

We can afford universal health care

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The dust had barely settled after Roy Romanow's ground-breaking prescription for Canadian health care when commentators renewed the woeful refrain that motivated Romanow's commission in the first place. "We can't afford universal public health care".

While Canada has actually held the line in health care expenditures – as a proportion of GDP, Canada spent that same 10% in 2002 as in 1992 – the voices of doom have one good point. The upward pressures on health care spending are relentless.

Medicine's success in developing new therapies that allow people longer, healthier lives is largely responsible for increasing costs. The increasingly short supply of health professionals, and the resultant need to pay more to retain and recruit them, generates further cost pressure.

Every industrialized country faces the same problem, and the choice that goes with that problem. Fund health care publicly, through taxes, or through private health insurance.

No one suggests the third option, which is not delivering needed health care at all. Even social conservatives don't advocate withholding care from those without the resources to pay.

A look south of the border dispels any doubt about the increasing magnitude of health care expenditures, whoever pays. The US relies more on private-pay than any other industrialized country. In 2002, Americans spent an extraordinary 14.9% of their GDP on health care. Projections suggest the US will spend 17.7% of their GDP on health care by 2012.

So, the question isn't whether we will pay, but who will pay. In other words, how will we distribute the costs, and benefits.

Take Ontario Premier McGuinty's recent suggestion that seniors bear a

greater proportion of their prescription drug costs. By promising to both eliminate the deficit and refrain from any tax increases, Ontario Liberals have put themselves in a straight-jacket that severely limits their options. Thus, McGuinty's frantic search for ways to decrease public expenditures.

Currently, the public, through their taxes, pay a large portion of seniors' drugs cost. As a result, the financial burden falls disproportionately on wealthier Canadians. In addition, corporations pay part of the cost.

If McGuinty cuts benefits, the elderly pay directly, and the burden falls on poorer, sicker Canadians. You can think of this as a tax that goes with being old and sick.

The policy may lead to some reduction in medication use by those who absolutely can't afford to fill their prescriptions. But research from both Canada and the US suggests that those unfilled prescriptions will result in increasing doctors' and emergency room visits.

Whether we are talking about prescription drugs, home care, doctors, or hospitals, the story is the same. Public pay, through taxes, means the burden falls disproportionately on the wealthier, and on corporations. Private pay means the burden falls on the sick, and because on average poorer people are sicker, it falls disproportionately on the poor.

This equity issue isn't the only reason that Roy Romanow recommended we maintain public funding for physician and hospital services, and extend public funding to prescription drugs and home care. Public funding is also far more efficient.

The US spends 32% of their health care dollars on administrative costs while Canada spends 16.7%. The reason is that the US funds a far greater proportion of their health care through private health insurance. Private insurers must develop insurance packages, sell insurance, evaluate applicants' risk, assess claims, and satisfy investors with a profit. Universal public health insurance bears none of these costs.

Further evidence of the efficiency of public pay comes from a comparison of the US Medicare program, which covers hospital services for all Americans over 65, and parallel private insurance. Growth in costs over the last 30 years has been substantially higher in the private arena than in

the public pay program.

All this suggests that if we could overcome our allergy to taxes, we would gain in both equity and efficiency by broadening, not contracting, public health care funding.

But what about the economy? Won't rolling back tax cuts slow down economic growth?

In Canada, public payment for health care actually benefits large unionized companies that must provide health benefits to their workers.

For instance, employers' health costs among American automakers amount to \$900 per vehicle. Canada's success in the auto industry is largely attributable to the far lower health benefits required of Canadian manufacturers.

Recent changes in US Medicare, bringing partial payments for drugs into the program for the first time, included a bailout of crippling retirement benefits for American industry.

We will, without doubt, be paying more for health care. Will we opt for inefficient, inequitable private pay? Or will we choose a public pay system that provides universal coverage and gives us more health care for the dollar?

Can we afford to maintain and extend public health care? We can't afford not to.