



**Population Aging, Health Care
Spending and Sustainability:
Do we really have a crisis?**

by

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September 2002

ISBN: 1-55282-027-4

Introduction

Health care reform has become the leading policy issue in Canada. A special report on health care reform has been submitted to the Alberta government and is being used as the framework for policy decisions in that province; the Standing Senate Committee on Social Affairs, Science and Technology is investigating the issue and will release a full report early this fall; and a special Commission on the Future of Health Care in Canada appointed by the federal government will report by the end of the year. The major thrust of all this research and consultative activity is the perception that escalating costs make the current structure and financing of health care in Canada unsustainable.

The issue of sustainability is the main subject of this paper. I identify three aspects of sustainability. The first relates to the ability of the economy to sustain current and projected levels of health care spending. The second issue involves the capacity of the full fiscal system (all governments combined) to withstand the pressures of rising health care expenditures. The third concern focusses on the ability of provincial/territorial governments to fulfill their constitutional commitment for the provision of health care. The analysis shows that if there is an issue of sustainability, it is confined to the third aspect. It is simply another dimension of the vertical fiscal imbalances that have developed in the Canadian fiscal system.

The paper is divided into two parts. The first part deals with the past and the present, while the second part takes a look at the future. Each part evaluates the three aspects of sustainability identified above.

Past and Present: 1980-81 to 2000-01

To place the current situation in perspective, Table 1 shows the major dimensions of total health care spending (public plus private) in Canada over the past 20 years.

Inspection of Table 1 leads to the following observations:

- In fiscal year 2000-01, Canadians spent nearly \$100 billion on health care; \$29 billion was spent directly as private expenditures and \$69 billion indirectly through public funding.
- 43 percent of total health care spending is for hospitals and other institutions; an additional 15 percent goes to drugs; payments to physicians through fee for service account for 14 percent of the total.
- Over the past 20 years, total health care spending in Canada increased, on average, at an annual rate of 7.4 percent; public spending on health, however, increased at a lower rate than private spending.

Table 1
Dimensions of health care spending in Canada,
selected fiscal years

	Health care spending \$ billions			Average annual percentage change in spending		
	1980-81	1992-93	2000-01	1980-81 to 1992-93	1992-93 to 2000-01	1980-81 to 2000-01
Health care spending						
public	17.5	52.3	69.0	9.6	3.5	7.1
private	5.8	18.7	28.6	10.3	5.4	8.3
total	23.3	71.0	97.6	9.7	4.1	7.4
hospitals and other institutions	12.7	35.1	42.0	8.8	2.3	6.2
physicians	3.6	11.4	13.8	10.0	1.6	6.9
other professions	2.3	7.2	11.1	9.9	5.5	8.1
drugs	2.0	8.7	14.8	13.1	6.8	10.6
home care	0.3	1.7	3.7	15.1	10.4	13.2
other	2.4	6.9	12.2	9.5	7.4	8.7
total	23.3	71.0	97.6	9.7	4.1	7.4

Source: Author's calculations based on data contained in Health Canada (2001).

- The fastest growth of both public and private health spending occurred from 1980-81 to 1992-93; over the most recent eight years of the sample period, the growth rate was cut in half.
- Over the entire period, the fastest-growing components of health care spending were home care, drugs and other professionals. The last two items involve largely private expenditures, and their rapid growth explains why private spending grew at a faster rate than public spending.

a. Economic sustainability

For the first aspect of sustainability, I compare total health care spending – public plus private – to measures of economic activity, specifically Gross Domestic Product (GDP) and consumer spending. The ratio of health care spending to GDP is shown in Table 2. The information contained in this table provides no support to the notion that the Canadian economy cannot support current levels of health care spending.

Total spending on health care accounted for 7.2 percent of GDP in 1980-81. Because of the fast growth of health spending in the 1980s, this ratio rose to 10.0 percent in 1992-93. Fiscal restraint in the 1990s reversed this upward trend so that the ratio was down to 9.1 percent by 2000-01, a level closer to that of 10 years earlier.

Public spending on health care diverted 5.4 percent of GDP to the public sector in 1980-81. At its peak in 1992-93, this ratio had increased to 7.4 percent, then fell steadily reaching 6.4 percent in 2000-01 – a ratio slightly higher than during the later part of the 1980s. For the two major components of public health care spending – payments to physicians and hospitals plus other institutions – the ratio of expenditures to GDP followed an inverted-U shape, increasing from 1980-81 to 1992-92 and then falling; the 2000-01 level was similar to that 20 years earlier.

As an alternative measure of economic sustainability, I related health care spending to consumer expenditures by deriving a measure of adjusted consumer spending which includes public expenditures on health care. I assumed that health care services are delivered by the private sector and are purchased at a price like any other private good, but that this change from public to private delivery does not affect the total amount spent. In effect, the amount of government revenue collected to pay for publicly funded health care is returned to taxpayers, thus reducing the size of the

Table 2
Health care spending as percentage of GDP,
selected fiscal years

	Fiscal year		
	1980-81	1992-93	2000-01
Health care spending			
public	5.4	7.4	6.4
private	1.8	2.6	2.7
total	7.2	10.0	9.1
hospitals and other institutions	3.9	5.0	3.9
physicians	1.1	1.6	1.3
other professions	0.7	1.0	1.0
drugs	0.6	1.2	1.4
home care	0.1	0.2	0.4
other	0.7	1.0	1.1
total	7.2	10.0	9.1

Source: As in Table 1; Statistics Canada, CANSIM II, Table 380-0001.

Table 3
Health care spending and consumer expenditures,
selected fiscal years

	Percentage of adjusted consumer expenditures		
	1980-81	1992-93	2000-01
Health care spending			
hospitals and other institutions	6.4	7.2	6.0
physicians	1.8	2.4	2.0
other professionals	1.2	1.5	1.6
drugs	1.0	1.8	2.1
other	1.2	1.4	1.8
total	11.8	14.6	14.0
Consumer expenditures			
tobacco and store-bought alcohol	4.0	3.9	3.1
restaurant and accommodation services	6.8	6.0	6.3
transportation and communications	13.8	12.8	15.0
recreation and entertainment	6.6	6.9	8.4
personal care	1.5	1.7	1.7
financial and legal services	4.1	4.7	6.0

Source: As in Table 1; Statistics Canada, CANSIM II, Table 380-0009.

government budget by the same amount on the revenue and spending sides. Similarly, taxpayers receive an increase in their budget equal to the revenue foregone by government, but must pay directly for the health care services they receive.

The ratio of total health care spending – which is treated entirely as private spending – to the adjusted value of consumer expenditures is shown in Table 3. Because health care spending is now treated like any other privately provided good or service, we can compare its share of the consumer budget to the share of other consumer goods and services. Table 3 shows that in 2000-01, health care spending accounted for 14 cents of each dollar of adjusted consumer spending, up by 2.2 cents from 1980-81. In 2000-01, Canadian consumers spent a larger portion of their adjusted spending budget on transportation and communications (15.0 percent) and on the sum of recreation, entertainment, restaurants and accommodation services (14.7 percent). The share of spending on physicians (2.0 percent) was slightly higher than the share of personal care expenditures (1.7 percent) and substantially lower than spending on tobacco and store-bought alcoholic beverages (3.1 percent). In 2000-01, Canadians spent the same share of their adjusted budget on financial and legal services (6.0 percent) as on hospitals and other institutions (6.0 percent).

b. Fiscal sustainability

The information contained in Tables 2 and 3 above does not support the notion that, either as income earners or as consumers, Canadians cannot afford the current level of health care spending. We spend on health care only 9 cents of each dollar of output produced by the economy. As consumers, we dedicate a smaller portion of our adjusted collective budget to health care than to the combination of recreation, entertainment, restaurants and accommodation services.

One may argue that, given the public funding of our health care system, the debate on sustainability involves government and not consumer budgets. To address this issue, I now turn to the second aspect of sustainability by evaluating the pressures that health care spending places on public finances. In this case, the measure of health care spending is confined to public spending only and the government sector includes federal, provincial/territorial and local governments. The ratio of public spending on health care to total government spending is shown in the first column of Table 4. Analysis of this table leads to the following observations:

- The proportion of total government revenues dedicated to financing health care increased steadily from 1980-81 to 1992-93, when it reached its peak value of nearly 17 percent.
- During the following eight years, this ratio followed a downward trend. In 2000-01, government spending on health care used up nearly three nickels out of each dollar of government revenue, a value only slightly higher than in 1980-81.

Table 4
Public health care spending as percentage
of government revenue, selected fiscal years

Fiscal year	Public health care spending as % of government revenues	Provincial health care spending as % of provincial revenues
1980-81	14.3	28.4
1985-86	15.7	30.6
1990-91	15.9	31.8
1992-93	16.9	34.8
1995-96	15.0	29.7
2000-01	14.6	30.5

Source: As in Table 1; Statistics Canada, CANSIM II, Table 380-0007 and CANSIM I, Matrix 8476.

Now I turn to the third aspect of sustainability, namely the fiscal capacity of provincial and territorial governments to finance health care spending. The ratio of provincial/territorial spending on health care to combined revenues is shown in the second column of Table 4, which gives rise to the following observations.

- As in the case of the public sector as a whole, the share of provincial/territorial revenues claimed by health care spending increased during the first 12 years of our sample period, rising from 28 percent in 1980-81 to nearly 35 percent in 1992-93.
- In the following eight years, the ratio of provincial/territorial health expenditures to the combined revenue of those governments fell; by 2000-01, the share of provincial/territorial revenues dedicated to health care was 30.5 percent or just 2.1 percentage points higher than 20 years earlier.

It seems to me that the trends in health care spending and government revenues do not lend support to the notion that Canadians are currently faced with a fiscally unsustainable situation. We are back to the situation we faced 20 years ago. If there is a sustainability problem with health care, it must be a future problem. The dimensions of this potential problem will be explored in the next section.

The Future

The growth of health care spending depends on the growth of the population, the change in the age structure of the population, the growth of health care costs per person within each age group, and the interactions among these factors. The age structure matters because the average cost of health care is higher for seniors than for others. The growth of the cost per person depends on the inflation rate and the growth of real costs which, in the future, depends on advances in diagnostic treatment, pharmaceutical technology and efficiency in the utilization of human and non-human resources.

In this section, the effect of future trends in the factors affecting health care costs will be analyzed within the framework of the three aspects of sustainability discussed earlier. The calculations performed for this section are based on the maintenance of the status quo. These projections basically assume that both the existing quality of health care services and the existing cost structure will persist into the future. Some of these assumptions will be relaxed in a subsequent section.

a. Population aging, health care spending and GDP

Population aging in Canada is not a new phenomenon. As shown in Table 5, the share of seniors (65 and older) in the total population edged up over the past 20 years, increasing from 9.4 percent in 1980 to 12.5 percent in 2000 (or an average of .16 percentage points per year). The special feature of the future is that the population aging process will accelerate as the share of the senior population is projected to increase at the rate of .34 percentage points per year over the next 25 years. By the year 2026, Canadians over the age of 65 will represent more than one-fifth of the total population.

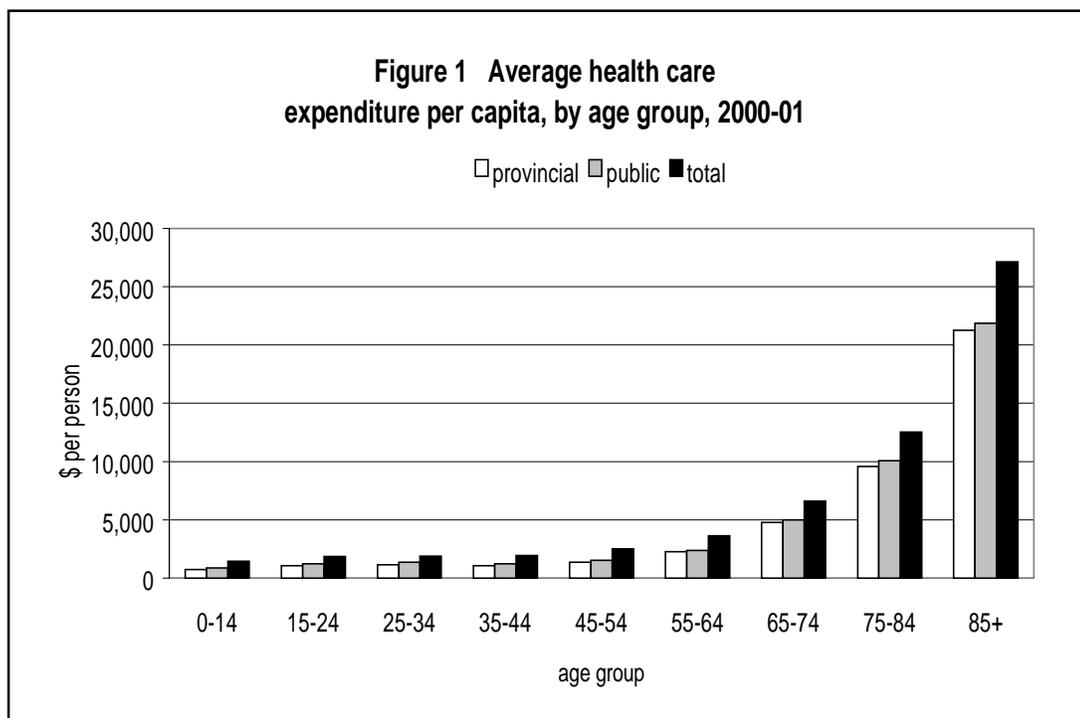
This rapid aging of the population will put pressures on the health care system because health care costs are much higher for seniors than for non-seniors. The data from Health Canada provide a breakdown of health care spending by selected age groups. As shown in Figure 1, the average cost of health care per person in the age group 65-74 is more than three times the average cost per person in the 25-44 age group.

In order to analyze the first aspect of health care sustainability, it is necessary to develop two projections, one for total health care spending and one for GDP. The assumptions used in the development of these projections are discussed in the Appendix. To quantify the effect of population aging, I produced two projections of health care costs. The first projection incorporates the projected growth of the total population, the assumed rate of inflation and the escalation of real costs, but leaves the age distribution of the population unchanged as it was in 2000. The second projection includes the projected change in the age distribution of the Canadian population.

Table 5
Population shares by selected age groups,
selected years, 1980 to 2026

Fiscal year	Percentage of population, by age group		
	65+	75+	85+
1980-81	9.4	3.5	0.8
1990-91	11.3	4.5	1.0
2000-01	12.5	5.6	1.4
2011-12	15.9	7.0	1.8
2021-22	19.5	8.5	2.3
2026-27	21.4	9.5	2.6

Source: Health Canada (2001); Statistics Canada (2001).



Source: Author's calculation based on data from Health Canada (2001).

As shown in Table 6, in the absence of population aging, the degree of sustainability of health care spending would improve in the future because such spending would claim a declining share of GDP. The first column of Table 6 shows that, in 25 years, health care spending would account for only 8.4 cents out of each dollar of output – 16 percent less than its peak value in 1992-93.

Adding population aging reverses this potential downward trend. The second column of Table 6 shows that the combination of population growth, population aging and increases in per capita costs by age group will result in a steady increase in the share of GDP directed at financing health care spending.

In my view, these increases do not reach crisis proportions and do not justify cries of unsustainability. Even with faster rates of population aging, 14 years from now (2016) health care spending will still be only 10 percent of GDP. Twenty-four years from now (2026), at 10.8 percent, it will be lower than the current ratio in the US and less than 10 percent higher than it was in 1992-93. If there is going to be a sustainability issue with health care spending in the future, it must have a fiscal dimension because – in terms of its share of GDP – health care spending is quite sustainable.

Table 6
Government spending on health care as percentage
of total government spending, selected fiscal years

Fiscal year	Without population aging (%)	With population aging (%)
2000-01	9.1	9.1
2006-07	8.9	9.4
2011-12	8.7	9.6
2016-17	8.6	10.0
2021-22	8.5	10.3
2026-27	8.4	10.8

Source: Author's calculations.

b. Health care and government sector revenues

In this section, I evaluate the issue of fiscal sustainability for the total government sector by relating the projected health care expenditures to the projected government revenues (details of the revenue projection are found in the Appendix). The information contained in Table 7 does not support the notion that, for the government sector as a whole, projected health care spending for the existing quality of health care is fiscally unsustainable. In 2000-01, 14.6 cents of each dollar of total government revenues were spent on health care. In the absence of population aging, the projected amount would fall steadily over the next 25 years by about 1.2 cents. With population aging, this amount would increase over the same period by 3.2 cents. Still, 25 years from now, the government sector would be allocating less than 18 cents of each revenue dollar to health care.

Table 7
Health care spending as percentage of GDP,
with and without population aging, selected fiscal years

Fiscal year	Without population aging (%)	With population aging (%)
2000-01	14.6	14.6
2006-07	14.2	15.1
2011-12	14.0	15.7
2016-17	13.7	16.3
2021-22	13.6	17.0
2026-27	13.4	17.8

Source: Author's calculations.

c. Health care and provincial/territorial government revenues

The delivery of health care services is a major responsibility of provincial/territorial governments. Therefore, a more appropriate evaluation of fiscal sustainability would involve the relationship between provincial/territorial expenditures on health care and their revenues (details of how these revenue projections were derived are found in the Appendix).

Table 8 presents a different picture of sustainability. Even in the absence of population aging, projected health care spending claims an increasing share of provincial/territorial revenues over the next 25 years. Without population aging, however, this increase is very small. In this case, the proportion of each dollar of provincial/territorial revenues dedicated to health care spending is projected to increase from 30.5 cents in 2000-01 to 32.0 cents in 2026-27. The increase is projected to be much larger when population aging is included. By the year 2026-27, with population aging, health care spending is projected to claim 43.2 cents of each dollar of provincial/territorial revenues.

This increase in the share of provincial/territorial revenue used to finance health care spending does not imply by itself that the existing publicly financed health care system is unsustainable. It implies that, under the current fiscal structures of provincial/territorial governments (including federal transfers), spending on non-health programs will have to grow at a slower rate so that these programs will account for a declining share of total revenues. Alternatively, it implies that total revenues must grow at a faster rate than what is projected under the existing revenue structure.

Since the growth of provincial/territorial revenues is affected by the growth of federal inter-governmental transfers, another avenue for slowing down the projected increasing share of provincial/territorial revenues dedicated to health care spending is to raise the contribution by the federal

Table 8
Provincial health care spending as percentage
of provincial revenues, selected fiscal years

Fiscal year	Without population aging (%)	With population aging standard CHST growth (%)	Faster CHST growth (%)
2000-01	30.5	30.5	30.5
2006-07	30.8	32.9	32.0
2011-12	31.2	35.3	34.1
2016-17	31.5	37.8	36.2
2021-22	31.8	40.4	38.4
2026-27	32.0	43.2	40.7

Source: Author's calculations.

government. This federal contribution has been restrained for a long time with the result that currently, the federal contribution to health care spending is a small fraction of provincial/territorial health expenditures.

The last column of Table 8 measures the effects of a selected increase in federal cash transfers under the Canada Health and Social Transfer (CHST). In the standard growth case, CHST cash payments follow the terms of the September 2000 agreement and, afterwards, they grow at the same rate as nominal GDP. In the alternative case, there is a permanent \$7 billion increase in 2002-03 and the new level of cash payments increases at the same rate as personal income tax revenue. As shown in the last column of Table 8, this higher growth of CHST cash payments would reduce the ratio of provincial/territorial health care spending to the revenues of those governments by 1.2 percentage points in 2011-12 and by 2.5 percentage points in 2026-27.

More on the effect of population aging

Since the potential issue of sustainability arises only because of population aging, it may be useful to elaborate on this subject. One way to evaluate the contribution of aging to the cost of health care is to compare the share of health care spending assigned to Canadians 65 years of age and over with their share of the population.

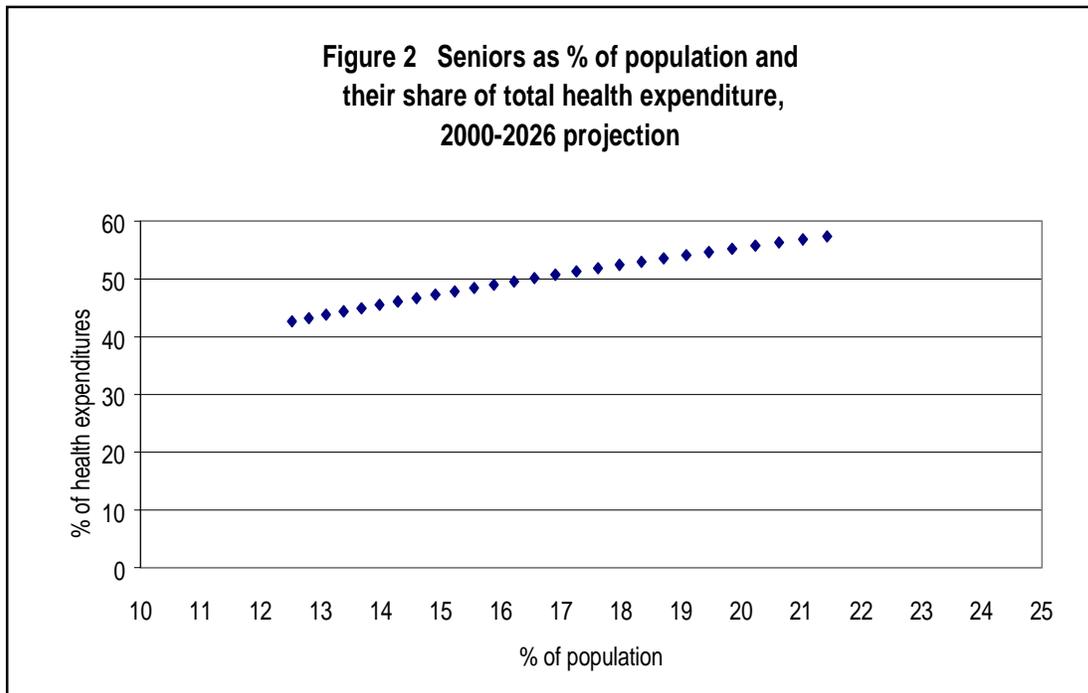


Figure 2 shows that, in 2000-01, seniors accounted for 43 percent of total health care spending but represented only 12.5 percent of the population. In 2026-7, seniors will represent 22 percent of the population and will be responsible for close to 60 percent of total health care spending.

Another way of measuring the health care implications of population aging is to look at its fiscal dimensions. The first column of Table 9 shows the dollar amount (adjusted for inflation) of the additional provincial/territorial health costs related to population aging expressed on a per capita basis. This amount was calculated as the difference between the projected health care expenditures with population aging and the projected values without population aging. This additional cost amounts to only \$150 per year in 2006-07, but increases rapidly over time and reaches the level of \$1,055 20 years later. The second column shows the equivalent values, this time expressed per person over the age of 25 – a group that represents the bulk of income earners. In this case, population aging will add \$224 annually per person over 25 in 2006-07 and six times that amount in 2026-27. My projections, therefore, indicate that if the aging-related increases in provincial/territorial health care costs were financed entirely through additional taxation, each person over the age of 25 would bear an additional tax burden (in 2001 dollars) of about \$19 per month in 2006-07 and \$118 per month 20 years later.

The last two columns compare the extra cost from population aging to provincial/territorial expenditures on education, both expressed as percentages of provincial revenues. They show that, in 2006-07, the projected health care costs resulting from population aging represent 2 percent of provincial/territorial revenues and are equivalent to 11 percent of education spending ($2.1/19.6 = 10.7$). Twenty years later, the aging factor is projected to account for 11 percent of provincial/

Table 9
Dimensions of population aging and provincial/territorial health care expenditures, selected years

Fiscal year	Additional health costs due to population aging			Education spending as % of provincial/territorial revenues
	per capita \$	per person over 25 \$	as % of prov./terr. revenues	
2006-07	150	224	2.1	19.6
2011-12	316	450	4.1	20.3
2016-17	515	719	6.2	20.0
2021-22	756	1,036	8.6	21.9
2026-27	1,055	1,416	11.1	22.3

Source: Author's calculations.

territorial revenues. The additional health care costs due to population aging are equivalent to half of education spending by provincial and territorial governments ($11.1/22.3 = 49.8$) in 2026-27. This means that, within the existing revenue structure of provincial and territorial governments and assuming no change in the projected values of other expenditures except education, provincial/territorial spending on education would have to be cut in half in 2026-27 to accommodate the extra health care spending due to population aging.

The issue of quality

The projections of health care spending contained in this paper are based on the assumptions that the quality of health care remains unchanged at its 2000-01 level and that there are no additional spending pressures in the future. These assumptions may not be warranted.

There is some evidence that Canada ranks very low among OECD countries in terms of MRIs, CT scanners and doctors, all expressed as a proportion of the population [Esmail 2002]. Upward pressures on Canada's health care costs have recently been identified by the Senate Standing Committee on Social Affairs, Science and Technology (2002). These cost pressures include: (a) the introduction of original, effective but very costly drugs, (b) the need to invest more in health care technology and health information systems, (c) population aging, (d) salary increases due to competition for human resources in health care, (e) growing public expectations, and (f) the need to fill serious gaps in our health safety net [Senate Committee 2002]. To the extent that the incorporation of improvements in the quality of health care and potential cost pressures into the projections further increases total costs of health care, it will raise all the ratios presented in the previous sections. Table 10 presents new estimates of sustainability based on the following assumptions: (a) provincial government spending on health care services is raised permanently by \$7 billion in 2002-03 and the new total amount is assumed to increase annually in line with the projections of inflation and real cost increases, and (b) CHST cash payments are raised by \$7 billion in 2002-03 and are projected to increase at the rate of personal income tax growth for the following 25 years.

Table 10 indicates that adding \$7 billion to health care expenditures and maintaining the same growth as for the standard case does not change much the ability of the economy or of the fiscal system as a whole to finance the higher health care spending. By 2026-27, fewer than 12 cents out of each dollar of GDP would be used for health care, up by less than one percentage point from the standard case discussed in section III (Table 8 with standard CHST growth). Twenty-five years from now, public financing of health care still would claim less than 20 cents per dollar of total government revenue, 1.6 cents more than under the standard case. Even the share of provincial/territorial revenues used to finance health care spending would increase little over the 25-year period, compared to the standard case, because the initial \$7 billion of extra spending would be matched by higher federal contributions and the higher federal contributions would grow faster than GDP.

Table 10
Estimates of sustainability under the
assumption of higher health care spending

Fiscal year	Total spending as % of GDP	Public spending as % of government revenues	Prov./terr. spending as % of prov./terr. revenues
2000-01	9.1	14.6	30.5
2006-07	10.0	16.5	35.2
2011-12	10.3	17.1	37.5
2016-17	10.6	17.8	39.8
2021-22	11.0	18.6	42.2
2026-27	11.5	19.5	44.8

Source: Author's calculations.

There seems to be a general view that improvements in the quality of health care provision will increase the growth rate of health costs in future, as it requires the addition of expensive equipment. This view may not be warranted for two reasons: (a) it fails to distinguish between levels and growth rates, and (b) it assumes that there is no room for improving efficiency in the delivery of health care services.

Although the *level* of health care spending will increase if additional public funds are made available to raise quality today, this level increase need not necessarily be associated with higher *growth rates*. Let us consider the case of new diagnostic equipment. This equipment is expensive and may involve a large initial capital cost. Its use, however, may not be costly. The purchase of such equipment will raise *average costs* immediately, but its use may generate low *marginal costs*. To the extent that the extensive use of new diagnostic equipment helps in the early detection of diseases, it actually may reduce treatment costs in the future, thus reducing growth rates of spending.

Faced with growth rates of health care spending in excess of the growth of provincial revenues, provincial governments are actively engaged in the development and testing of different systems of health care delivery within the framework of the Canada Health Act. They are increasingly focussing on health policy rather than financial policy towards health care. To the extent that these efforts will lead to efficiencies in the delivery of health care services, they will create a publicly funded health care system that rests on stronger foundations of sustainability than is indicated by the results shown in Table 10.

A related issue: redistribution

The main focus of the current debate on the issue of fiscal sustainability suggests that calls for reform of the health system in Canada are motivated by changing views about equity. Studies of fiscal redistribution have shown that publicly funded universal health care is a major tool of fiscal redistribution because lower-income individuals have equal access to health care services, but contribute a below-average share of their financing due to the moderate progressivity of the tax system. Publicly funded health care, therefore, embodies the principle of sharing which has served as a moral underpinning of public policy in Canada. It is this principle that is being attacked under the guise of affordability arguments. Well-to-do Canadians who favour a two-tier health care system are not looking at lower overall costs of health care. In fact, they are willing to pay more, not in taxes to strengthen the public health care system for all Canadians, but in direct payments to private health care providers to acquire better health care services for themselves.

An indication of this shift in values is provided by (a) the use of regressive revenue sources in some provinces to raise funds for health care financing, (b) recent increases in these taxes in order to offset reductions in progressive income taxes, and (c) proposals for health care co-payments which, when combined with the call for lower personal income taxes, would reduce the progressivity of the tax system. If the level and distribution of the benefits from publicly financed health care expenditures remain unchanged, these changes in the revenue mix will result in a lower degree of redistribution delivered by the fiscal system.

This policy shift is due partly to recent changes in federal priorities. At a recent conference in Winnipeg, federal officials identified international competitiveness as a major objective of federal policy. They claimed that Canada ranks low in terms of its spending on innovation activity, but high on public health care spending. The implication of this claim is that innovation activity and a competitive tax system are a higher priority for the federal government than quality health care for Canadians.

This ranking of priorities has been reflected in the direction of federal policies during the 1990s – notably increased spending on innovation and reduction in income taxes on the one hand, and reduced CHST cash transfers to the provinces on the other. The provinces are under pressure from many directions. The richer provinces are trying to emulate the federal government in the economic area by reducing income taxes, but this policy further reduces their ability to finance quality health care already weakened by lower federal transfers. The less affluent provinces are in an even more precarious situation as they try to maintain competitive tax structures in order to prevent the outflow of mobile factors of production. In an attempt to offset the revenue loss from lower federal transfers and reduced income taxes, provinces are turning to new revenue sources which either are outright regressive or are less progressive than the income taxes they replace.

Whether a reduction in the degree of fiscal redistribution in Canada is a deliberate objective of federal policy is not known. What is clear, however, is that the federal retreat from its longstanding commitment to finance a substantial share of provincial/territorial social programs is leading to such a result.

A redistributive issue particularly relevant to the health care debate is the fiscal treatment of seniors. Federal and provincial/territorial governments have developed a complex plethora of programs aimed at helping Canadians maintain their standard of living after they retire from the labour force (normally at age 65). Some of these programs offer financial benefits paid out of general revenue (Old Age Security pensions), other programs offer pensions based on compulsory contributions (Canada and Quebec Pension Plans), and still other programs offer preferential treatment under the personal income tax system (Registered Pension Plans and Registered Retirement Saving Plans). The tax assistance for retirement saving plans is effectively a transfer payment to middle- and upper-income Canadian seniors, who form the bulk of the beneficiaries from these programs. These transfer payments amount to tens of billions of dollars per year and help raise the standard of living of this select group of seniors in their post-retirement years while increasing the tax burden on all Canadians. Why, one may ask, can we afford such a generous tax treatment of a select group of seniors but we are told that we cannot even afford the public funding necessary to maintain the existing quality of health care?

Within the framework of a publicly funded health care system, the extra purchasing power provided by tax assistance for retirement saving plans cannot be used to buy additional health care services. Those seniors who benefit from the above preferential tax treatment are entitled to the standard health care services provided by the government and can use the extra income from tax-assisted retirement savings to increase their private consumption. These select seniors would benefit from a two-tier health care system because they would be able to acquire, through the support of all Canadian taxpayers, additional health care services for themselves. In my view, if it can be shown that there is an affordability issue, a more equitable alternative is for the government to reduce the current level of tax assistance for middle- and upper-income seniors and use the tax savings to increase funding for a public health care system that benefits all Canadians.

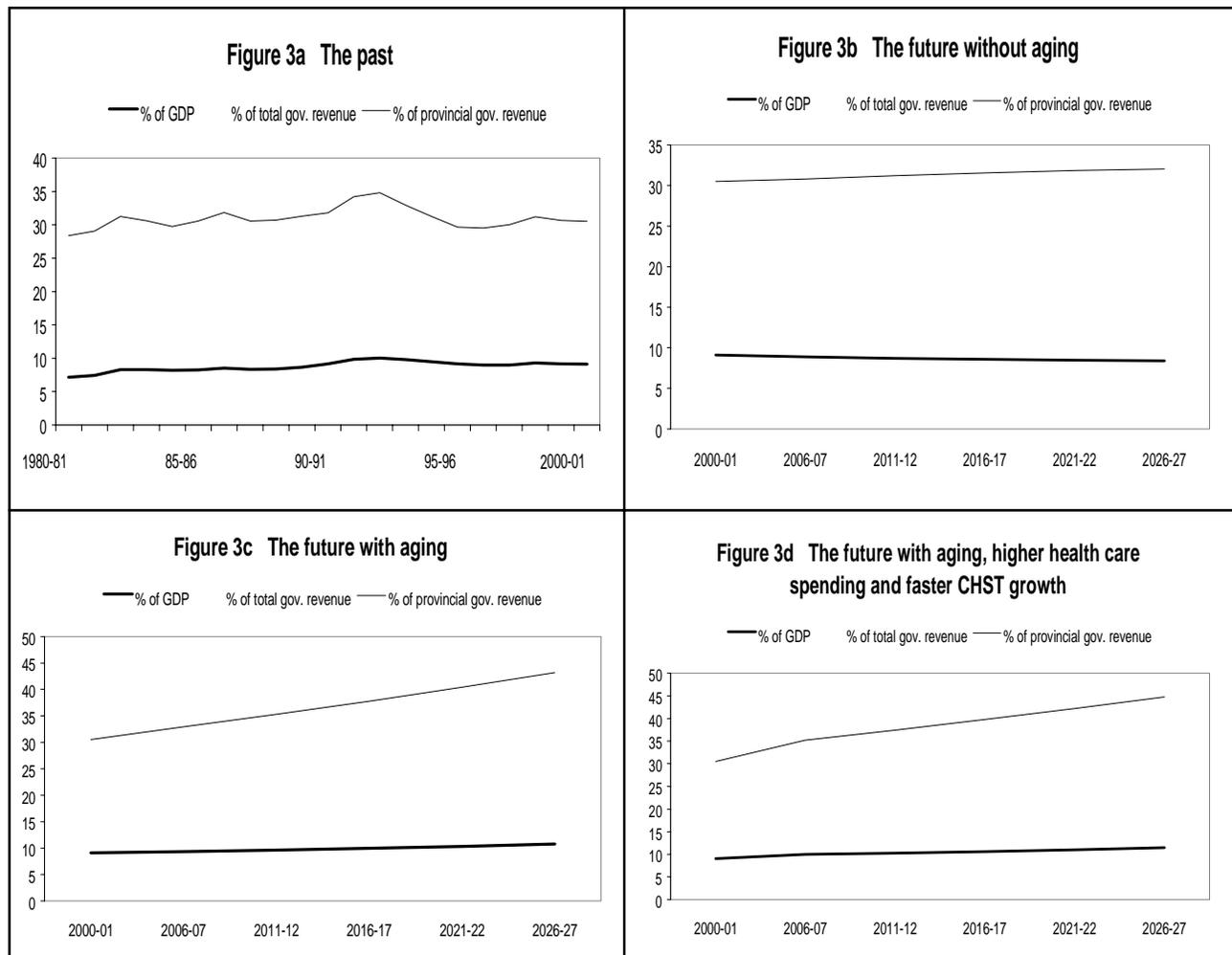
Summary and Conclusions

The debate over health care in Canada has been steered towards the issue of sustainability. This paper presents information on three aspects of sustainability. That information is summarized in Figure 3, which indicates that the broadly held view that the current publicly financed system is unsustainable does not rest on a solid factual foundation. Even with population aging and an additional \$7 billion per year increase, 25 years from now total health care spending in Canada will claim a share of GDP (11.5 percent) which is smaller than the share of GDP currently claimed in the US.

The debate over the future of health care in Canada contains three distinct, though interrelated components: values, sustainability and efficiency

Values

Although the issues associated with the financing of health care are important, the fundamental choice is about values. The publicly funded health care system is an incarnation of a set of values that have been held by Canadians throughout the history of this country, particularly a willingness to share wealth among regions with different economic potential and among individuals in different economic positions, and a collective commitment to deliver redistribution through a variety of government programs both on the tax and spending side.



These values have come under increasing attack as the role of government is being redefined to accommodate the globalization and information revolution. Instead of allowing these values to be eroded by external forces, we should bring this issue up front, debate it nationally and make explicit value choices. In this respect, the fundamental question to be asked is: Will greater economic inequality among Canadians, a downgraded role of government in redistribution, and the erosion of the publicly funded health care system enhance human development and the quality of life for all Canadians?

Sustainability

In the most general and most meaningful sense, sustainability refers to the capacity of the economy to finance the projected levels of health care spending. In that context, the statement that we cannot afford the existing health care system is nonsense. We currently spend less than ten cents for each dollar of output and we will continue to spend less than ten cents for the next 15 years. We will be spending less than 12 percent of GDP 25 years from now even if we add an extra \$7 billion per year to improve the health care infrastructure. Sustaining the projected levels of health care spending over the next 25 years simply requires shifting to the health care sector one or two percentage points out of the 90 cents of GDP currently used for non-health purposes.

When debating the issue of health care sustainability, it may be useful to ask the following question: How can we spend nearly 12 percent of GDP for recreation and entertainment (including restaurants, accommodation services, tobacco and alcohol) without complaining, but we cannot afford to spend 10 percent of GDP on health care? This paper shows that, if there is any sustainability problem at all, it relates only to the ability of provincial/territorial governments to handle the spending pressures in health care originating from the accelerated pace of population aging over the next 25 years. Although provincial and territorial governments may face difficult fiscal choices because of the escalating costs of health care, the fiscal system as a whole is capable of handling projected future costs of health care under the existing structure.

The fiscal pressures on provincial/territorial governments arise largely from the reduced federal commitment to the financing of social programs delivered by the provinces and territories. Within the framework of fiscal capacity, the issue of sustainability is really an issue of vertical fiscal imbalances. It is generated largely by the federal retrenchment from its commitment to be a major partner in the financing of social programs delivered by the provinces/territories. In the past, when the federal government proposed to reduce its cash contributions to these social programs, it offered a suitable transfer of income tax points – as it did in the 1964 proposal for opting-out and the 1977 Established Programs Financing arrangement. Over the past 25 years, however, the federal government has unilaterally changed the terms of those financing arrangements for the purpose of reducing its cash contributions to the point where it has become a minor partner.

Sustainability is really an issue of fiscal federalism. In this respect, there is a clear choice between two major options. The federal government can restore its role as a reliable major partner by increasing its cash contribution to the financing of provincial/territorial social programs, agreeing to a suitable growth of its contribution and making a commitment not to change unilaterally these financing arrangements. Alternatively, the federal government can withdraw entirely from its partnership role and transfer to the provinces a suitable portion of its personal income tax room in a manner that maintains equitable treatment of all provinces over the long run.

Efficiency

The question of efficiency relates to the health care delivery system itself and involves changes in the structure of the health care system. It is at the heart of health policy.

Currently, health care policy is being shaped by fiscal considerations, and proposals for reforming the delivery of health care are largely directed at their potential for reducing government spending. Although fiscal considerations do impose some constraints on the feasibility of certain reform proposals, the main objective of health policy should be the provision of uniform quality health care to all Canadians, independent of their place of residence or their economic status, and in an efficient and effective manner. Efficiency improvements in the delivery of health care services should be pursued by all provinces, not simply because they reduce government expenditures, but because they improve the quality of health care.

In concluding, I want to stress that we should not let the focus on fiscal sustainability obscure the fact that ultimately the debate about health care reform is not about dollars and cents but about fundamental values. The choices that we make collectively will shape the future of Canada beyond the confines of the health care debate.

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The author is thankful to Haifang Huang and Betty Zhang for excellent research assistance, and to Ewald Boschmann, Vaughan Dickson, Mike Farnworth and Annette Ryan for helpful comments.

Endnotes

1. See, for example Ruggeri, Van Wart and Howard (1997).
2. See, for example, Aba et al. (2002).

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Appendix

The average annual growth rate of GDP is determined by three major factors: the growth of employment, the growth of output per employed person and the inflation rate. In my projections for the period from 2000 to 2026, I used the following assumptions for the average annual growth rates: 1.2 percent for employment, 1.25 percent for labour productivity and 1.9 percent for inflation, resulting in a growth rate of nominal GDP of 4.41 per year. I assumed that total government revenues grow in line with nominal GDP.

For provincial/territorial revenues, I used the approach developed in Ruggeri (2001). To develop the projections of health care spending, I divided the population into selected age groups and calculated the average cost in each group – for total health care spending, total public spending and provincial/territorial spending – based on the data and age breakdowns provided in Health Canada (2001). The population projections are based on the ‘medium’ projection by Statistics Canada. I assumed that the average cost in each age group will increase at the same annual rate – namely, inflation (1.9 percent) times real increases (1.5 percent). Given a population growth of .6 percent per year, the growth rate of health care expenditures in the absence of population aging would be 4.05 percent per year.

One could argue that the growth of employment, and perhaps GDP and government revenues, will be different with and without population aging because the changing age structure of the population will create different labour market conditions. Taking full account of the dynamics of population changes would require a more complex model than the one used in this paper. In my calculations, using the same economic and revenue projection under the two alternative age structures of the population implicitly assumes that employment growth is determined by the labour demand side and that the labour supply side adjusts through changes in participation rates.