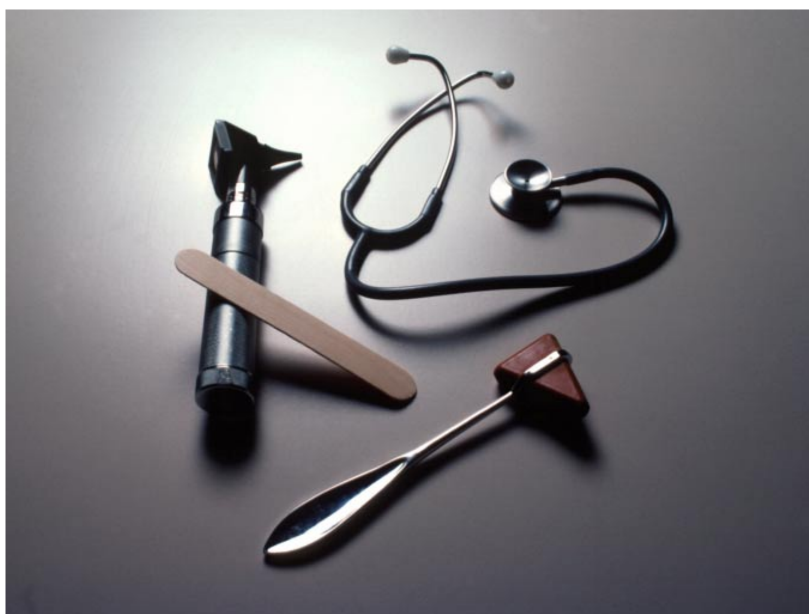
Health Care in Saskatchewan

-- Thinking Outside the Box --



News Release

SUBMISSION TO THE MEDICARE REVIEW COMMISSION
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Introduction

Health care is the number one issue for most Canadians.

Fifty-two percent of respondents in an May 2000 Angus Reid poll identified health care as their top national concern and another 90% identified it as the highest priority for our governments in the future. Why? The reason is clear from the same polling data: 80% of all Canadians believe the health care system is in crisis.

Even with the additional resources now being pumped into health care by governments, the future of health care in our country, and especially in Saskatchewan, remains threatened by demographic trends and the cost of new technology. Unless significant reforms are made to our system of health care, it will not be sustainable in the future. The Canadian Taxpayers Federation believes these reforms must be the focus of the Medicare Review Commission's final report.

We need a sustainable and effective health care system. It's time to modernize the *Canada Health Act* to include new principles like quality, accountability, sustainability, and choice. It's time to think outside the box.

The Condition of Health Care in Canada

Canadians deserve to hear the real story about the state of Medicare. The reality is that the five "sacred" principles of the *Canada Health Act* (universality, accessibility, comprehensiveness, portability, and public administration) are, for the most part, violated each and every day in Canada.

- Universality? Yes, we all have the universal right to queue up on a waiting list. A person living in Saskatchewan can wait twice as long as a patient in Ontario for some cancer treatments. And worker compensation boards purchase services from health facilities to avoid waiting lists and jump the queue.
- Accessibility? Increasingly, it's a function of where you live in Canada. For example, in-vitro fertilization (IVF) treatments are covered in some provinces but not in others.
- Comprehensiveness? Again, which services are covered largely depends on which province a person resides in, and what public administrators deem to be medically necessary.
- Portability? Sure, so long as a person has their chequebook to cover fee differences between provinces and insured versus non-insured services.
- Public administration? Yes, but private funding now represents 29% ($27.5 billion) of total health care spending in Canada. The private sector already effectively delivers many health care services including the operation of ambulances, nursing homes, and MRI clinics.

A May 1999 Angus Reid poll, commissioned by the Ontario Medical Association, found that 71% of Canadians want to change the *Canada Health Act* because the five founding principles do not meet the country's current health care needs. Clearly, public confidence in our current health care system is at an all-time low.

The politicians have been reading the polls and have responded by devoting more and more public spending. In September of last year, Ottawa and the provinces signed a five-year deal that will increase transfers to the provinces in support of health care by $2.8 billion in the fiscal year 2000-01, and will boost federal funding from $15.5 billion currently to $21.1 billion by 2005. The feds have also promised another $1 billion for new technology over the next two years, $800 million for primary care reforms, and another $500 million for a national electronic health information system.

The federal and provincial governments should be commended for acknowledging that there are serious problems facing health care. But simply pouring more money in the top is not the long-term answer. And by refusing to look outside the parameters of the existing *Canada Health Act*, policy-makers are excluding a wide range of potential remedies.

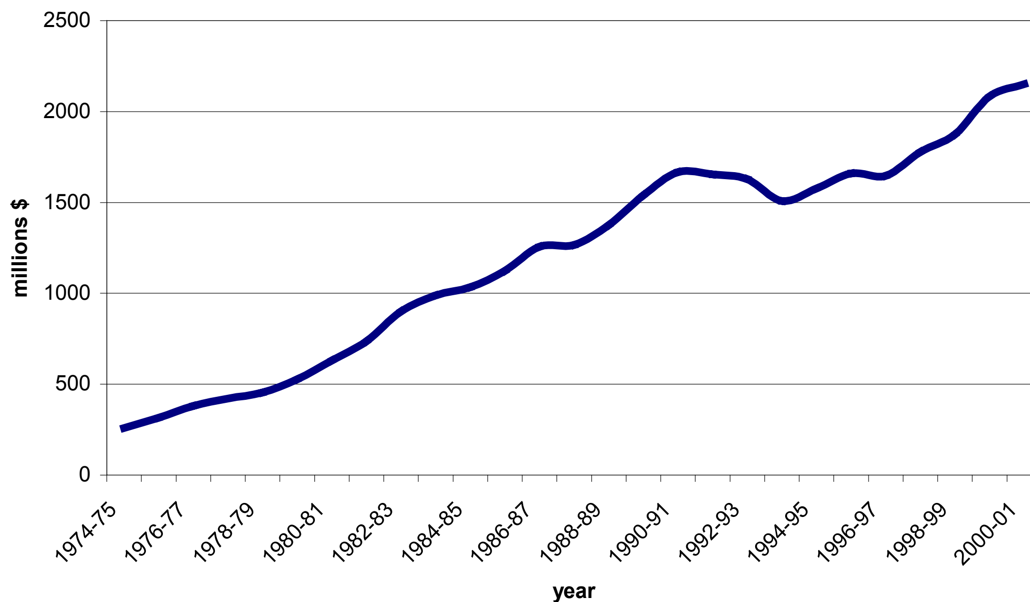
Health Care Costs Are Soaring

Over the past decade, health care has been in a perpetual state of crisis. The system's appetite for dollars seems insatiable.

Since 1980, health care costs in our country have exploded, rising much faster than inflation, population and GDP. Health care spending is rising sharply across Canada and now tops $95.1 billion in 2000. Public spending rose 6.7% in 1999 and 7.7% (forecasted) in 2000 for a total of $67.6 billion. Private health spending also grew, but at a slower rate: 4.5% in 1999 and an estimated 5% in 2000 for a total of $27.5 billion. Public and private health spending combined works out to $3,094 for every Canadian man, woman, and child.

Of every health dollar, hospitals account for the largest portion at 31.8% this year, down from 45.2% in 1976. By contrast, drug costs are growing sharply and now represent 15.5% of total health spending in 2000. Spending on physician services fell to a record low of 13.5% of every health dollar in 2000 from a high of 15.7% in 1997. That figure is expected to rise again in the near future as new salary and service agreements between doctors and various provincial governments take effect.

In Saskatchewan the upward trend is the same. Health care expenditures have been increasing at a rate of about 8% each year for the past three years, including a 11% jump in 1999-2000 (see chart).



A Strong Health Care System Needs A Strong Economy

Obviously, a strong health care system needs a strong and growing economy to support it. This is particularly true in a time of rising health care costs due to technological advances and demographic trends.

<u>We therefore oppose higher taxes or health care premiums, because higher taxes are an attack on the economy's ability to support the health care's long-term funding needs.</u>

Saskatchewan already has some of the highest taxes in Canada. We need reduced taxes to attract more investment, create new jobs, and improve the standard of living of Saskatchewan residents. Higher taxes will only suppress economic potential of the province and encourage out-migration of people and business.

A smaller, poorer tax base cannot support our growing health care needs. But a larger, more prosperous tax base can support health care at reasonable tax rates. This is what we should be striving for.

<u>More jobs mean healthier individuals and a healthier economy to support health care costs.</u>

The provincial Medicare Review Commission's "Caring for Medicare" paper says that poverty and associated problems (poor nutrition, poor housing, lack of education and opportunity, etc.) are at the root of many health care problems. A strong economy that produces good jobs and good wages is obviously the best way to combat the poverty of individuals, families, and communities. A stronger provincial economy will also be better able to support needed social and educational programs.

<u>Again, we need lower taxes, not higher taxes and premiums, to grow wealth and jobs in the province and combat poverty.</u>

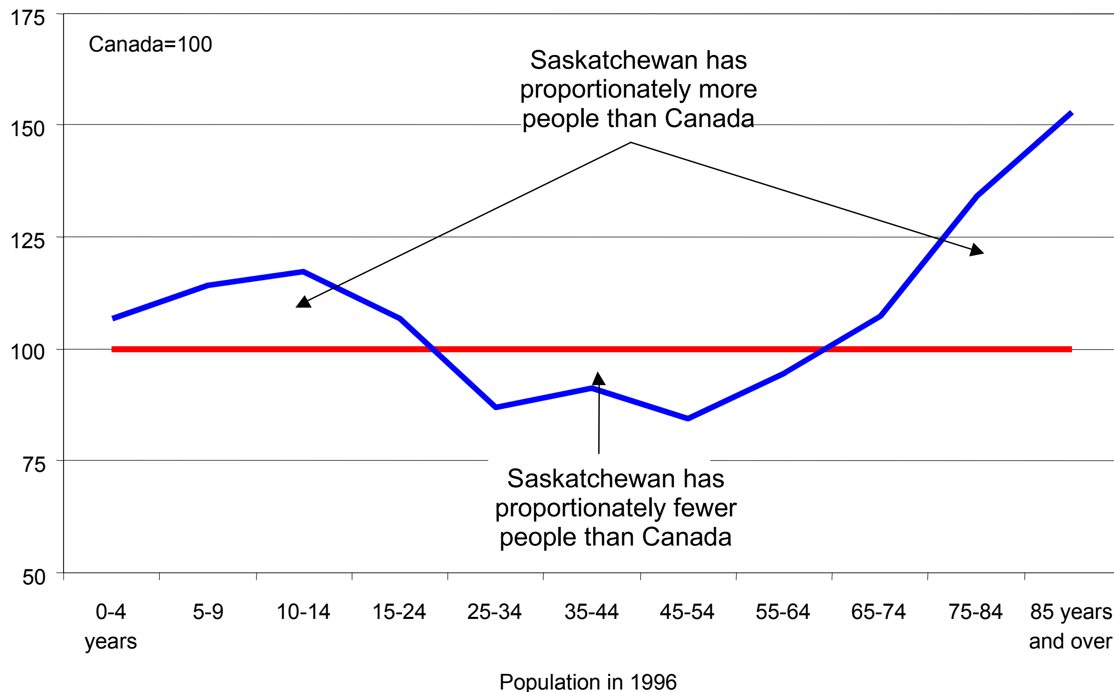
The Demographic Challenge

One of the most important issues facing the long-term wellbeing of Canada's health care system is the changing demographics in our country and our province.

Canada has an ageing population. In 1966, the ratio of workers to retirees was 8 to 1. It is currently 5 to 1 and in less than two decades it will be 3 to 1. Obviously, these statistics will have important ramifications not only for our public pensions, but for our health care as well.

Saskatchewan suffers from a triple whammy. First, our province has a stagnant population. Saskatchewan's population only grew by 0.3% from 1991-1999.

Population Age Groups, Canada and Saskatchewan



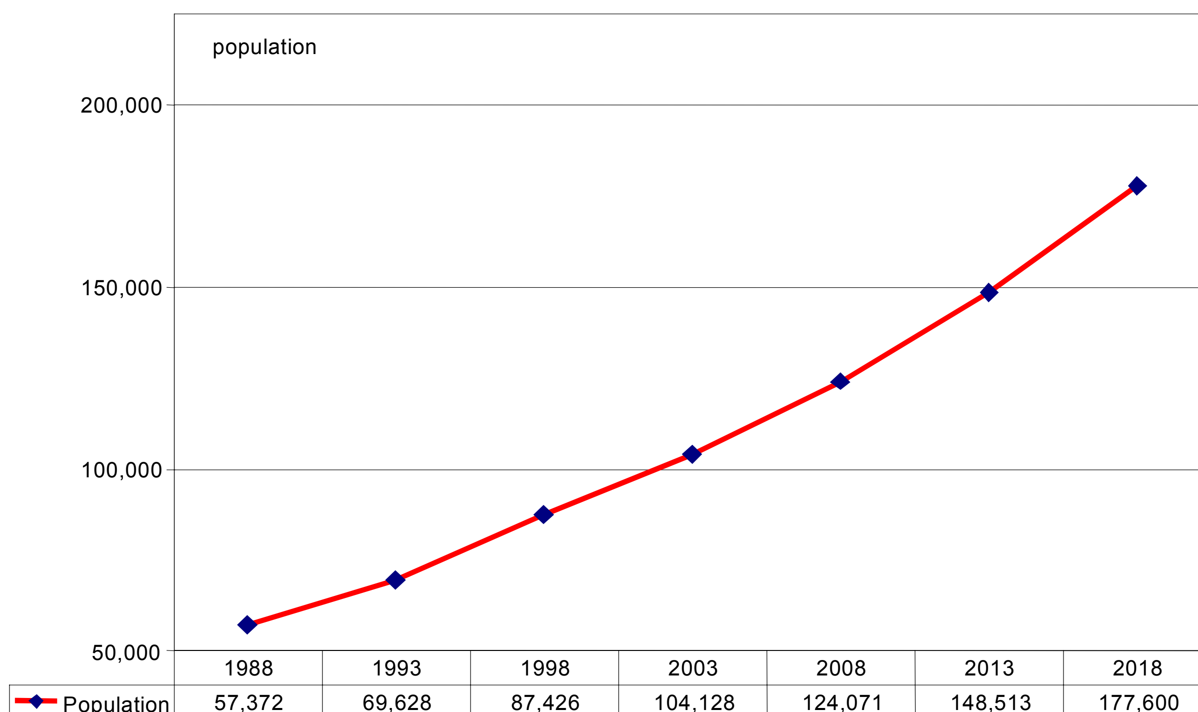
Second, we have a rapidly ageing population. Compared to the rest of Canada, we have the highest number of seniors and children compared to working age people. That dip in the middle of the graph is where our working people should be, instead of working in other provinces.

Part of the reason Saskatchewan has Canada's oldest population because so many young working-age people leave due to lack of economic opportunity at home.

The fact that our province has the highest proportion of people 65 and older is doubly important since providing medical services for seniors accounts for approximately 50% of all health care expenditures.

And third, our Native population is also growing dramatically in relation to the rest of the population - at a pace of 3% to 4% per year. This is an issue for a couple of reasons. The “Caring For Medicare” paper suggests that poverty leads to more health problems and higher health care costs; and our Native population certainly tends to be poorer than the rest of the population. Being poorer they are also less able to pay taxes, and (moreover) Treaty Indians are eligible for several tax exemptions that may grow as a result of current court actions.

Registered Indian Population Projection
(constant fertility and mortality, 1988 to 1998 migration)



	1988	1993	1998	2003	2008	2013	2018
Population	57,372	69,628	87,426	104,128	124,071	148,513	177,600

If the number of Native people in Saskatchewan rises to a third of the population in 25 or 30 years as is predicted, and they are not paying taxes, it would mean the starvation of funding for important social programs like health care upon which many Native people themselves rely upon.

As a result of all these trends, Saskatchewan’s tax base may have limited potential to expand to pay for increased health care costs. So change is not a matter of “if”, but of “when” these demographic changes and other trends will force a change to the status quo. Otherwise, the inevitable result will be further rationing, a massive tax increase, more patients being forced to the U.S. for treatment, or a combination of all three.

Health Care's Unfunded Liability

As a result of the way that the health care system is structured and funded, a massive unfunded liability has been created. In other words, under the present arrangements, current and future generations of taxpayers have made a promise - indeed assumed an obligation - to provide comparable health care in the future.

A brief comparison is helpful: Canada's public health care is a 'pay-as-you go' system, just like the Canada Pension Plan (CPP). Rather than accumulating and building funds in savings accounts now to pay future bills, current contributions (payroll deductions in the case of CPP, and general tax revenues in the case of health care) are used to pay for current costs.

Both programs have massive unfunded liabilities. The future liability of the Canada Pension Plan is an incredible $485 billion. The future liability in the health care system, however, is an unbelievable $1.2 trillion dollars. That amount represents our current obligation to provide health care in the future. To put this in perspective, the unpaid liability of the health care system exceeds the total direct debt of all governments in Canada by almost 300%! This is an enormous obligation on our government and, of course, future taxpayers.

A recent study by the Association of Pension Managers suggests that public spending on pensions and health care could rise from 13% of economic output to 23% in 2030. According to other actuarial reports, in order to fund the current level of health care if we were to pay for it through raising taxes it would require either:

- A 70% increase in federal and provincial personal income tax rates,
- A 400% increase in the GST from 7% to 35%, or
- An increase in payroll taxes to 17% of gross pay.

How can we possibly pay for this?

The missing link is capitalization. In other words, setting aside money for your future retirement (in the case of the CPP) or your future health care. The government has recognized this with the CPP. It is currently investing part of the excess CPP premiums to build a fund from which baby boomers can draw benefits when they hit retirement age. But in health care, the government steadfastly refuses to plan for future health care. Governments need to take immediate steps to address this massive unfunded liability, and also to protect patients – who should not, and need not, suffer because of the failure of our governments to recognize the extent of this problem.

But in the meantime, waiting lines continue for a wide range of services in every province, and an ever-ageing population will place increasing and tremendous pressures on the health care system. Unless governments take action soon, these pressures will inevitably lead to much higher taxes, or a further reduction in health services, including even longer waiting lists.

Finding the Funds and Controlling the Costs

If capitalization is a long-term project to fund future health care costs, where do we get the money to seed it? And how do we pay for immediate needs if not through higher taxes?

Prioritize Spending

If more funding is needed for health care, some of it should come from cuts in more wasteful or less important programs. But health care already consumes 40% of the provincial budget. Realistically, the financial sustainability of our health care system must be achieved through greater efficiency in health care itself or by finding funds elsewhere.

Private Funding

74% of health care spending in Saskatchewan is public spending, compared to the Canadian average of 70%. This suggests there is some minor room to expand the role of individuals and private insurers in funding health care in Saskatchewan.

Canadians seem willing to undertake a greater role in funding their own health care needs. In an August poll, 58% of Canadians supported restricting Medicare to “a set of core services.” A poll in February of 1999, 61% of Canadians agreed that they “should be allowed to buy any surgery or lawful medical service they want.”

Efficient Spending

Ultimately, the financial sustainability of our health care system must be achieved through greater efficiency and better allocation of resources, not simply the application of more public or private funds.

The Americans, for example, spend much more than we do (both privately and publicly) for a health care system that is in many ways inferior to ours. A recent study of Canadian health care by Martin Zelder of the Fraser Institute showed that increased health care spending did not improve health care outcomes (i.e. reduced waiting times) except in drug spending and capital spending. This indicates that we are often not getting the best bang for our health care buck.

So how do we allocate existing health care dollars more efficiently?

Finding Savings

The capital costs of construction, high-tech equipment, etc., might be minimized by contracting-out to privately-run facilities. If doctors are competing for the public health care system’s business and providing their own infrastructure, savings could be

substantial. Better home care programs could also minimize the need to construct and staff new facilities.

Using market tools to control costs?

Zelder's study suggests that the health care system as it operates in Canada does not channel funds to where they are needed most. The public health care system has no efficient control on costs, and no "non-bureaucratic" means of allocating resources. Since Medicare is a "free service" to the health care consumer, and physicians are paid on a "fee for service" basis, there are powerful incentives to overuse or misuse the system. The introduction of "efficiency incentives" is needed.

Doctor-based efficiency incentives.

One option is the so-called "capitation model" which pays physicians on a per-patient basis, rather than fee-for-service basis, thereby encouraging them to use the system more efficiently. This is currently being explored in Ontario (primary care reform) and is not dissimilar to the operation of health maintenance organizations in the U.S.

But making physicians the financial gatekeepers of the health care system might pit them against their patients, who are not impacted by the costs of using health care. Both doctors and patients have to be involved if efficiency incentives are to work.

Consumer-based efficiency incentives

Several researchers have looked at ways and means of giving individuals control over their own portion of public health care spending to encourage cost savings. All these proposals have some things in common:

1. They promote the efficient spending of public money in a publicly funded health care system through financial incentives to health care consumers.

2. They are not intended to raise money, but to control costs.

3. They empower consumer choice in health care, and rely on the ability of doctors to compete with one another on costs and fees.

4. They do not inhibit access to the health care system.

For example:

- David Gratzer, the author of Code Blue, proposes giving everyone a medical savings account for the first few hundred dollars of health care needs each year. If the account runs out in a certain year, you pay for costs "out of pocket" until you reach the deductible on your insurance. But if you don't exhaust your account in any one year, the surplus is carried forward for future medical expenses.

- The Consumer Policy Institute (CPI) proposes health care allowances that are replenished yearly by the government. If you spend your allowance you pay out-of-pocket until insurance kicks in. If you don't spend your allowance, half goes back to the government, and the other half you keep for future medical expenses and eventual investment in an RRSP. CPI wants certain preventative health measures to remain completely "free".

- James Gilles of York University proposes giving everyone a publicly-funded health care debit card. Once the card runs out the insurance kicks in, but any unused amount on the debit card in any single year is awarded to you as taxable income.

- Robert Macintosh, former head of the Canadian Bankers Association says that an individual's health care costs should be added to their tax bill at the end of the year as a "taxable benefit". There would be a ceiling to protect against catastrophic costs and exemptions for the disabled, seniors, dependants, etc.

These are innovative proposals for enlisting health care consumers in the battle to contain health care costs and make health care spending more efficient. We recommend that the Saskatchewan be a "test bed" for such proposals.

Conclusion

The ability of Canada's governments to finance our health care system is in dire need of reform. Our policy-makers must prescribe remedies now to effectively deal with important demographic and technological challenges that threaten its sustainability.

Securing the future of health care means building a strong Saskatchewan economy.

The Commission's "Caring for Medicare" discussion paper fails to connect the demographic realities facing our health care system and our economy. The prospect of an older and relatively poorer population, increasingly dependent on health care, is a looming disaster for health care and other services in Saskatchewan.

We need more jobs in Saskatchewan and more gainfully employed working-age people to support health care and other necessary social services. We need lower taxes, not higher taxes and premiums, to build this future.

Securing the future of health care means saving now for the future of health care.

Demographic changes and other trends, like more expensive technologies, will force a change to the Canadian system. Capitalization must occur or the pay-as-you-go approach to health care will result in further rationing, a massive tax increase, further health care demand shifted to the U.S., or a combination of all three.

Securing the future of health care means enlisting patients to help control costs.

There are several innovative proposals to encourage the efficient allocation of public health care resources by giving "consumers" more control over health care spending. Saskatchewan should test and evaluate these proposals.

Securing the future of health care requires thinking "outside of the box".

So thick is the mythology surrounding Medicare that honest and open discussion of its future has become the political equivalent of kryptonite. We fear that our inability to discuss its shortcomings will prevent us from making progress towards solutions. How tragic it would be if Medicare died on the table because we lacked the foresight, the flexibility, and the courage to do what is needed to save it.

There is a saying that "Only Nixon could go to China." In the same way Saskatchewan, as the birthplace of Medicare, may be the place where serious reforms must spring from. To a country full of politicians who are afraid to even discuss health care, we must find the foresight, the flexibility, and the courage to show the way.