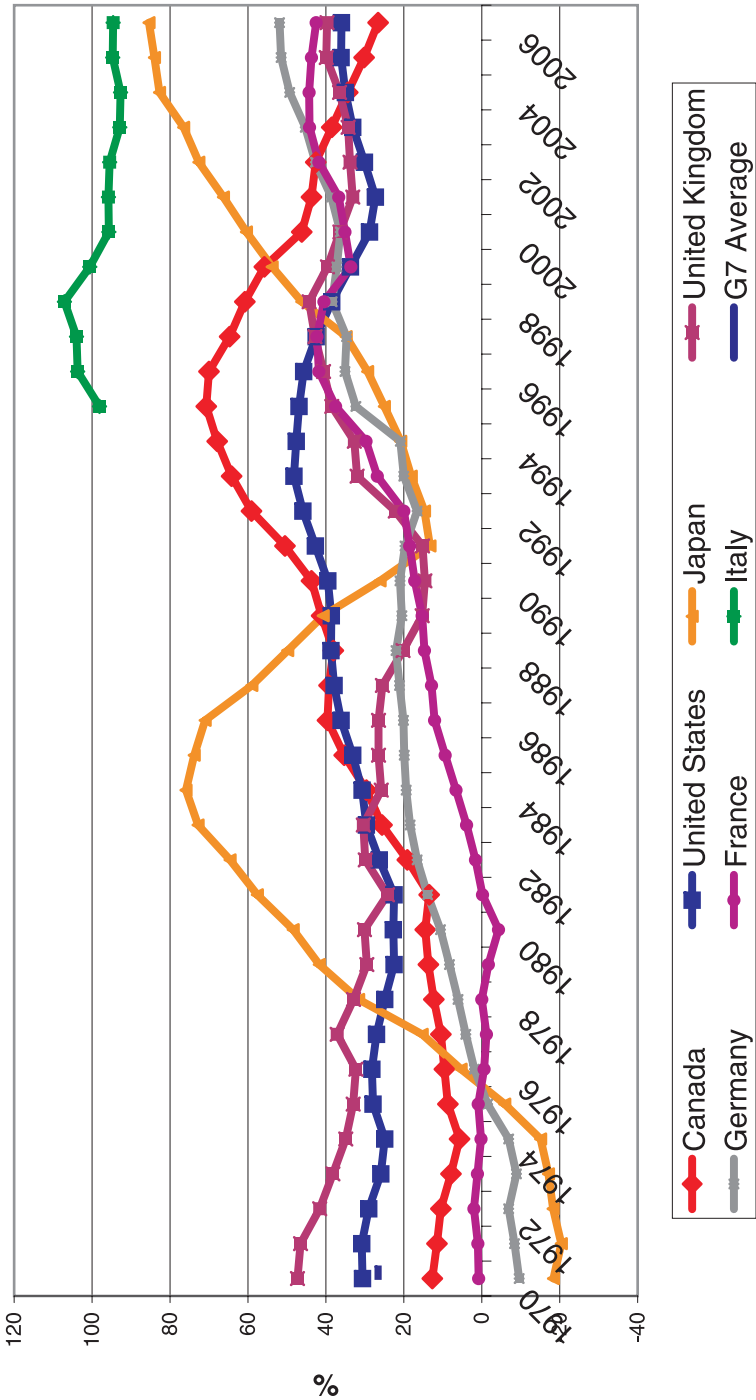
But aggregate provincial Medicare spending – doctors and hospitals – has not been rising relative to GDP (See the left-hand scale). Medicare took up virtually the same share of our national income in 2005/06 as it did a quarter of a century earlier. Total provincial spending on health took up a somewhat larger share, but this includes provincial spending on pharmaceuticals, which has been escalating rapidly. As is now well understood, sole-source funding permits cost control – fragmented financing does not. Costs have been contained in the Medicare programs, not in the mixed pub-

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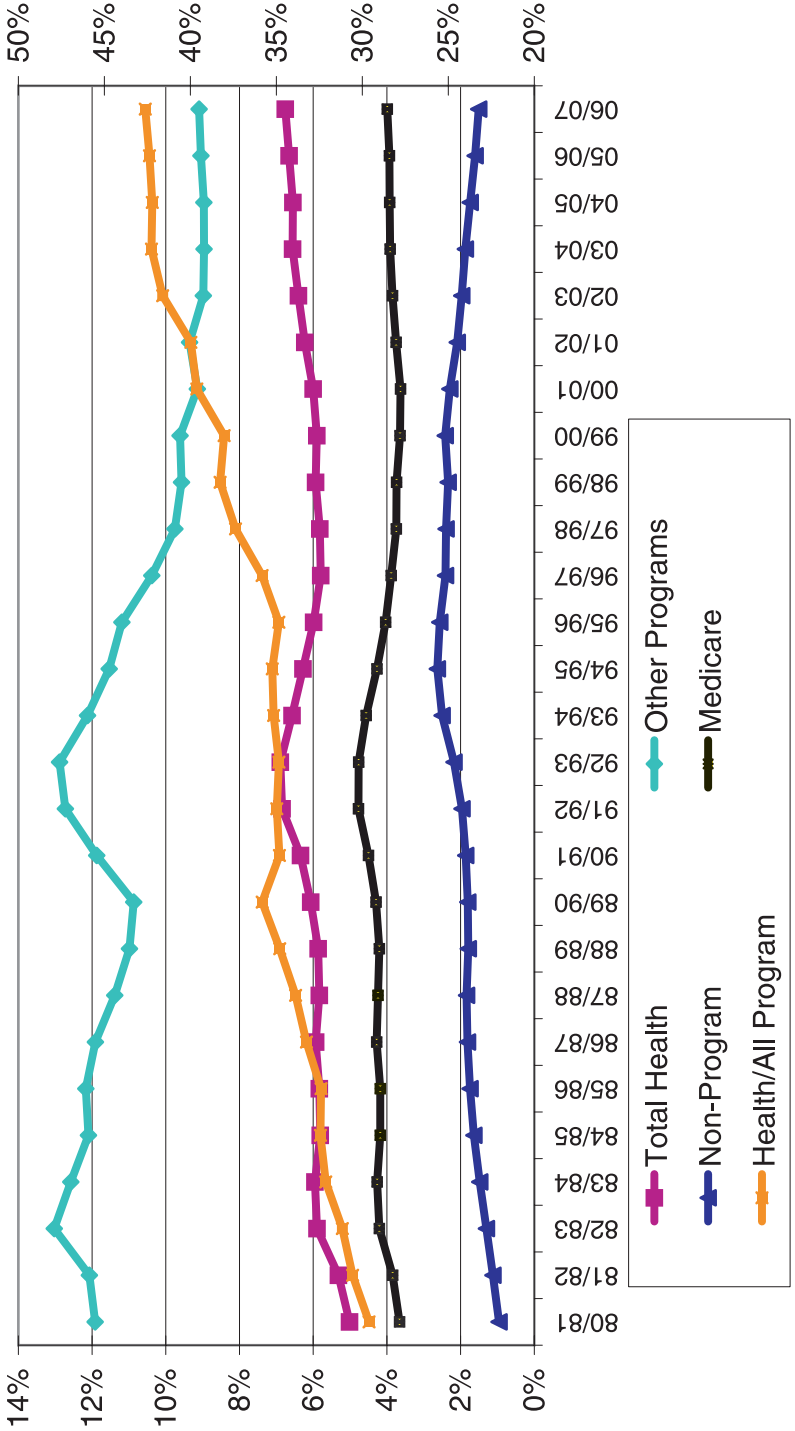
12 Here and subsequently, fiscal data are from the Fiscal Reference Tables compiled annually by Finance Canada. See Department of Finance Canada, “Fiscal Reference Tables,” online: Department of Finance Canada <<http://www.fin.gc.ca/purl/frt-e.html>>. Figure 3 is from Table #57. Health expenditure data are from Canadian Institute for Health Information, *National Health Expenditure Trends, 1975-2007* (Ottawa: Canadian Institute for Health Information, 2007).

13 This trend is primarily driven by growth in the economy. The debt itself has shrunk very slowly because federal surpluses have been small relative to the hundreds of billions in accumulated debt.

**Figure 2**  
**General Government Net Financial Liabilities (% of GDP)**  
**G-7 Countries 1970-2006**



**Figure 3**  
**Canadian Provincial Government Expenditures as percent of GDP**  
**1980/81 to 2006-07**



lic-private programs, which is why pharmaceutical manufacturers bitterly oppose universal Pharmacare. It is also why the Canadian Medical Association advocates more private payment to its members.

But the “Klein line” is – or was – real, so if Medicare spending was not taking up a larger share of national income, other provincial spending must have taken up a smaller share – and it did. Provincial spending on non-health programs fell steadily from 12.9% of national income in 1992/93 to 9.0% in 2002/03. Could this not reasonably be described as “crowding out,” even if health spending itself was not taking a larger share of income?

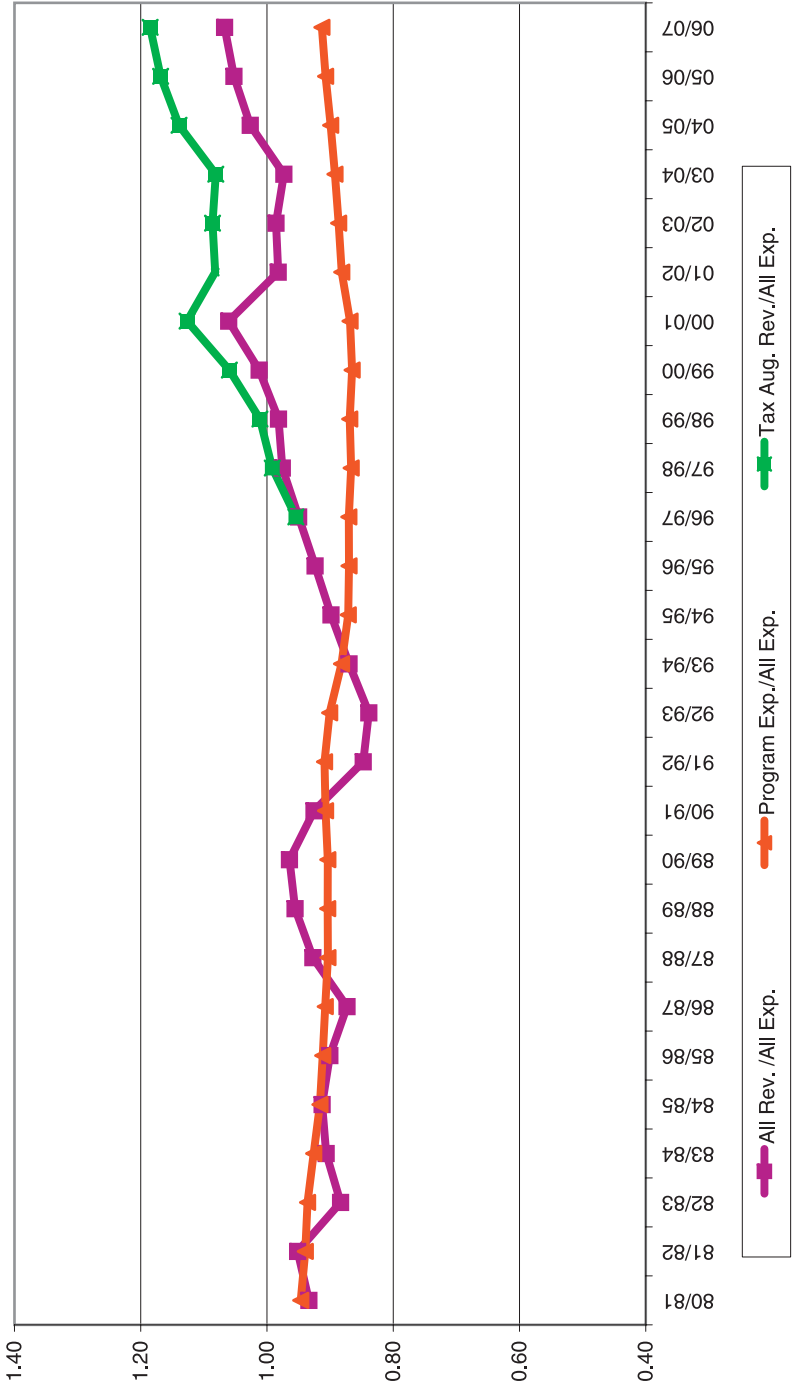
It could, except that Medicare was not taking up a larger share of provincial revenue either. Indeed, if provinces had not cut their tax rates, Medicare spending would be taking a steadily shrinking share of provincial revenue. Even after these cuts, Medicare’s revenue share is about where it was twenty years ago. Total health spending takes a somewhat larger share, but this is entirely attributable to the revenue foregone through tax cuts, not to “out-of-control” spending.

So the “Klein line” disappears when health spending is compared to provincial revenues rather than expenditures. This is why, when the B.C. Conversation on Health was announced, the provincial government doggedly insisted on referring to provincial expenditures as “the Budget” and refused to talk about revenues – even though for most people, it is total revenues, not other forms of spending, that determine the sustainability of a particular spending pattern.

Since health has taken a rising share of expenditures, but not of revenues, it follows that provincial revenues must have risen faster than expenditures – and they have. Figure 4 shows the ratio of provincial government total revenues to total expenditures. This ratio was below unity – in aggregate, provinces were in deficit – for the whole period prior to 1998/99. Since then, however, the ratio has fluctuated around unity, with small deficits and larger surpluses. If one adds back the revenue foregone through cuts in tax rates (as estimated by Finance Canada) the provinces would now be enjoying very large surpluses. Provincial governments, like the federal government, have chosen to use their greatly improved fiscal position as an opportunity to cut taxes. But these choices make nonsense of claims that the public health care system is fiscally unsustainable, financially out of control.

With the restoration of fiscal balance one might expect the “Klein line” to have stabilized – and it has (Figure 3). The “Klein line” was a reflection not of health spending per se, but of the process of restoring balanced provincial budgets, and that process, despite major tax cuts, is now complete.

**Figure 4**  
**Canadian Provincial Governments, Total Revenues over Total Expenditures**  
**1980/81 to 2006/07**



Meanwhile, however, the privatization agenda proceeds apace, so the “Klein line” has presumably served its political purpose.<sup>14</sup>

## Lost Opportunities? Clinical Practice Variations

While claims of fiscal unsustainability have dominated public debate, opportunities for really serious reform have been largely ignored. There are a host of small ways in which health care delivery can be improved, and costs lowered, that have been demonstrated in particular settings but are not taken up more generally. New techniques – and especially new drugs – that offer expanded treatment (and income) opportunities proliferate rapidly, but it is very difficult to get providers to do less, regardless of the evidence. “More is better” is deeply ingrained, as illustrated by the forty-year history of day care surgery.

Clinical practice variations, however, demonstrate powerfully the possibility of change. Patterns of care vary widely across regions, with no evidence of differences in patient needs or outcomes. As an example, Figure 5 shows age-sex standardized admission rates for common cardiac diagnoses (acute myocardial infarct, congestive heart failure, angina and “chest pain”).<sup>15</sup>

Admission rates in major Canadian cities varied from 508 per 100,000 in Vancouver, to nearly twice as high, 964 and 925, in Saskatoon and Kingston. Toronto (779), Ottawa (776), and Montreal (740) were all roughly fifty percent above Vancouver. The Canadian average rate (985) was higher still, nearly twice that in Vancouver, because admission rates are much higher outside major urban areas. But why?

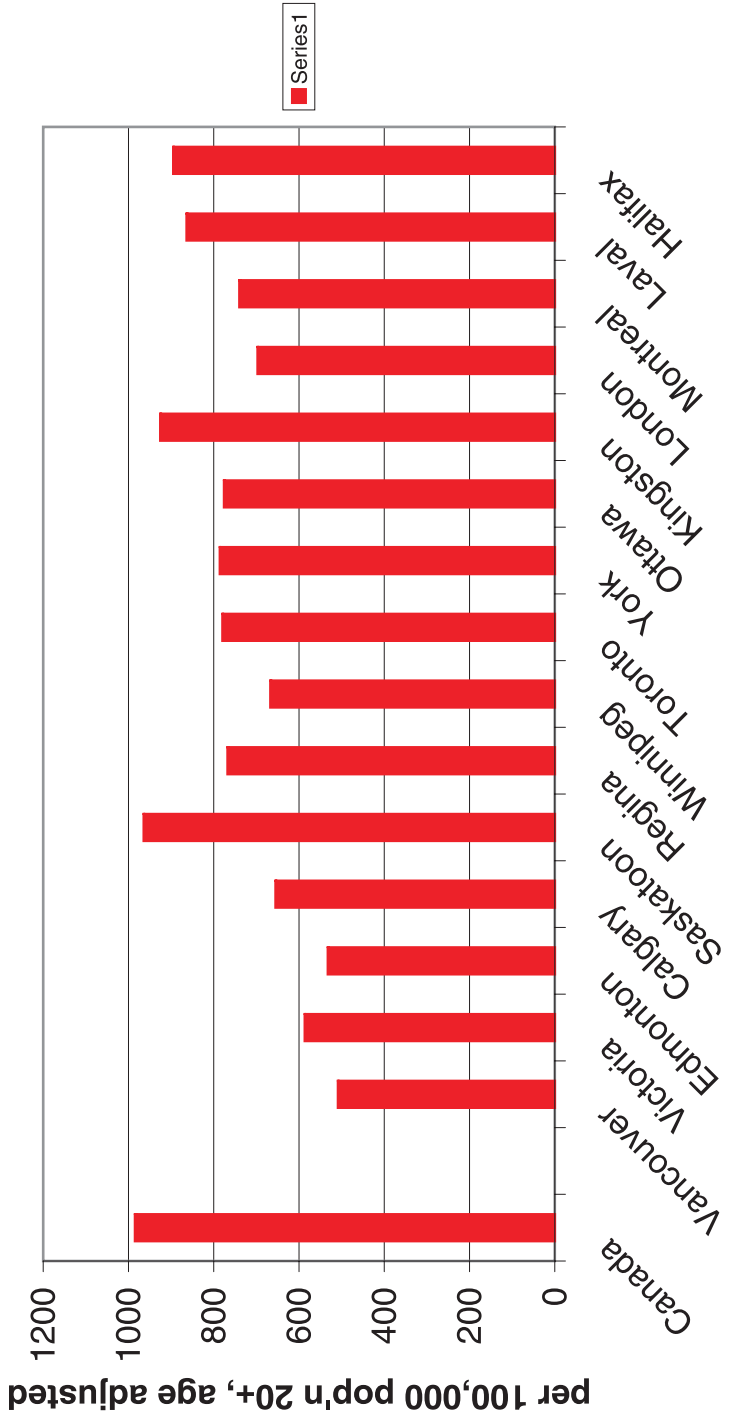
Are Vancouverites simply healthier than other Canadians (and Saskatoonians sicker)?<sup>16</sup> Are they being under treated and, if so, is their health

14 The claim of “unsustainability” continues to draw strength, however, from allegations that the aging of the population will in future generate unsustainable costs. Few propositions have been more comprehensively refuted by numerous detailed analyses, for over thirty years. Yet the mythical “grey tsunami” rolls on impervious to all evidence, because it sounds plausible and serves a well-defined political agenda.

15 Jack V. Tu, *et al.*, eds., *Canadian Cardiovascular Atlas: A Collection of Original Research Papers Published in the Canadian Journal of Cardiology* (Toronto: Institute for Clinical Evaluative Sciences, 2006).

16 In fact Vancouverites do have lower obesity rates than other Canadians, but no one has linked this to hospital admissions.

**Figure 5**  
**Hospital Admission Rates, Selected Cardiac Conditions**  
**Canadian Cities, 1996/97 to 1999/00**



suffering? Or are practice patterns in the east simply more conservative – and more costly – for no good reason, or at least none related to patient outcomes. Similar variations in the United States have been analyzed in great detail.<sup>17</sup> After adjusting for patient health status, regions with higher intensity of servicing and higher cost show worse outcomes – higher patient mortality – and no differences in self-reported patient satisfaction.

Such clinical variations have been observed in studies over the last forty years. Yet no one in provincial ministries of health, or hospitals, or among the medical community, seems to regard these findings as indicating an opportunity for reform. Contrary to the endless call for more money to support more hospital beds, staff and interventions, Canadians may on average be overusing in-patient care by a significant margin.<sup>18</sup>

And maybe not. The central point is that it has been nobody's job to find out – and to respond appropriately. Attempts to change practice patterns might lead to bruising encounters with the clinical community, most of whom are firmly convinced that whatever they are doing is right, whatever clinicians elsewhere may do. So the public discourse is dominated by claims of shortages. But what if Canadian cardiac admission rates could be cut in half, without risk to patients? That would be real reform. Only in Vancouver, you say? Pity.

There is no reason to assume that cardiac care is atypical, only unusually well documented, thanks to the *Canadian Cardiovascular Atlas*. One could assemble a wide array of other examples of variation in intervention patterns that lack any evidentiary base, and several analysts have. The information to support reform is “out there” in the research literature, and not at all obscure – indeed it is widely known among researchers. But very little happens. Instead the public (and to a considerable extent the politicians) are distracted by myths – by calls for redistribution, not reform.

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17 Elliott S. Fisher, *et al.*, “The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality and Accessibility of Care” (2003) 138 *Annals of Internal Medicine* 273; Elliott S. Fisher, *et al.*, “The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care” (2003) 138 *Annals of Internal Medicine* 288.

18 Our rates of inpatient use are well above those in the leading American health maintenance organizations.