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# EVERY NUMBER TELLS A STORY

## *A Review of Public and Private Health Expenditures and Revenues in Canada, 1980–2000*

339-02 Detailed Findings • By Glenn G. Brimacombe

### HIGHLIGHTS

- From 1992 to 1997, public per capita spending on health care in Canada was not out of control (after adjusting for inflation), and remained under 1992 levels.
- While the overall public–private distribution of health care spending moved from 76:24 in 1980 to 71:29 in 2000, it remained virtually unchanged for the categories of hospitals, other institutions, physicians and other health spending—which constitute 69.2 per cent of total health spending.
- At \$25.1 billion in 1998, over 90 per cent of private sources of revenue came from out-of-pocket expenditures (55 per cent) and private health insurance claims (37 per cent). The breakdown varies by category (e.g., physicians, prescribed drugs).
- Canada ranks among leading OECD countries in total health expenditures as a percentage of GDP; however, there are differences in the proportion of public and private funding by category of expenditure. If we are to move to a more integrated health care system, we must consider how to financially align sectors that have different degrees of public and private sector funding.



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## Preface

The Leaders' Roundtable on Health, Health Care and Wellness, established by The Conference Board of Canada, identified a series of research projects that needed to be carried out in relation to its mandate to encourage a constructive debate on health care in Canada. In particular, participants expressed the need for a clearer understanding of expenditure movements within and between the public and private sectors. This issue was in fact identified as a high priority. In response, *Every Number Tells a Story* undertakes a review of health expenditures and revenues from 1980 to 2000 and attempts to fill this information gap. This report is one of the Conference Board's contributions to the ongoing issue of health care funding in our country.

Anne Golden  
President and Chief Executive Officer  
The Conference Board of Canada

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## EVERY NUMBER TELLS A STORY

### *A Review of Public and Private Health Expenditures and Revenues in Canada, 1980–2000*

339-02 Detailed Findings • By Glenn G. Brimacombe

Health spending is a contentious issue. Canada's health care system is a source of national pride; it distinguishes us from the United States and, in the minds of many, makes us a better country in which to live. However, throughout the 1990s, intense debate in Canada ensued over the current level and year-over-year increases in health spending. In particular, concerns were—and continue to be—raised about the level and distribution of public and private funding in the system.

This is not unexpected, given that the federal, provincial and territorial governments have all had to respond to significant external pressures to place their fiscal houses in order. Health spending, on average, accounts for approximately one-third of provincial and territorial government spending, and therefore, the sector is not immune to the consequences of fiscal austerity.

At the same time, there is a high degree of public sensitivity about the range of policy levers that have been used to implement health policy in an era of cost containment. Some of them have had the effect, whether intentionally or not, of shifting the burden of cost from the public to the private sector. (This includes de-insuring medical services, increasing co-payments and deductibles for publicly funded pharmacare programs and shorter stays in hospitals.) In response, some are concerned that we are moving towards an increasingly privatized "American-style" system.

While rhetoric about what we may or may not become is politically charged and of interest to all Canadians, we should be sensitive to how the distribution of health services will be affected if individuals have to increasingly rely on out-of-pocket expenditures and/or private insurance. The reality is that Canada currently has a mixed system in terms of the funding responsibilities of the public and private sectors. The relative emphasis, however, depends on which sector of the health care system is under consideration.

Given these complex and challenging policy issues, what are the facts when it comes to public and private health spending in Canada? More clearly, what is the record of public and private health spending over the past two decades, by category of expenditure? Furthermore,

how are private revenues raised and distributed throughout the health care system?

*Every Number Tells a Story* reviews the two related concepts of public and private expenditures and private sector revenues in health care from 1980 to 2000, with the objective of providing information and analysis to inform the public dialogue. In specific terms, the report examines public and private health expenditure trends by category and considers their relationship to one another. It also pays close attention to the range of financial mechanisms by category of expenditure that are used to privately fund health care (such as out-of-pocket expenditures and claims paid by private health insurers). In addition, this report compares Canada's record to other member countries of the Organization for Economic Co-operation and Development (OECD) on a number of generally accepted measures of health care spending.

*Every Number Tells a Story* reviews the recent state of public and private funding for health care—but it does not endorse a particular view of what the division between the public and private sectors should be. Furthermore, given the confusion that can arise between the concepts of *funding* and *delivery* in health care systems, this report focuses exclusively on the former and not the latter. While issues of delivery are clearly relevant to the current policy discussion when it comes to the future of Canada's health care system, they are beyond the scope of this report.

In reviewing public and private health expenditures and revenues from 1980 to 2000, this report complements an earlier Conference Board of Canada publication, *The Future Cost of Health Care in Canada, 2000 to 2020*.

Based on this analysis, a number of key findings emerge:

- As a general statement, depending on how deeply one reviews the trends in public and private health expenditures and private revenues, different patterns emerge in different magnitudes. This fact makes it difficult to generalize about whether public and private categories of expenditure are moving together in a complementary manner or are substituting for one another—when in fact they may be doing both at different points in time.

- Public health spending was not “out of control” over the past decade. Real public per capita spending increased, on average, by 2.2 per cent per year from 1980 to 2000, after adjusting for population and inflation. However, from 1992 to 1997, real per capita spending in absolute terms fell and remained under 1992 levels.
- In terms of the distribution of total health spending, the public share decreased from 76 per cent in 1980 to 71 per cent in 2000, while the private share increased from 24 to 29 per cent over the same time period. Of note, the public-private share of spending for hospitals, other institutions, physicians and other health spending remained virtually unchanged from 1980 to 2000 and accounted for 69 per cent of total health spending in Canada in 2000. This is not to say that private health expenditures have not increased over time—they have. However, for the most part, private expenditures in specific categories increased in proportion with a large majority of public expenditures.
- From 1988 to 1998, total private funding increased from \$12.7 billion to \$25.1 billion. Of that amount, in 1998, out-of-pocket expenditures and private health insurance constituted 55 per cent and 37 per cent, respectively. The distribution between the two categories varies significantly depending on which category of expenditure is considered. For example, out-of-pocket expenditures accounted for 98 per cent of total sources of private funding for physicians, and private health insurance accounted for 59 per cent of all sources of private funding for prescribed drugs. Interestingly, for the category of other institutions, all private sources of funding were derived exclusively from out-of-pocket sources.
- Placed in an international context, while Canada ranks among the leading member countries of the Organization for Economic Co-operation and Development (OECD) in terms of total health spending in relation to gross domestic product (GDP), it differs from others in the proportion of public and private funding, by category of expenditure.

While these findings are important and relevant to the public dialogue about the funding responsibilities of the public and private sectors, it is their policy repercussions that demand our attention.

As we contemplate Canada’s future health care system, we must keep in mind not only the kind of policy proposals that are on the table, but also how we get from where we are to where we need to go. This begs the question of policy implementation, and how we can financially align sectors of the health care system that are fundamentally different (for example, physicians who derive 99 per cent of their earnings from the public sector; other professionals who earn 90 per cent of their revenues from the private sector; and other institutions that receive 25 per cent of their revenues from the private sector—and are funded exclusively through out-of-pocket payouts). If primary health care reform or an expanded publicly financed home care or pharmaceutical program is a high public policy priority, how do we bring together diverse sectors in a more financially seamless structure? Ultimately, we need to think about how we might align incentives in the system more advantageously.

Finally, perhaps the most difficult issue is where we should draw the respective lines for the public and private sectors when it comes to funding health care. Should we examine the (more balanced) funding relationships that exist among other OECD countries? If we did, what would be the effects of a higher proportion of private sector funding on our ability to achieve the public policy objectives that we have set out for our health system, such as equitable access, cost effectiveness, income protection, patient choice and clinical autonomy? Furthermore, if the private sector were to play a greater role in funding health care, how sensitive should we be to the possibly uneven distribution of services that may occur as a result? Conversely, where there is an active role for the private sector, should we look to strengthen the role of the public sector?

These are issues that are not easily resolved, but are ones that require significant reflection as we continue to search for ways to make Canada’s health care system more cost effective, efficient, integrated and innovative.

# Introduction

Prior to and since the inception of Medicare, the general public and policy makers alike have continued to focus on the level of funding for health care in Canada. Not unexpectedly, a number of different and contentious views exist concerning what the level and funding mix should be within and between the public and private sectors.

Certainly, there are scarce public resources available for health care and other important public priorities. As a consequence, discussion about the respective roles of the public and private sectors will likely continue to intensify over the coming decade.

Understanding that health care in Canada is largely funded through the public purse (in 2000, 70 per cent of our health care system was publicly funded), a number of reviews have focused on public sector spending on health care and some aggregate measures of the private sector's role. However, few, if any, inquiries look at how public and private health spending by category come together and their possible relationship(s) to one another.

Furthermore, very little has been published in the Canadian context specifically on the range of financial mechanisms that are used to privately fund health care. That is, what are the absolute level and relative contribution of out-of-pocket expenditures as well as claims paid by private health insurers for each category of expenditure?

The debate about the respective roles of the public and private sectors from a financing point of view continues to unfold in Canada. As a contribution to this debate, *Every Number Tells a Story* provides a historical point of departure in terms of bringing together the two related concepts of public and private health *expenditures* and private sector *revenues*.

This research report is descriptive in its analysis. It reviews the recent state of public and private funding for health care; however, it does not endorse any particular view of what the division between the public and private sectors should be. Furthermore, the data that are presented are aggregated at the federal, provincial and

territorial levels—recognizing that the provinces and territories have constitutional responsibility for the governance, structure and funding of their health care systems.

Given the confusion that can arise between the concepts of the *funding* (how monies are raised to pay for health care) and *delivery* (who owns the location where services are delivered) of health care systems, this report's exclusive focus is on the former and not the latter. While issues of delivery are clearly relevant to the current policy discussion when it comes to the future of Canada's health care system, they are beyond the scope of this paper.

*Every Number Tells a Story* also provides a form of "symmetry of analysis." It not only reviews the recent past from 1980 to 2000, but complements an earlier Conference Board report that estimates the future cost of health care in Canada from 2000 to 2020.<sup>1</sup>

Furthermore, to provide a more complete perspective, this paper also compares the financing of Canada's health care system to that of Organization for Economic Co-operation and Development (OECD) member countries.

The report is organized as follows. Following the introduction, the first chapter defines the parameters of the report. Chapters 2 and 3 provide an overview of total, public and private spending in current, real and per capita dollar terms. Chapter 4 reviews the public and private distribution of health spending by category of expenditure. Further disaggregating the data, Chapter 5 provides a more detailed review of total, public and private health spending by category of spending. Chapter 6 converts current and per capita spending into shares of total, public and private spending.

Chapter 7 begins the review of private sources of funding in the Canadian health care system. Similar to Chapter 6, Chapter 8 converts current private sources of funding into their respective shares. Finally, Chapter 9 places the financing of Canada's health care system within an international context, measured by a number of standard health expenditure metrics.

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<sup>1</sup> Glenn G. Brimacombe, Pedro Antunes and Jane McIntyre, *The Future Cost of Health Care in Canada, 2000 to 2020* (Ottawa: The Conference Board of Canada, 2001).

## Defining the Parameters of the Study

Before reviewing in detail public and private health expenditure data in Canada, it is important to have a clear understanding of how the information has been categorized. For the purposes of our research inquiry, the report separates health expenditure data two specific ways:

- By *category* of expenditure: In which areas or sectors of the health care system are public and private monies spent?
- By private *sources* of funding: Through what mechanisms and at what level are private monies raised and allocated to the areas or sectors of the health care system?

In the former, seven categories of health expenditure have been identified: hospitals, other institutions, physicians,

other professionals, drugs, capital, and other health spending. Some of these categories have sub-components that will be noted in the paper (e.g., drugs versus prescribed drugs).

In the latter, sources of private sector funding include out-of-pocket expenditures, health insurance claims paid by insurers as well as the costs of administering those claims; investment income and donations received by institutions; private spending on health-related capital construction and equipment; and health research funded by private sources.<sup>1</sup>

Based on these two ways of categorizing health spending in Canada, the remainder of the report focuses on: (1) total, public and private expenditure trends; and (2) private sources of funding health care, from 1980 to 2000.<sup>2</sup>

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1 For a complete definition of what is included in each category, please refer to Appendix A, or The Canadian Institute for Health Information, *National Health Expenditure Trends, 1975–2000(f)* (Ottawa: The Canadian Institute for Health Information, 2000), pp. 50–56.

2 Health spending by the public sector is accounted for through federal, provincial and territorial public reporting mechanisms. Most private sector expenditures and

revenues, however, are estimated from survey data (such as the Family Expenditure Survey and the Statistical Household Survey undertaken by Statistics Canada). Where the survey has not been carried out on an annual basis, trend data have been estimated. For more information, see *National Health Expenditure Trends, 1975–2000(f)*, (Ottawa: Canadian Institute for Health Information, 2000) pp. 50–61.

## Total, Public and Private Health Spending in Canada

In order to better understand where health care expenditures are likely to head, it is important to briefly review from where we have come over the past 20 years. This does not suggest that the recent past is necessarily a prologue, but it does shed light on how total, public and private health care spending patterns have changed (or in some cases remained the same) over the past two decades.

In 1980, Canada spent a total of \$22.3 billion on health care. Of that total, \$16.8 billion came from the public sector, and \$5.4 billion came from the private sector. In 2000,<sup>1</sup> Canada spent \$95.1 billion, of which \$67.5 billion came from the public sector, and \$27.5 from the private sector.

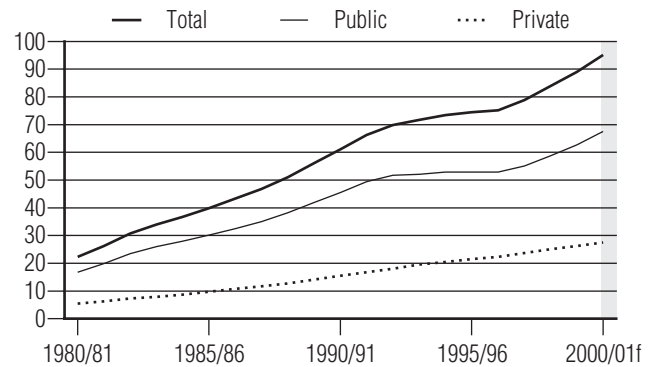
From 1980 to 2000, total, public and private health care expenditures grew by an annual rate of 7.5 per cent, 7.2 per cent and 8.4 per cent, respectively. However, this belies the fact that there have been a number of expenditure growth cycles over this period. More specifically, health expenditure growth was more robust in the 1980s than in the 1990s.

Framed in a slightly different format, Table 1 also provides an overview of the annual growth rate in total, public and private health expenditures, in five-year increments. While both public and private health expenditure growth was robust from 1980 to 1990, public sector increases from 1990 to 2000 were more moderate when compared to those of the private sector.

This is also underscored when one examines year-over-year percentage changes in total, public and private health expenditures.<sup>2</sup> Charts 1 and 2 demonstrate that while the data represent broad measures of health expenditure movements, the percentage change in total and public expenditures moved in unison over the 20-year period. Private health spending, particularly in the 1990s, appeared to move counter-cyclically with total and public spending.

The relationship between movements in public and private spending can be attributed to at least two factors. First, governments in the early 1990s had to deal with the long-term consequences of deficit financing. Given that health budgets consume the largest share of provincial and territorial government

**Chart 1**  
**Total, Public and Private Health Care Expenditures, 1980–2000(f)**  
(\$ millions)



Source: Canadian Institute for Health Information, 2000.

revenues, they were not immune to the consequences of fiscal austerity.

Second, the manner in which public and private expenditures moved throughout the 1990s suggests that they may have been acting as a substitute for one another.<sup>3</sup> More specifically, as health spending in the public sector was constrained, some would argue that it had the effect of transferring some of the costs to the private sector (e.g., through de-institutionalization of care, higher co-payments/deductibles for public prescription drug programs, de-insurance of medical services and increased

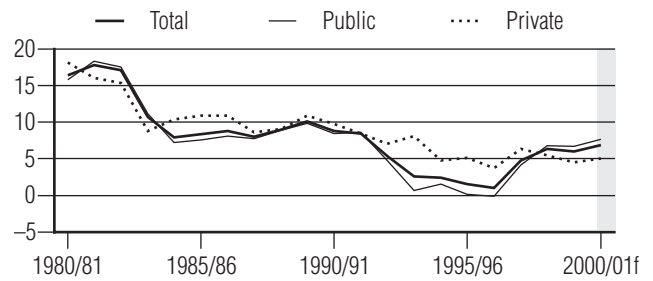
**Table 1**  
**Total, Public and Private Health Expenditures, Five-Year Annual Growth Rates, 1980–2000(f)**  
(\$ millions)

	1980	1985	1990	1995	2000(f)
Total Health Expenditures	22,308.7	39,858.5	61,125.2	74,534.1	95,126.9
Average annual per cent change	-	12.3	8.9	4.0	5.0
Total Public Expenditures	16,852.1	30,111.7	45,548.1	52,972.1	67,587.7
Average annual per cent change	-	12.3	8.6	3.1	5.0
Total Private Expenditures	5,456.5	9,746.9	15,577.1	21,562.0	27,539.2
Average annual per cent change	-	12.3	9.8	6.7	5.0

Source: Canadian Institute for Health Information, *National Health Expenditure Trends, 1975–2000(f)*.

reliance on home care support services). While this is a general statement that reflects the aggregated cycles in public and private health spending, it will be important to examine each category of spending in greater detail.

**Chart 2**  
**Total, Public and Private Health Care Expenditures, 1980–2000(f)**  
 (per cent change)



Source: Canadian Institute for Health Information, 2000.

- 1 All figures provided by the Canadian Institute for Health Information for the year 2000 are forecast (f). Numbers may not add up due to rounding.
- 2 While nominal (or current dollar) figures are used, it is important to note that similar cycles of year-over-year increases in 1992 constant dollars hold throughout the period.
- 3 A "substitution" is said to occur when an expenditure increase (decrease) in one area leads to a decrease (increase) in another. Conversely, a "complementary" relationship

is said to exist when an increase (decrease) in spending in one area leads to an increase (decrease) in spending in another. There may also be situations where expenditure movement could be interpreted as being a substitute or complement when there is no logical basis to support either category. For more discussion of this phenomenon in the Canadian context, refer to *The Evolution of Public and Private Health Care Spending in Canada, 1960 to 1997* (Ottawa: Health Action Lobby, Canadian Institute for Health Information, and Health Canada, 1999).

## Real Per Capita Health Spending

After adjusting health spending for inflation and population, real per capita total, public and private health spending in 1980 stood at \$1,793, \$1,306 and \$486, respectively (see Table 2). In 2000, the same categories increased to \$2,784, \$2,000 and \$783. This represents an annual increase of 2.2 per cent, 2.2 per cent and 2.4 per cent from 1980 to 2000.

Similar to Chart 2, Chart 3 shows that the annual percentage change in per capita total and public health spending moved in unison, while private spending

throughout the 1990s moved counter-cyclically. While there were cycles of expenditure growth in the 1980s and 1990s, the average annual growth for real per capita total, public and private spending was 1.6 per cent, 1.3 per cent, and 2.5 per cent throughout the 1990s (see Table 2). Once again, this trend largely reflects government policy decisions to rein in public health spending.

The record of real public per capita spending on health care from 1980 to 1992 shows a steady increase in spending. However, from 1992 to 1997, spending in absolute terms had fallen and remained below 1992 levels.

That point is particularly important, for it underscores the fact that public spending on health care, in the aggregate, was not “out of control” in the 1990s. In fact, some would argue that public spending on health care was too controlled. Placed in this context, the “fiscal famine” that all governments weathered in the 1990s had a significant impact in moderating overall allocations to the health sector.<sup>1</sup>

**Table 2**

**Real Per Capita Total, Public and Private Health Expenditures, Five-Year Annual Growth Rates, 1980–2000(f)**

(\$ 1992)

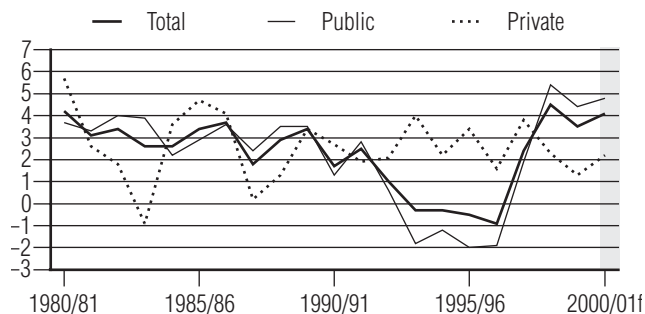
	1980	1985	1990	1995	2000(f)
Total Health Expenditures	1,793	2,079	2,378	2,435	2,784
Average annual per cent change	–	3.0	2.7	0.5	2.7
Total Public Expenditures	1,306	1,533	1,765	1,734	2,000
Average annual per cent change	–	3.3	2.9	–0.4	2.9
Total Private Expenditures	486	546	613	701	783
Average annual per cent change	–	2.4	2.3	2.7	2.2

Source: Canadian Institute for Health Information, *National Health Expenditure Trends, 1975–2000(f)*.

**Chart 3**

**Real Per Capita, Total, Public and Private Health Care Expenditures, 1980–2000(f)**

(per cent change)

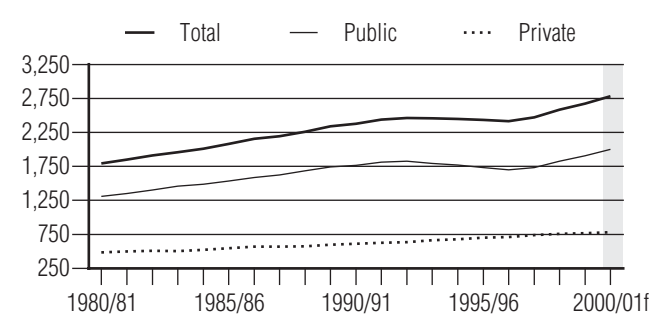


Source: Canadian Institute for Health Information, 2000.

**Chart 4**

**Real Per Capita, Total, Public and Private Health Care Expenditures, 1980–2000(f)**

(constant, \$ 1992)



Source: Canadian Institute for Health Information, 2000.

1 James G. Frank, Vice-President and Chief Economist, The Conference Board of Canada, “Choosing Canada’s Health Care Future—Lessons of the 1990s and the Challenges Ahead,” (Presentation at the Ontario Medical Association Annual Meeting, April 27, 2001).

## The Public–Private Distribution in Funding Health Care

While total, public and private health expenditures, in the aggregate, have increased from 1980 to 2000, each category of spending increased at different rates. As a consequence, there were fluctuations in the overall distribution between public and private spending in Canada (see Table 3).

**Table 3**  
**Share of Total Public–Private Health Care Spending, 1980–2000(f) \***

	1980	1985	1990	1995	2000(f)
Total	76:24	76:24	75:25	71:29	71:29
Hospitals	92:8	91:9	91:9	90:10	92:8
Other Institutions	72:28	75:25	73:27	70:30	71:29
Physicians	98:2	99:1	99:1	99:1	99:1
Other Professionals	16:84	15:85	15:85	13:87	10:90
Drugs	25:75	29:71	32:68	33:67	33:67
Capital	64:36	75:25	82:18	81:19	89:11
Other Health Spending	87:13	87:13	83:17	80:20	85:15

\*Numbers are rounded. Appendix A provides a definition for all categories of expenditures.

Source: Canadian Institute for Health Information, *National Health Expenditure Trends, 1975–2000(f)*.

Specifically, the overall public–private ratio shifted from 76:24 in 1980 to 71:29 in 2000.<sup>1</sup> Although the change in the overall ratio alarms those who would argue that the system was becoming increasingly privatized (also known as *passive privatization*<sup>2</sup>), this is only partially right. The public–private distribution remained virtually unchanged for the 20-year period for such key categories as Hospitals (92:8), Other Institutions (71:29), Physicians (99:1), and returned close to its 1980 level for Other Health Spending (85:15). As of 2000, these categories account for 69.2 per cent of total health spending in Canada.

While the ratio for these categories has not changed appreciably, it does raise questions, however, not only about what the appropriate *balance* is between public and private funding, but also about the *absolute level* of funding that has gone into

the system. In the former case, the public–private ratio suggests that there is little passive privatization occurring within the categories of hospitals, other institutions and physicians. This may be due to the fact that there is little scope within the Canadian context to transfer the costs of services in each of these categories in which the private sector has played a small role (or cannot compete effectively to deliver services).

This is not to say that private health expenditures have not increased over time—they have. However, for the most part, private expenditures in specific categories of expenditure have been increasing in proportion to a large majority of public expenditures.

Table 3 also shows that, over the same period of time the share of public spending going to drugs and capital spending has increased by 8 and 25 percentage points, respectively. The only category to reflect a significant increase in the share of private spending was that of other professionals.<sup>3</sup>

In addition to examining public and private expenditure movements within one category, it is also of increasing interest to examine the degree to which health policy decisions in the public sector have shifted costs to other private sector categories of expenditure. For example, shorter stays in hospitals have shifted costs that were previously covered by the public system to the private sector (where prescription drug costs, for example, will be paid for by out-of-pocket expenditures or private insurance claims). Shorter hospital stays have also introduced other direct and indirect private costs that are borne by patients (and their families) who return home to recover.

The increased desire by Canadians to use the services of a broader range of providers (e.g., midwives, practitioners of alternative medicines and physiotherapists) has also transferred costs from one public expenditure category (e.g., physicians) to another private expenditure category (e.g., other professionals). These decisions that are made by policy makers, providers and individuals influence the changing rate of growth in public and private expenditures. As a result, the “relationships” between public and private expenditure data between different categories warrant further scrutiny.

1 Canadian Institute for Health Information, *National Health Expenditure Trends, 1975–2000(f)*.

2 The concept refers to a series of unplanned and uncoordinated policy decisions implemented by governments that—whether intentionally or not—have shifted costs from the public to the private sector either *within* a category of expenditure (e.g., de-insurance of physician services), or *between* categories of expenditure (e.g., shorter lengths of stays in public hospitals and private sector coverage for prescription drugs). Working Group on Health System Financing, Canadian Medical Association, *Towards A New Consensus on Health Care Financing in Canada* (Ottawa: Canadian Medical Association, 1993).

3 As defined by the Canadian Institute for Health Information, “drugs” encompass prescribed drugs and non-prescribed drugs (which include over-the-counter drugs and personal health supplies). Capital expenditures include expenditures on construction, machinery and equipment of hospitals, clinics, first-aid stations and residential care facilities. Other professionals include privately practicing dentists, denturists, chiropractors, massage therapists, orthoptists, osteopaths, physiotherapists, podiatrists, psychologists, private duty nurses and naturopaths.

## Moving from Macro to Micro

While the above analysis is important and relevant to the current debate about the overall level and distribution of health spending, it is limited by the very nature of dealing with aggregated data. As the title of this paper suggests, a number of expenditure patterns are revealed only if we move from a general to a specific approach and continue to mine the data. With this in mind, this chapter of the report provides an overview of total, public and private health spending in current dollars and on a per capita basis for each major category of spending.

In so doing, it is important to note the limitations of the data. While aggregated data such as total, total public and total private expenditures can be adjusted for price effects, this becomes much more difficult to achieve when the data are separated into discrete categories. A deflator would have to be developed for all seven categories of expenditure in order to accurately capture price movements. While this has been accomplished in some categories of expenditure (e.g., physician services), it has not been replicated across the board. As a consequence, the data are presented in current dollars and are adjusted for population.<sup>1</sup>

### Hospitals

From Table 4, overall total, public and private health spending on hospitals increased annually by 6.1 per cent, 6.1 per cent and 6.0 per cent over the 1980 to 2000 period. Although all three segments experienced a decline in the rate of growth in spending from 1980 to 1995, total and public hospital expenditures increased from 1995 to 2000. Interestingly, total private spending fell in absolute terms from 1995 to 2000.

Given the increase in population over the 20-year period in relation to increases in total, public and private spending in hospitals, per capita total and public spending increased, on average, by 4.9 per cent, 4.9 per

**Table 4**  
**Total, Public and Private Health Expenditures, Hospitals, Five-Year Annual Growth Rates, 1980–2000(f)**  
(\$ millions)

	1980	1985	1990	1995	2000(f)
Total Health Expenditures	9,333.7	16,257.5	23,819.9	25,699.3	30,235.6
Average annual per cent change	–	11.7	7.9	1.5	3.3
Total Public Expenditures	8,584.5	14,735.0	21,579.6	23,154.6	27,814.7
Average annual per cent change	–	11.4	7.9	1.4	3.7
Total Private Expenditures	749.2	1,522.6	2,240.3	2,544.7	2,420.9
Average annual per cent change	–	15.2	8.0	2.6	–1.0

Source: Canadian Institute for Health Information, *National Health Expenditure Trends, 1975–2000(f)*.

cent and 4.8 per cent, respectively (see Table 5). As well, per capita private spending fell in absolute terms from 1995 to 2000.

Given the range of policy decisions that have been implemented to reduce the absolute number of beds and to find more innovative and efficient ways to provide care that has been delivered within an acute care setting (e.g., day surgery, less invasive care, increased reliance on community-based care and home care), it is not unexpected to see that increases in public spending on hospitals have moderated.

Furthermore, if one accepts that public and private spending should move together, (that is, that they are “complements”), then the rates of growth from 1980 to 1995 can, in part, be explained by three facts. First, there has been a continuing shift away from in-patient care to ambulatory care, which has the effect of reducing complementary private spending on hospital services. Second, 92 per cent of total hospital expenditures comes from the public sector. Finally, there is virtually no privately funded

**Table 5**  
**Total, Public and Private Per Capita Health Expenditures, Hospitals, Five-Year Annual Growth Rates, 1980–2000(f)**

	1980	1985	1990	1995	2000(f)
Total Health Expenditures	380.72	629.10	859.90	875.50	983.27
Average annual per cent change	–	10.6	6.4	0.4	2.3
Total Public Expenditures	350.16	570.18	779.02	788.81	904.54
Average annual per cent change	–	10.2	6.4	0.3	2.8
Total Private Expenditures	30.56	58.92	80.88	86.69	78.73
Average annual per cent change	–	14.0	6.5	1.4	–1.9

Source: Canadian Institute for Health Information, *National Health Expenditure Trends, 1975–2000(f)*.

hospital delivery network in existence, and therefore no direct competition for publicly funded hospitals in Canada.<sup>2</sup> As a result, reductions (or increases) in the rate of growth in public funding would contribute to reduced (or increased) hospital capacity and associated private expenditures.

This would suggest that private spending on hospitals tends to be related to the extent of available public funding.<sup>3</sup> Furthermore, the public-private ratio has remained virtually unchanged over the 20-year period; that is, public and private spending on hospitals have closely mirrored one another.

However, this explanation does not hold from 1995 to 2000, a period when public sector funding increased and private sector funding decreased. In the end, it would appear that, depending on the selected time frame, the public and private sector relationship may be complementary, or alternatively, one might substitute for the other.<sup>4</sup>

Given these trends in spending, a related policy question arises: what kind of spending patterns have emerged under the category of other institutions?

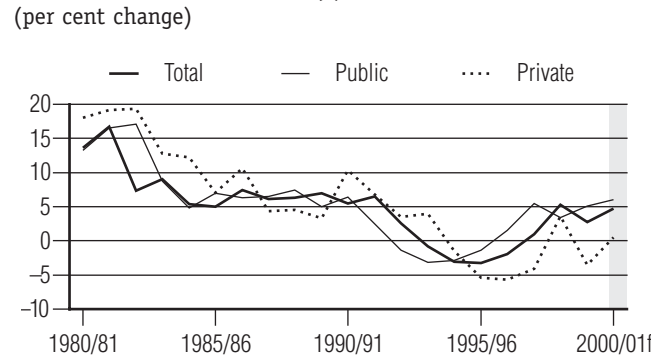
### Other Institutions

Throughout the 1990s, governments focused their attention on hospitals and their downsizing.<sup>5</sup> While this led to a series of reductions in bed capacity, it also highlighted the important role that other facilities can play in delivering more cost-effective care. With this in mind, what kind of changes in expenditure patterns have we seen for the category of other institutions from 1980 to 2000?

For purposes of clarity, the category of other institutions includes a range of care facilities for those who reside at the institution more or less permanently. This covers residential care facilities and homes for the aged (including nursing homes), facilities for persons with physical disabilities, developmental delays, psychiatric disabilities, alcohol and drug problems, and facilities for emotionally disturbed children.

Table 6 shows that total, public and private spending on other institutions increased annually by an average of 6.5 per cent, 6.4 per cent and 6.7 per cent respectively over the 20-year period. At the same time, the annual growth rate in five-year increments for total and public health spending on other institutions continued to follow a

**Chart 5**  
**Per Capita Total, Public and Private Hospital Expenditures, 1980–2000(f)**  
(per cent change)



Source: Canadian Institute for Health Information, 2000.

downward trend. In contrast, the annual growth rate for private spending remained consistent, in the 7 to 9 per cent range between 1980 and 1995, then falling below the year-over-year increase in public spending from 1995 to 2000.

Adjusting for population, the expenditure relationships hold among total, public and the private sector expenditures (see Table 7).

**Table 6**  
**Total, Public and Private Health Expenditures, Other Institutions, Five-Year Annual Growth Rates, 1980–2000(f)**  
(\$ millions)

	1980	1985	1990	1995	2000(f)
Total Health Expenditures	2,544.9	4,106.3	5,757.5	7,317.2	8,937.1
Average annual per cent change	—	10.0	7.0	4.9	4.1
Total Public Expenditures	1,826.8	3,066.9	4,176.1	5,083.1	6,299.2
Average annual per cent change	—	10.9	6.4	4.0	4.4
Total Private Expenditures	718.2	1,039.4	1,581.4	2,234.1	2,637.9
Average annual per cent change	—	7.7	8.8	7.2	3.4

Source: Canadian Institute for Health Information, *National Health Expenditure Trends, 1975–2000(f)*.

**Table 7**  
**Total, Public and Private Per Capita Health Expenditures, Other Institutions, Five-Year Annual Growth Rates, 1980–2000(f)**

	1980	1985	1990	1995	2000(f)
Total Health Expenditures	103.81	158.90	207.85	249.27	290.64
Average annual per cent change	—	8.9	5.5	3.7	3.1
Total Public Expenditures	74.51	118.67	150.76	173.17	204.85
Average annual per cent change	—	9.8	4.9	2.8	3.4
Total Private Expenditures	29.29	40.22	57.09	76.11	85.78
Average annual per cent change	—	6.5	7.3	5.9	2.4

Source: Canadian Institute for Health Information, *National Health Expenditure Trends, 1975–2000(f)*.

Given the emphasis that has been placed on “right-sizing” the institutional sector and developing other complementary structures to provide care for Canadians (e.g., community-based care models), one might have expected to see more pronounced increases in public spending on other institutions.<sup>6</sup> That having been said, over the last decade, per capita public spending on hospitals increased by 16.1 per cent, while per capita public spending on other institutions increased by 35.8 per cent.<sup>7</sup>

At the same time, with almost 30 per cent of total spending on other institutions coming from the private sector, one would also expect that a growing and ageing population might provide an incentive to build up this sector’s capacity. The reality is that per capita private spending for other institutions increased by 50 per cent from 1990 to 2000.

Questions remain about whether those facilities categorized under other institutions have the capacity to deal with the demands that are increasingly being placed upon them. However, it is clear that increases in per capita public and private spending on them have outpaced that of hospitals by a significant margin throughout the 1990s. (And this is notwithstanding the facts that such new monies could have been reallocated away from hospitals and that there are significant differences in the absolute level of funding available to each sector.)

### Physicians

The medical profession has attracted a disproportionate amount of interest when it comes to the level and distribution of public and private spending for medical care in Canada—and this is not unexpected given that in addition to earnings, physicians have control over a large proportion of resources in the health care system.<sup>8</sup>

Table 8 shows that total, public and private spending on physicians increased annually by 7.0 per cent, 7.0 per cent and 6.3 per cent over the 1980 to 2000 period. At the same time, the annual growth rate in five-year increments for total and public health spending on physicians continued to fall from 1980 to 1995. This is not unexpected, given the combination of mechanisms (e.g., global expenditure caps, earnings thresholds and prorations of fees) that were either imposed or negotiated to restrict overall expenditure growth.<sup>9</sup>

From 1995 to 2000, the rate of increase in public expenditure for physicians can likely be attributed to a combination of factors including: the removal of caps, thresholds and prorations; concern over the supply, mix and distribution of physicians; and the improved fiscal position of governments.

Of interest, annual per capita increases in private health spending have surpassed the public sector by a factor of at least 2:1 since 1990 (see Table 9 and Chart 6). While this is due, in part, to the range of services that has been de-insured in addition to other medical services that have never been publicly insured, it still represents only 1 per cent of total spending on physician services.

### Other Professionals

As defined in Appendix A, the category of other professionals captures a range of providers in the health care system. In the aggregate, total, public and private spending increased annually by an average of 8.4, 5.9 and 8.7 per cent from 1980 to 2000 (see Table 10).

Of the three categories, public spending was compressed throughout the 1990s, while private spending continued to grow at a consistent pace. That having been said, 90 per cent of health spending in this category came from the

**Table 8**  
**Total, Public and Private Health Expenditures, Physicians, Five-Year Annual Growth Rates, 1980–2000(f)**  
(\$ millions)

	1980	1985	1990	1995	2000(f)
Total Health Expenditures	3,287.5	6,046.7	9,245.8	10,595.4	12,798.3
Average annual per cent change	–	13.0	8.9	2.8	3.9
Total Public Expenditures	3,236.0	5,963.1	9,157.2	10,485.2	12,623.3
Average annual per cent change	–	13.0	9.0	2.7	3.8
Total Private Expenditures	51.5	83.6	88.6	110.1	175.0
Average annual per cent change	–	10.2	1.2	4.4	9.7

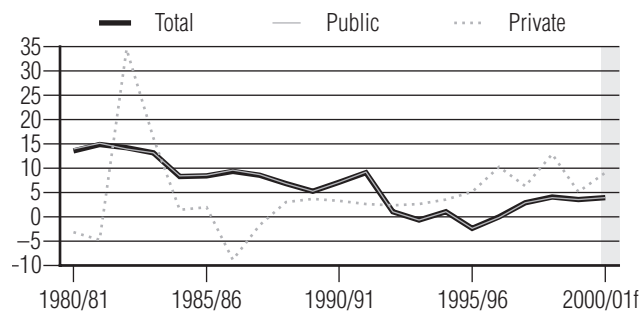
Source: Canadian Institute for Health Information, *National Health Expenditure Trends, 1975–2000(f)*.

**Table 9**  
**Total, Public and Private Per Capita Health Expenditures, Physicians, Five-Year Annual Growth Rates, 1980–2000(f)**

	1980	1985	1990	1995	2000(f)
Total Health Expenditures	134.09	233.98	333.77	360.95	416.20
Average annual per cent change	–	11.8	7.4	1.6	2.9
Total Public Expenditures	131.99	230.75	330.57	357.20	410.51
Average annual per cent change	–	11.8	7.5	1.6	2.8
Total Private Expenditures	2.10	3.24	3.20	3.75	5.69
Average annual per cent change	–	9.1	–0.2	3.2	8.7

Source: Canadian Institute for Health Information, *National Health Expenditure Trends, 1975–2000(f)*.

**Chart 6**  
**Per Capita, Total, Public and Private Physician Expenditures, 1980–2000(f)**  
(per cent change)



Source: Canadian Institute for Health Information, 2000.

**Table 10**  
**Total, Public and Private Health Expenditures, Other Professionals, Five-Year Annual Growth Rates, 1980–2000(f)**  
(\$ millions)

	1980	1985	1990	1995	2000(f)
Total Health Expenditures	2,260.0	4,131.9	6,494.2	8,591.7	11,248.8
Average annual per cent change	–	12.8	9.5	5.8	5.5
Total Public Expenditures	365.4	618.8	998.7	1,097.2	1,147.6
Average annual per cent change	–	11.1	10.0	1.9	0.9
Total Private Expenditures	1,894.6	3,513.0	5,495.5	7,494.5	10,101.2
Average annual per cent change	–	13.1	9.4	6.4	6.2

Source: Canadian Institute for Health Information, *National Health Expenditure Trends, 1975–2000(f)*.

private sector. Most of what is currently funded by the public sector is partial (or in some cases full) coverage for care (e.g., chiropractors, physiotherapy, podiatry and dentistry).

Adjusting for population, Table 11 confirms that growth in public spending on other professionals was severely restricted, standing at levels in 2000 that are comparable in current dollars to 1990 levels. Not unexpectedly, increases in private spending have had a large influence on total spending in the category of other professionals.

Of note, the two categories of physicians and other professionals capture the range of health care professionals as defined by the Canadian Institute for Health Information.<sup>10</sup> When one compares rates of expenditure growth by category (Tables 8 and 10, or 9 and 11), one sees that when it comes to the public purse, physicians appear to have received

a majority of new resources. Part of the explanation lies in the fact that physicians and other professionals received 99 per cent and 10 per cent, respectively, of their funding from governments. The other point is that the data suggest that governments have restricted the allocation of new monies to cover a broader array of services delivered by other professionals.<sup>11</sup>

### Drugs

From 1980 to 2000, only two categories of health spending have experienced a significant increase in the share of public spending—drugs and capital.<sup>12</sup> For drugs, the share of public spending increased from 25 per cent in 1980 to 33 per cent in 2000.<sup>13</sup> Over this period of time, total, public and private spending on drugs increased annually by 10.8 per cent, 12.5 per cent and 10.1 per

cent, respectively.<sup>14</sup> While drugs are still paid for predominantly through the private sector, all three categories have experienced periods of double-digit increases over the 20-year period (see Table 12).

On a per capita basis, increases in public sector spending have consistently outpaced those of the private sector from 1980 to 2000 (see Table 13).

Chart 7, which separates drugs into total prescribed drugs and non-prescribed drugs, provides additional insight on expenditure movements. In the aggregate, expenditures on prescription drugs have tended to outpace

total and non-prescription drugs over the 20-year period.

### Capital

Capital expenditures refer in many ways to “bricks and mortar,” or the physical infrastructure of the health

**Table 11**  
**Total, Public and Private Per Capita Health Expenditures, Other Professionals, Five-Year Annual Growth Rates, 1980–2000(f)**

	1980	1985	1990	1995	2000(f)
Total Health Expenditures	92.18	159.89	234.44	292.70	365.81
Average annual per cent change	–	11.6	8.0	4.5	4.6
Total Public Expenditures	14.90	23.95	36.05	37.38	37.32
Average annual per cent change	–	10.0	8.5	0.7	0.0
Total Private Expenditures	77.28	135.94	198.39	255.32	328.49
Average annual per cent change	–	12.0	7.9	5.2	5.2

Source: Canadian Institute for Health Information, *National Health Expenditure Trends, 1975–2000(f)*.

**Table 12****Total, Public and Private Health Expenditures, Drugs, Five-Year Annual Growth Rates, 1980–2000(f)**

(\$ millions)

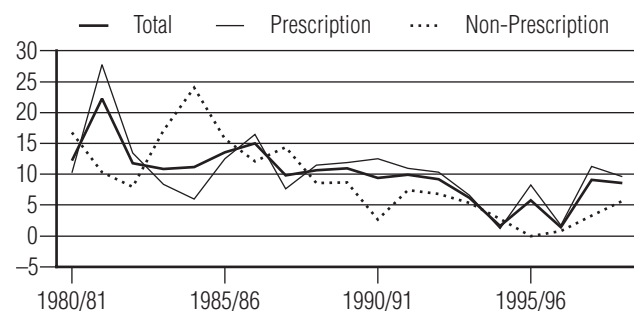
	1980	1985	1990	1995	2000(f)
Total Health Expenditures	1,881.5	3,793.4	6,882.3	9,997.7	14,707.8
Average annual per cent change	–	15.1	12.7	7.8	8.0
Total Public Expenditures	461.9	1,109.8	2,229.8	3,260.3	4,906.7
Average annual per cent change	–	19.2	15.0	7.9	8.5
Total Private Expenditures	1,419.6	2,683.6	4,652.5	6,737.3	9,801.2
Average annual per cent change	–	13.6	11.6	7.7	7.8

Source: Canadian Institute for Health Information, *National Health Expenditure Trends, 1975–2000(f)*.**Table 13****Total, Public and Private Per Capita Health Expenditures, Drugs, Five-Year Annual Growth Rates, 1980–2000(f)**

	1980	1985	1990	1995	2000(f)
Total Health Expenditures	76.75	146.79	248.45	340.59	478.30
Average annual per cent change	–	13.8	11.1	6.5	7.0
Total Public Expenditures	18.84	42.94	80.50	111.07	159.57
Average annual per cent change	–	17.9	13.4	6.6	7.5
Total Private Expenditures	57.91	103.84	167.96	229.52	318.74
Average annual per cent change	–	12.4	10.1	6.4	6.8

Source: Canadian Institute for Health Information, *National Health Expenditure Trends, 1975–2000(f)*.**Chart 7****Per Capita, Total, Public and Private Prescription Expenditures, 1980–2000(f)**

(per cent change)



Source: Canadian Institute for Health Information, 2000.

care system. They cover the construction of facilities and the purchasing of machinery and equipment for hospitals, clinics, first-aid stations and residential care facilities.

Expenditures in this category reflect the degree to which we invest to renew the infrastructure of our system. Table 14 shows that from 1980 to 2000, total, public and private spending on capital increased annually by

6.4 per cent, 8.2 per cent and 0.3 per cent.<sup>15</sup>

Of note, public spending rates from 1995 to 2000 increased by 11.8 per cent, annually. These rates reflect the fact that the public share of capital spending increased from 64 per cent in 1980 to 89 per cent in 2000. It also raises the question as to why there was such a dramatic shift in the private sector's contribution to capital projects in the health care system.

On a per capita basis, Table 15 demonstrates the degree to which the share of private capital in the health care system dropped over the 20-year period. Private per capita spending fell by 0.8 per cent annually from 1980 to 2000.

While per capita public spending on capital increased annually by 7.0 per cent from 1980 to 2000, ongoing concerns have been expressed in terms of purchasing new equipment and machinery, notwithstanding the need to develop additional capacity in the long-term and chronic care sectors.<sup>16</sup>

**Other Health Spending**

The category of other health spending contains a number of different elements within it (e.g., prepayment administration, public health, health research and home care—see Appendix A). For this reason alone it is difficult to come to any firm statement about aggregate spending patterns (see Table 16). However, recent announcements by the federal government regarding its support for health research initiatives (e.g., the Canadian Institutes for Health Research, the Canada Foundation for Innovation and the Health Transition Fund) have contributed to public sector growth in this category.

That said, one can observe that, in the aggregate, the annual growth rate in five-year increments in total and private spending declined from 1980 to 2000, although as a share of total spending, private spending increased from 13 per cent to 15 per cent from 1980 to 2000. Similarly, increases in public spending fell from 1980 to 1995 and levelled out to 2000.

Adjusting for population, Table 17 presents a trend similar to that revealed in Table 16. It shows that from 1995 to 2000, the rate of growth in private per capita spending fell slightly.

**Table 14****Total, Public and Private Health Expenditures, Capital, Five-Year Annual Growth Rates, 1980–2000(f)**

(\$ millions)

	1980	1985	1990	1995	2000(f)
Total Health Expenditures	990.7	1,657.7	2,123.5	2,171.7	3,443.2
Average annual per cent change	–	10.8	5.1	0.4	9.7
Total Public Expenditures	635.3	1,243.3	1,740.1	1,751.0	3,064.3
Average annual per cent change	–	14.4	7.0	0.1	11.8
Total Private Expenditures	355.4	414.4	383.4	420.7	379.0
Average annual per cent change	–	3.1	–1.5	1.9	–2.1

Source: Canadian Institute for Health Information, *National Health Expenditure Trends, 1975–2000(f)*.**Table 15****Total, Public and Private Per Capita Health Expenditures, Capital, Five-Year Annual Growth Rates, 1980–2000(f)**

	1980	1985	1990	1995	2000(f)
Total Health Expenditures	40.41	64.15	76.66	73.98	111.98
Average annual per cent change	–	9.7	3.6	–0.7	8.6
Total Public Expenditures	25.91	48.11	62.82	59.65	99.65
Average annual per cent change	–	13.2	5.5	–1.0	10.8
Total Private Expenditures	14.50	16.03	13.84	14.33	12.32
Average annual per cent change	–	2.0	–2.9	0.7	–3.0

Source: Canadian Institute for Health Information, *National Health Expenditure Trends, 1975–2000(f)*.**Table 16****Total, Public and Private Health Expenditures, Other Health Spending, Five-Year Annual Growth Rates, 1980–2000(f)**

(\$ millions)

	1980	1985	1990	1995	2000(f)
Total Health Expenditures	2,010.2	3,865.1	6,802.0	10,161.2	13,756.0
Average annual per cent change	–	14.0	12.0	8.4	6.2
Total Public Expenditures	1,742.3	3,374.8	5,666.6	8,140.7	11,732.0
Average annual per cent change	–	14.1	10.9	7.5	7.6
Total Private Expenditures	267.9	490.3	1,135.4	2,020.5	2,024.0
Average annual per cent change	–	12.8	18.3	12.2	0.0

Source: Canadian Institute for Health Information, *National Health Expenditure Trends, 1975–2000(f)*.**Table 17****Total, Public and Private Per Capita Health Expenditures, Other Health Spending, Five-Year Annual Growth Rates, 1980–2000(f)**

	1980	1985	1990	1995	2000(f)
Total Health Expenditures	81.99	149.56	245.55	346.16	447.35
Average annual per cent change	–	12.8	10.4	7.1	5.3
Total Public Expenditures	71.07	130.59	204.56	277.33	381.53
Average annual per cent change	–	12.9	9.4	6.3	6.6
Total Private Expenditures	10.93	18.97	40.99	68.83	65.82
Average annual per cent change	–	11.7	16.7	10.9	–0.9

Source: Canadian Institute for Health Information, *National Health Expenditure Trends, 1975–2000(f)*.**Summary**

This chapter has broken down health spending in each category by its total, public and private components. Due to the limitations of developing a methodology that would accurately capture price increases for each category of health spending the data are presented in current (or nominal dollars) and on a per capita basis to capture population changes.

More practically, this chapter also raises a challenging policy conundrum: how can we develop a more seamless approach to accessing care given the different proportions of funding that come from the public and/or private sectors? For example, if there were to be an increasing focus on the role of community-based care models and other health professionals, how would they be integrated into a system that receives 90 per cent of its funding from the private sector? Furthermore, how would they complement or compete with those of physicians and hospitals, who receive 99 per cent and 92 per cent of their revenues from the public system? This does not necessarily suggest that we must “publicize” other professionals and move them into the public sector. It does, however, raise the issue of how we ensure that patients have access to care and can pay for that care, either collectively through the public purse or individually through other mechanisms (e.g., private health insurance premiums, out-of-pocket expenditures) in a manner that does not become a barrier to obtaining care.

This increasing focus may be less of a concern in terms of the delivery of health services, particularly if private models of care lie within the rubric of a publicly funded system. However, the data tell us that, depending on the sector in question, the private sector plays significantly different roles when it comes to

funding the health care system. As a result, we will face a number of policy challenges as we look for ways to design

a system that is integrated, cost effective, accountable and innovative.

- 1 In an attempt to measure price movements, the Consumers' Price Index (CPI) could be used; however, the results would not provide the level of analytical detail that is required. Each category of health expenditure has a number of different factors that contribute to a different combination of price and volume changes over the 1980 to 2000 period. For this reason, and without a generally accepted methodology, it is problematic to analyze each category in inflation-adjusted terms.
- 2 This is a growing area of contention given the recent increase of private facilities that offer a number of diagnostic and therapeutic procedures that appear to be in violation of the Canada Health Act. This is separate from Bill 11 in Alberta, which has been introduced and which allows for-profit private contractors to provide care that is funded by the public sector. For the purposes of this report, these expenditures are captured under physician services.
- 3 That is, they are complementary in nature— see footnote 3, p. 6. Examples would include paying for services privately that are not covered by the public system, such as a private or semi-private room.
- 4 For more discussion, see *The Evolution of Public and Private Health Care Spending in Canada, 1960 to 1997* (Ottawa: Health Action Lobby, Canadian Institute for Health Information, and Health Canada, 1999).
- 5 *Downsizing Canada's Hospitals, 1986/87 to 1994/95*, Health Reports, Spring 1997, vol. 8, no. 4. *An Overview of Specialty Care in Canada: Issue Identification and Policy Challenges* (Ottawa: Canadian Medical Association, 2001) and Glenn G. Brimacombe and Lorraine Pigeon, *A Review of the Funding Flows of Regional Health Authorities in British Columbia* (Ottawa: The Conference Board of Canada, 2001).
- 6 This raises an important methodological issue of how we account for home care expenditures in Canada. For comparative purposes, Canada utilizes the same definition as the Organization for Economic Co-operation and Development (OECD), which collects data on the home health care component of home care that is provided by individuals in health occupations. As a result, the home support component (homemaking and personal care) is not included. However, public data sources (from public sources) do not always make the distinction between the two. This means that home care expenditures can be overstated according to the narrow definition and understated according to the broader definition. While it is difficult to identify expenditures for home care in the private sector, they can be detected under more aggregate categories (such as other health care practitioners or other health care services) that are identified by Statistics Canada's Statistical Household Survey (SHS). The Canadian Institute for Health Information is examining the feasibility of redefining home care to include home support and to better identify expenditures in the private sector.
- 7 Of note, total public per capita spending in Canada increased by 33.7 per cent from 1990 to 2000.
- 8 For more information, see M.G. Taylor, *Insuring National Health Care* (The University of North Carolina Press, 1990) and C.D. Naylor, *Private Practice, Public Payment, Canadian Medicine and the Politics of Health Insurance 1911–1966* (McGill-Queen's University Press, 1986).
- 9 M.L. Barer et al, "Re-Minding Our Ps and Qs: The Costs of Capping Costs for Medical Care" *Health Affairs*, vol. 15, no. 2 (1996), pp. 216–234. J. Hurley et al, "Physician Responses to Global Expenditure Caps in Canada: A Common Property Perspective" *Millbank Quarterly*, vol. 75, no. 3 (1997), pp. 343–364.
- 10 Given the manner in which the data are collected, the statement is qualified to reflect the fact that salaries for nurses and other practitioners (including some physicians) paid for by the public purse are included in the totals for other categories of expenditure (e.g., hospitals, other institutions). Since they are not reported separately, it would be difficult to determine how these practitioners have fared in comparison with physicians.
- 11 As set out under the Canada Health Act, there is no legislative requirement for provincial and territorial governments to publicly fund services beyond insured health care services (e.g., medically necessary hospital services, physician services and in-hospital surgical-dental services), and extended health care services (e.g., certain aspects of long-term residential care and the health aspects of home care and ambulatory care services).
- 12 It is important to keep in mind that the category of drugs can be separated into two categories: (1) prescription drugs; and (2) non-prescription drugs (which include over-the-counter drugs and personal health supplies [see Appendix A]).
- 13 It is important to note that the category of drugs excludes drugs dispensed in hospitals and other institutions. Assuming that these drugs are publicly funded, the numbers presented likely under-represent the total public expenditure on drugs.
- 14 Looking at prescription drugs from 1980 to 1998, total, public and private expenditures have increased annually by 11.6 per cent, 12.5 per cent and 11.0 per cent, respectively.
- 15 The public figures do not include monies that were included in the September 2000 First Ministers' Health Accord (e.g., \$1 billion over two years for medical equipment and \$500 million for health information technologies).
- 16 As part of the First Ministers' Health Accord, the federal government set aside \$1.0 billion over two years to fund the purchase of medical equipment. See also the Canadian Association of Radiologists' presentation to the Senate Standing Committee on Social Affairs, Science and Technology, March 2001, and Specialty Care in Canada—Issue Identification and Policy Challenges by the Canadian Medical Association (Ottawa: Canadian Medical Association, 2001).

## “Share” and Share Alike: How Are Total, Public and Private Dollars Spent?

The previous chapter focused on the “hard facts” of health care funding in terms of total, public and private expenditures in current dollars for each category. There are, however, limitations by not being able to adjust current expenditures for price movements (i.e., increases or decreases). Thus, while the information is relevant and useful in reviewing expenditure trends within and between categories, we cannot isolate the impact of price movements or changes in the volume of services delivered that affect overall expenditures.

Given this methodological limitation, the data are presented in terms of how each category is distributed across total, public and private spending. This in-depth examination provides a clearer sense of whether the relative share of spending for each category increased, decreased or remained the same. It can also indicate where the money moved to (or from) and offer insights into future trends.

It is also important to keep in mind that shares of spending exist in relation to other categories. As a result, some categories may be increasing at a rate that is deemed to be “appropriate” (by governments, the public and/or providers), but may fall (rise) in relation to total, public and/or private spending due to the rate of acceleration (deceleration) of growth in other categories.<sup>1</sup>

For example, Table 18 shows that between 1980 and 2000, the share of total spending on hospitals dropped from 41.8 per cent of total health care spending to 31.8 per cent. Similarly, the share of total, public and private spending on hospitals declined over the same period.

While the hospital sector experienced increases in terms of current funding and on a per capita basis, its share of total, public and private health spending continued to decline over the 20-year period. As a result, while spending increased, the implication is that it did not increase in line with other categories of spending.

At the same time, while other institutions accounted for 11.4 per cent of total health spending in 1980, they accounted for 9.4 per cent in 2000. While the public share of spending remained relatively stable from 1980 to 2000, the private share decreased.

Given the focus that has been placed on the need to move towards more responsive and adaptive community-based delivery structures, one might have expected to see additional resources, relatively speaking, invested in the category of other institutions. Conversely, one could also argue that this category held its own in a world of fiscal downsizing, given that 71 per cent of spending came from

the public sector. From 1990 to 2000, public and private per capita expenditures increased by 35.8 per cent and 50.3 per cent, respectively.

For physicians, the share of total, public and private health spending declined slightly from 1980 to 2000. Recognizing that 99 per cent of what physicians earn is derived from the public sector, it would appear that governments have had some success in moderating overall allocations to the medical profession. From 1990 to 2000, public per capita expenditures increased by 2.2 per cent per year (compared to an annual rate of 9.6 per cent in the previous decade). A question arises in relation to this fact: what kind of impact has this had on the supply, mix and distribution of physicians, and on timely access to quality medical care?

For the category of other professionals, one can see that the total share of health spending increased from 10.1 per cent in 1980 to 11.8 per cent in 2000. However, it is interesting to note that the public share decreased from 2.2 per cent to 1.7 per cent, while the private share increased from 34.7 per cent to 36.7 per cent. In a relative sense, less public money was allocated to other professionals while more private dollars were required to access care. This is not unexpected, considering that 90 per cent of expenditures came from the private sector.

If future policy direction seeks to more effectively integrate other providers into a publicly funded health care system (e.g., primary health care reform), a significant amount of public monies will have to be invested or transferred from the private to the public sector. This approach raises two fundamental questions. First, is this a feasible policy approach, and second, by what mechanism(s) do we initiate the process of re-distributing monies from the private to the public sector?

Of all the categories of health spending (excluding other health spending), drugs is the only one that experienced a significant increase in its share of total, public and private spending from 1980 to 2000. This is not unexpected, given the rates of growth that this category experienced over the 20-year period in both the public and private sectors.

For capital expenditures, the total share dropped consistently throughout the 1980 to 2000 period. However, while the public share experienced cycles of growth, the private share continued to fall. Public spending on capital significantly outpaced that of the private sector—to the

**Table 18**  
**Share of Total, Public and Private Health Care Spending, 1980–2000(f)**

	1980	1985	1990	1995	2000(f)
<b>Hospitals</b>					
Per cent share of Total Health Care Expenditures	41.8	40.8 (↓)	39.0 (↓)	34.5 (↓)	31.8 (↓)
Per cent share of Public Health Care Expenditures	50.9	48.9 (↓)	47.4 (↓)	43.7 (↓)	41.2 (↓)
Per cent share of Private Health Care Expenditures	13.7	15.6 (↑)	14.4 (↓)	11.8 (↓)	8.8 (↓)
<b>Other Institutions</b>					
Per cent share of Total Health Care Expenditures	11.4	10.3 (↓)	9.4 (↓)	9.8 (↑)	9.4 (↓)
Per cent share of Public Health Care Expenditures	10.8	10.2 (↓)	9.2 (↓)	9.6 (↑)	9.3 (↓)
Per cent share of Private Health Care Expenditures	13.2	10.7 (↓)	10.2 (↓)	10.4 (↑)	9.6 (↓)
<b>Physicians</b>					
Per cent share of Total Health Care Expenditures	14.7	15.2 (↑)	15.1 (↓)	14.2 (↓)	13.5 (↓)
Per cent share of Public Health Care Expenditures	19.2	19.8 (↑)	20.1 (↑)	19.8 (↓)	18.7 (↓)
Per cent share of Private Health Care Expenditures	0.9	0.9 (→)	0.6 (↓)	0.5 (↓)	0.6 (↑)
<b>Other Professionals</b>					
Per cent share of Total Health Care Expenditures	10.1	10.4 (↑)	10.6 (↑)	11.5 (↑)	11.8 (↑)
Per cent share of Public Health Care Expenditures	2.2	2.1 (↓)	2.2 (↑)	2.1 (↓)	1.7 (↓)
Per cent share of Private Health Care Expenditures	34.7	36.0 (↑)	35.3 (↓)	34.8 (↓)	36.7 (↑)
<b>Drugs</b>					
Per cent share of Total Health Care Expenditures	8.4	9.5 (↑)	11.3 (↑)	13.4 (↑)	15.5 (↑)
Per cent share of Public Health Care Expenditures	2.7	3.7 (↑)	4.9 (↑)	6.2 (↑)	7.3 (↑)
Per cent share of Private Health Care Expenditures	26.0	27.5 (↑)	29.9 (↑)	31.2 (↑)	35.6 (↑)
<b>Capital</b>					
Per cent share of Total Health Care Expenditures	4.4	4.2 (↓)	3.5 (↓)	2.9 (↓)	3.6 (↑)
Per cent share of Public Health Care Expenditures	3.8	4.1 (↑)	3.8 (↓)	3.3 (↓)	4.5 (↑)
Per cent share of Private Health Care Expenditures	6.5	4.3 (↓)	2.5 (↓)	2.0 (↓)	1.4 (↓)
<b>Other Health Spending</b>					
Per cent share of Total Health Care Expenditures	9.0	9.7 (↑)	11.1 (↑)	13.6 (↑)	14.5 (↑)
Per cent share of Public Health Care Expenditures	10.3	11.2 (↑)	12.4 (↑)	15.4 (↑)	17.4 (↑)
Per cent share of Private Health Care Expenditures	4.9	5.0 (↑)	7.3 (↑)	9.4 (↑)	7.3 (↓)

The arrows indicate whether the percentage share has increased (↑), decreased (↓) or remained the same (→) over the last five-year period. Numbers may not add up to 100 due to rounding.

Source: Canadian Institute for Health Information, *National Health Expenditure Trends, 1975–2000(f)*.

point where the public share increased from 64 per cent in 1980 to 89 per cent in 2000.

Finally, other health spending, which incorporates a number of different elements, has seen its total share of health spending continue to increase over the 1980 to 2000 period. The public share increased significantly from 10.3 per cent in 1980 to 17.4 per cent in 2000. Aside from 2000, the private share generally increased from 4.9 per cent to 7.3 per cent.

In summary, a number of different categories experienced shifts in the share of total, public and private spending in Canada from 1980 to 2000. For example, grouped in related categories, the share of total, public and private spending

for hospitals and, for the most part, other institutions have followed a downward trend over the 20-year period.

Physicians also saw their share of total and public spending fall, with a fairly stable share of private spending. At the same time, other professionals witnessed a steady reduction in the share of public funding, coupled with a slight upward trend in the private and total share.

One would suspect that there are different reasons as to why the total, and/or public and/or private shares have increased or decreased; however, more significantly, these shifts have important implications for the health care system, particularly when a category of expenditure

has a high concentration of funding from either the public or private sector.

For example, the declining share of public funds for hospitals and physicians may have implications for timely access to care in situations or areas where there are limited or no other alternatives. Similarly, when hospitals are downsized, one would expect that additional investments will be made in the other institutions category.

The declining share of public funds for physicians, hospitals and other institutions raises several questions. To what degree have expenditures on drugs contributed to the need for fewer resources, relatively speaking? In short, to what extent have drugs acted as a substitute for other forms of care?

Also, what impact (if any) are changes in the share of public and private spending having on timely access

to quality care? Is passive privatization (see footnote 2, page 9) occurring to such an extent that services that were formerly available through the public sector are now being transferred to the private sector? In other words, is cost shifting taking place? Or are categories with a high degree of public (or private) funding being forced to absorb reductions in funding (i.e., cost containment)? If so, in cases where certain sectors of the health care system are predominantly publicly funded with no established private alternative (e.g., hospitals, physicians and other institutions), then any "savings" resulting from cost-containment measures have likely been compressed or internalized in the system. This could result in some combination of more efficient, effective and innovative ways to deliver care that would not impede reasonable access, compromised access and/or the lengthening of queues.

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1 Some would argue that a "denominator effect" can mask significant increases in actual spending by category by downplaying growth in dollar terms (i.e., the numerator). While actual expenditure movements are addressed in Chapter 5 of the report, the "shares" approach is designed to give the reader a sense of the relative priority of each sector over time (in effect, a form of revealed preferences) in terms of how public and private resources are allocated among a series of expenditure categories.

## Private Sources of Funding Health Care

Although a number of studies have reviewed health care expenditures in Canada,<sup>1</sup> the subject of private sources of funding health care in Canada has received only limited attention.

However, private health care funding is important for at least two reasons. First, on average, 29 per cent or \$27.5 billion (2000) of the health care system is funded by private sources, which primarily include out-of-pocket expenditures and private health insurance claims. Second, as shown in Table 3 of this report, depending on the category of expenditure, the level of financial participation by the private sector varies considerably.<sup>2</sup> That having been said, the reality is that Canada's health care system is a mixture of public and private sources of funding—although several categories are dominated by the public sector (such as hospitals, physicians and capital), or the private sector (for example, other professionals).

Chapter 2 through 6 of this paper present a review of public and private health expenditures. In turn, this section considers, in detail, the most recent information on private health revenues by category of expenditure in Canada.

As defined by the Canadian Institute for Health Information, there are three ways in which private sources of funding are categorized for health care. Combined, these three categories account for 100 per cent of total private sources of revenue in the health care system:<sup>3</sup>

1. **Out-of-pocket:** expenditures made by individuals for health care goods and services
2. **Private health insurance:** claims paid out by commercial and not-for-profit insurance firms, including the cost of administering claims
3. **Non-consumption health expenditures:** non-patient revenues received by health care institutions (e.g., donations, investment income); spending on health-related capital construction and equipment; and health research funded by private sources

Table 19 provides an overview of total private health funding for Canada broken down by its component parts, from 1988 to 1998. This period represents the most up-to-date information that is publicly available.

Over that 10-year period, total private funding increased from \$12.7 billion to \$25.1 billion. Overall, funding increased on an annual basis by 7.0 per cent. At the same time, out-of-pocket expenditures increased by 6.3 per cent, private health insurance by 9.5 per cent, and non-consumption health expenditures by 2.5 per cent. For each year of comparison, the annual growth rate

**Table 19**  
**Total Private Sources of Funding by Category, Annual Growth Rates, 1988–98**  
(\$ millions)

	1988	1991	1995	1998
Total Private Sources of Funding	12,795.4	16,894.9	21,562.0	25,105.8
Average annual per cent change		9.7	6.3	5.2
Out-of-Pocket	7,435.3	9,332.1	11,716.6	13,752.9
Average annual per cent change		7.9	5.9	5.5
Private Health Insurance	3,734.2	5,534.6	7,541.3	9,278.4
Average annual per cent change		14.0	8.0	7.2
Non-Consumption Health Expenditures	1,625.9	2,028.1	2,304.1	2,074.5
Average annual per cent change		7.6	3.2	-3.4

The most recent expenditure data available, by source of funding are from 1988 to 1998.

Source: Canadian Institute for Health Information.

for private health insurance consistently outpaced that of all other categories.

Table 20 presents the data adjusted for population.<sup>4</sup> From 1988 to 1998, total private per capita sources of funds increased by 5.7 per cent on an annual basis. Similarly, revenues from out-of-pocket sources increased by 5.1 per cent, private health insurance by 8.2, and non-consumption health expenditures by 1.2 per cent. One also notes that per capita spending on non-consumption health expenditures in 1998 was below 1991 levels.

**Table 20**  
**Total Private Per Capita Sources of Funding by Category, Annual Growth Rates, 1988–98**  
(\$ millions)

	1988	1991	1995	1998
Total Private Sources of Funding	477.47	602.72	734.55	830.00
Average annual per cent change		8.1	5.1	4.2
Out-of-Pocket	277.45	332.92	399.15	454.67
Average annual per cent change		6.3	4.6	4.4
Private Health Insurance	139.34	197.45	256.91	306.75
Average annual per cent change		12.3	6.8	6.1
Non-Consumption Health Expenditures	60.67	72.35	78.49	68.58
Average annual per cent change		6.0	2.1	-4.4

Source: Canadian Institute for Health Information.

The year-over-year increases in private health insurance claims raise a number of possibilities:

1. Are Canadians being asked to pay for services that are no longer covered by the public system?
2. Are they using the same range of privately insured health care services more frequently?
3. Are they accessing an expanded array of services that are provided privately and independent from the range of services in the public sector?<sup>5</sup>
4. Is the insurance industry experiencing an increase in its cost structure and passing it on to policyholders, and/or
5. Is the insurance industry reflecting an increase in profitability?

As outlined in previous chapters of the report, there are limitations when comparing sources of funding health care in current dollars (see Chapter 5). One way to consider expenditure movements in total funding and per capita terms is to convert private health dollars into their respective "shares" (see Table 21).

From 1988 to 1998, one can see that there were shifts between how the three categories account for private monies in the health care system. While the share allocated to out-of-pocket expenditures fell and then levelled off, the share allocated to private health insurance continued to climb. That having been said, in 1998, out-of-pocket expenditures were roughly 1.5 times higher than private insurance payouts. At the same time, the share of non-consumption health expenditures consistently decreased.

While these aggregated trends are important, they are limited in terms of the general information and patterns they reveal. Therefore, similar to the approach taken in Chapter 5 of this report, it is apropos to continue to mine the data and examine how each category of expenditure accounts for private sources of funding.

## Hospitals

Private sources of funds that were allocated to hospitals grew from \$1.9 billion in 1988 to \$2.4 billion in 1998

**Table 21**  
*Share of Total Private Sources of Funding, by Category, 1988–98*

	1988	1991	1995	1998
Total Private Sources of Funding	100.0	100.0	100.0	100.0
Out-of-Pocket	58.1	55.2	54.3	54.8
Private Health Insurance	29.2	32.8	35.0	37.0
Non-Consumption Health Expenditures	12.7	12.0	10.7	8.3

Source: Canadian Institute for Health Information.

**Table 22**  
*Total Private Sources of Funding for Hospitals, Annual Growth Rates, 1988–98*  
(\$ millions)

	1988	1991	1995	1998
Total Private Sources of Funding	1,903.1	2,421.4	2,544.7	2,455.1
Average annual per cent change		8.4	1.2	-1.2
Out-of-Pocket	518.0	585.8	541.5	563.2
Average annual per cent change		4.2	-1.9	1.3
Private Health Insurance	274.4	386.9	435.0	583.1
Average annual per cent change		12.1	3.0	10.3
Non-Consumption Health Expenditures	1,110.8	1,448.7	1,568.1	1,308.9
Average annual per cent change		9.3	2.0	-5.8

Source: Canadian Institute for Health Information.

(see Table 22). This represents an annual growth rate of 2.6 per cent. Over the same period of time, out-of-pocket expenditures, private insurance and non-consumption expenditures increased by 0.8 per cent, 7.8 per cent, and 1.7 per cent, respectively.

While out-of-pocket expenditures grew modestly, private insurance showed the greatest expansion by more than doubling overall expenditures from 1988 to 1998. Some of this increase reflected the rising number of Canadians who require some form of hospital care—and use private health insurance to cover ancillary services (such as a private room and television). The remainder represents a combination of services that were either previously funded by the public sector and have been de-insured, or were services that did not have a private charge and that now have an associated fee.

Adjusted for population, private per capita sources of funding increased from \$71 to \$81 over the 10-year period (see Table 23). This represents an annual growth

**Table 23**  
*Total Private Per Capita Sources of Funding for Hospitals, Annual Growth Rates, 1988–98*

	1988	1991	1995	1998
Total Private Sources of Funding	71.02	86.38	86.69	81.17
Average annual per cent change		6.7	0.1	-2.2
Out-of-Pocket	19.33	20.90	18.45	18.62
Average annual per cent change		2.6	-3.1	0.3
Private Health Insurance	10.24	13.80	14.82	19.28
Average annual per cent change		10.5	1.8	9.2
Non-Consumption Health Expenditures	41.45	51.68	53.42	43.27
Average annual per cent change		7.6	0.8	-6.8

Source: Canadian Institute for Health Information.

rate of 1.3 per cent. Of note, out-of-pocket expenditures dropped by 0.4 per cent and private health insurance and non-consumption health expenditures increased by 6.5 per cent and 0.4 per cent, respectively.

Furthermore, funding levels for non-consumption health expenditures in 1998 were only slightly above 1988 levels. While per capita levels had increased throughout the early and mid-1990s, one has to ask why there has been such a precipitous decrease from 1995. Is it due to a lack of fundraising campaigns or appropriate tax incentives for the private sector, Canadians' unwillingness to give, or to the fact that hospitals have focused more attention on governments to provide additional public funding (to the point where 89 per cent of capital funding comes from the public sector)?

### Other Institutions

From 1988 to 1998, total private funding for other institutions increased annually by 6.7 per cent (see Table 24). It is interesting to note that out-of-pocket expenditures increased by this very same amount. While the rates of growth in out-of-pocket funding continued to fall over the period, this funding accounted for 100 per cent of how other institutions are funded from private sources.

More clearly, the data confirm that no claims are being paid by private insurance for services rendered by other institutions in Canada (see Tables 24 and 25). While this is an interesting finding, it is perhaps counterintuitive to what one would have expected, given the public policy debate about the need for an increased role for care provided by other institutions.<sup>6</sup> In the absence of a viable marketplace that would allow Canadians to set aside adequate resources (e.g., long-term care insurance) to afford

**Table 24**  
**Total Private Sources of Funding for Other Institutions, Annual Growth Rates, 1988-98**  
(\$ millions)

	1988	1991	1995	1998
Total Private Sources of Funding	1,270.4	1,768.3	2,234.1	2,439.2
Average annual per cent change		11.7	6.0	3.0
Out-of-Pocket	1,270.4	1,768.3	2,234.1	2,439.2
Average annual per cent change		11.7	6.0	3.0
Private Health Insurance	0.0	0.0	0.0	0.0
Average annual per cent change		0.0	0.0	0.0
Non-Consumption Health Expenditures	0.0	0.0	0.0	0.0
Average annual per cent change		0.0	0.0	0.0

Source: Canadian Institute for Health Information.

**Table 25**  
**Total Private Per Capita Sources of Funding for Other Institutions, Annual Growth Rates, 1988-98**

	1988	1991	1995	1998
Total Private Sources of Funding	47.40	63.08	76.11	80.64
Average annual per cent change		10.0	4.8	1.9
Out-of-Pocket	47.40	63.08	76.11	80.64
Average annual per cent change		10.0	4.8	1.9
Private Health Insurance	0.0	0.0	0.0	0.0
Average annual per cent change		0.0	0.0	0.0
Non-Consumption Health Expenditures	0.0	0.0	0.0	0.0
Average annual per cent change		0.0	0.0	0.0

Source: Canadian Institute for Health Information.

care provided by other institutions, individuals would either have to wait for access to services within the public system or continue to pay out of their own pockets.

### Physicians

In total, the amount of private funding for physicians grew from \$80 million in 1988 to \$150 million in 1998 (see Table 26). This represents a growth rate of 6.5 per cent. While out-of-pocket expenditures increased on an annual basis by 6.3 per cent, private insurance increased at a clip of 18.2 per cent per year.<sup>7</sup>

When adjusted by population, a similar expenditure growth pattern emerges (see Table 27), with approximately \$5 per person going to medical care. Interestingly, while increases in private insurance have increased more dramatically than out-of-pocket expenditures, out-of-pocket expenditures represent 98 per cent of private sources of funds for physicians. Framed another way, for

**Table 26**  
**Total Private Sources of Funding for Physicians, Annual Growth Rates, 1988-98**  
(\$ millions)

	1988	1991	1995	1998
Total Private Sources of Funding	80.0	91.9	110.1	150.1
Average annual per cent change		4.7	4.6	10.9
Out-of-Pocket	79.4	90.6	108.3	146.9
Average annual per cent change		4.5	4.6	10.7
Private Health Insurance	0.6	1.4	1.8	3.2
Average annual per cent change		32.6	6.5	21.1
Non-Consumption Health Expenditures	0.0	0.0	0.0	0.0
Average annual per cent change		0.0	0.0	0.0

Source: Canadian Institute for Health Information.

**Table 27**  
**Total Private Per Capita Sources of Funding for Physicians, Annual Growth Rates, 1988–98**

	1988	1991	1995	1998
Total Private Sources of Funding	2.98	3.28	3.75	4.96
Average annual per cent change		3.2	3.4	9.8
Out-of-Pocket	2.96	3.23	3.69	4.86
Average annual per cent change		3.0	3.4	9.6
Private Health Insurance	0.02	0.05	0.06	0.11
Average annual per cent change		35.7	5.1	22.3
Non-Consumption Health Expenditures	0.0	0.0	0.0	0.0
Average annual per cent change		0.0	0.0	0.0

Source: Canadian Institute for Health Information.

each dollar spent on physician services through private health insurance, \$46 comes from out-of-pocket sources.

While 98 per cent of private revenues for physicians come from out-of-pocket expenditures, 99 per cent of total revenues come from the public sector. Given the high degree of concentrated public funding, it is not surprising that there is no viable medical market for the provision of private insurance in Canada. The data also suggest that any move to shift the financial burden of medical services from the public to the private sector has resulted in an increased out-of-pocket burden for Canadians. This may have a differential impact on Canadians' access to care, depending on their level of discretionary income.<sup>8</sup>

### Other Professionals

From 1988 to 1998, total, out-of-pocket and private insurance increased on an annual basis by 7.1 per cent, 6.0 per cent and 8.6 per cent, respectively (see Table 28).

**Table 28**  
**Total Private Sources of Funding for Other Professionals, Annual Growth Rates, 1988–1998**  
(\$ millions)

	1988	1991	1995	1998
Total Private Sources of Funding	4,605.2	5,917.6	7,494.5	9,160.1
Average annual per cent change		8.7	6.1	6.9
Out-of-Pocket	2,744.5	3,243.8	4,084.2	4,906.4
Average annual per cent change		5.7	5.9	6.3
Private Health Insurance	1,860.7	2,673.8	3,410.3	4,253.6
Average annual per cent change		12.8	6.3	7.6
Non-Consumption Health Expenditures	0.0	0.0	0.0	0.0
Average annual per cent change		0.0	0.0	0.0

Source: Canadian Institute for Health Information.

For each year of comparison, the annual growth rates for private insurance outpaced those of out-of-pocket payouts. That being said, out-of-pocket funding represented 53.6 per cent of total private funding for other professionals in 1998.

Adjusted for population, total, out-of-pocket and private insurance increased by 5.8 per cent, 4.7 per cent and 7.3 per cent from 1988 to 1998 (see Table 29). It is important to keep in mind that the public-private distribution for other professionals (standing at 90 per cent private) is the polar opposite of that for physicians (at 99 per cent public). Not unexpectedly, private health insurance has a significant role to play in underwriting the costs of services provided by other professionals.

**Table 29**  
**Total Private Per Capita Sources of Funding for Other Professionals, Annual Growth Rates, 1988–98**

	1988	1991	1995	1998
Total Private Sources of Funding	171.84	211.10	255.32	302.82
Average annual per cent change		7.1	4.9	5.9
Out-of-Pocket	102.42	115.72	139.13	162.20
Average annual per cent change		4.2	4.7	5.2
Private Health Insurance	69.44	95.38	116.18	140.62
Average annual per cent change		11.2	5.1	6.6
Non-Consumption Health Expenditures	0.0	0.0	0.0	0.0
Average annual per cent change		0.0	0.0	0.0

Source: Canadian Institute for Health Information.

### Prescribed Drugs

Chapter 5 of the paper focuses on the expenditure category of drugs—which encompasses prescribed and non-prescribed drugs (including over-the-counter drugs and personal health supplies—see Appendix A). Given the focus of the current policy debate on the importance of and potential role for a national pharmacare program, the rapid escalation in the costs of prescription drugs,<sup>9</sup> and the fact that 100 per cent of non-prescribed drugs and over-the-counter drugs are funded through out-of-pocket expenditures, this chapter exclusively addresses the role of the private sector in funding prescribed drugs.

From 1988 to 1998, total private funding for prescribed drugs increased annually by 10.4 per cent (see Table 30). Over the same period, out-of-pocket expenditures and private insurance increased by 9.5 per cent and 11.0 per cent. Interestingly, from 1991 to 1995, year-over-year increases in out-of-pocket funding slightly outpaced those of private insurance. This trend reversed from 1996 to 1998. Some reasons behind this reversal include increased co-payments and deductibles that were introduced by

**Table 30**  
**Total Private Sources of Funding for Prescribed Drugs, Annual Growth Rates, 1988–98**  
(\$ millions)

	1988	1991	1995	1998
Total Private Sources of Funding	2,034.0	2,861.9	4,033.8	5,458.6
Average annual per cent change		12.1	9.0	10.6
Out-of-Pocket	902.7	1,189.4	1,683.6	2,237.8
Average annual per cent change		9.6	9.1	9.9
Private Health Insurance	1,131.3	1,672.5	2,350.1	3,220.8
Average annual per cent change		13.9	8.9	11.1
Non-Consumption Health Expenditures	0.0	0.0	0.0	0.0
Average annual per cent change		0.0	0.0	0.0

Source: Canadian Institute for Health Information.

government-funded pharmacare programs, as well as prescribed drugs that were either removed or not included on provincial/territorial formularies.

Adjusting for population, there were robust increases in total private funding for prescribed drugs from 1988 to 1998 (see Table 31). In particular, total, out-of-pocket and private health insurance increased annually by 9.0 per cent, 8.2 per cent, and 9.7 per cent. Of note, in 1998, out-of-pocket expenditures accounted for 41 per cent of private funding, while private insurance accounted for the remaining 59 per cent.

If, in the future, discussions around a national pharmacare program were to gain momentum, one critical question of policy implementation would have to be addressed: what should be the role of the private sector? And, if the public sector were to play a more significant role in funding prescribed drugs, how would we go about “transferring” more than \$3.2 billion worth of private

**Table 32**  
**Total Private Sources of Funding for Capital, Annual Growth Rates, 1988–98**  
(\$ millions)

	1988	1991	1995	1998
Total Private Sources of Funding	351.0	329.7	420.7	398.4
Average annual per cent change		-2.1	6.3	-1.8
Out-of-Pocket	0.0	0.0	0.0	0.0
Average annual per cent change		0.0	0.0	0.0
Private Health Insurance	0.0	0.0	0.0	0.0
Average annual per cent change		0.0	0.0	0.0
Non-Consumption Health Expenditures	351.0	329.7	420.7	398.4
Average annual per cent change		-2.1	6.3	-1.8

Source: Canadian Institute for Health Information.

**Table 31**  
**Total Private Per Capita Sources of Funding for Prescribed Drugs, Annual Growth Rates, 1988–98**

	1988	1991	1995	1998
Total Private Sources of Funding	75.90	102.10	137.42	180.46
Average annual per cent change		10.4	7.7	9.5
Out-of-Pocket	33.68	42.43	57.36	73.98
Average annual per cent change		8.0	7.8	8.9
Private Health Insurance	42.22	59.67	80.06	106.48
Average annual per cent change		12.2	7.6	10.0
Non-Consumption Health Expenditures	0.0	0.0	0.0	0.0
Average annual per cent change		0.0	0.0	0.0

Source: Canadian Institute for Health Information.

health insurance payouts that are currently allocated to prescribed drugs?

### Capital

While private funding for capital increased annually from 1992 to 1995, it has experienced year-over-year decreases between 1988 and 1991, and 1996 and 1998 (see Tables 32 and 33). Overall, private sources for capital increased by 1.3 per cent per year from 1988 to 1998.

Given the concerns that have been expressed by a number of stakeholders about the status of the physical infrastructure of the system (e.g., buildings and associated equipment) and a limited technological endowment (e.g., Computer-Aided Tomography [CAT] scanners, Magnetic Resonance Imagers [MRIs] and lithotripters) one might expect that the private sector could play a more significant role—particularly in the latter half of the 1990s. Perhaps some lessons could be learned from the Private Financing Initiative in the United Kingdom.<sup>10</sup>

**Table 33**  
**Total Private Per Capita Sources of Funding for Capital, Annual Growth Rates, 1988–98**

	1988	1991	1995	1998
Total Private Sources of Funding	13.10	11.76	14.33	13.17
Average annual per cent change		-3.5	5.1	-2.8
Out-of-Pocket	0.0	0.0	0.0	0.0
Average annual per cent change		0.0	0.0	0.0
Private Health Insurance	0.0	0.0	0.0	0.0
Average annual per cent change		0.0	0.0	0.0
Non-Consumption Health Expenditures	13.10	11.76	14.33	13.17
Average annual per cent change		-3.5	5.1	-2.8

Source: Canadian Institute for Health Information.

## Other Health Spending

As identified in Chapter 5, the category of other health spending is a collection of a number of different elements (see Appendix A). That being said, there are a few points that should be made about specific components (see Table 34). First, health research, which accounts for 100 per cent of monies under non-consumption health expenditures, grew from \$164.1 million in 1988 to \$367.2 million in 1999—an annual increase of 8.4 per cent. To complement this increase, the federal government announced a series of significant funding initiatives in this area (witness the creation of the Canadian Institutes for Health Research, the Canada Foundation for Innovation and the Health Transition Fund).

**Table 34**  
**Total Private Sources of Funding for Other Health Spending, Annual Growth Rates, 1988–98**  
(\$ millions)

	1988	1991	1995	1998
Total Private Sources of Funding	766.8	1,267.5	2,020.5	1,977.3
Average annual per cent change		18.2	12.4	-0.70
Out-of-Pocket	135.4	217.7	361.4	392.5
Average annual per cent change		17.2	13.5	2.8
Private Health Insurance	467.3	800.0	1,344.0	1,217.7
Average annual per cent change		19.6	13.8	-3.2
Non-Consumption Health Expenditures	164.1	249.8	315.2	367.2
Average annual per cent change		15.0	6.0	5.2

Source: Canadian Institute for Health Information.

Second, out-of-pocket expenditures, which account for a number of items (such as home care, medical transportation and training of health workers) increased by 11.2 per cent annually from 1988 to 1998—although the trend for year-over-year increases is a downward one.

Third, pre-payment administration, which accounts for 100 per cent of monies under private insurance, increased from \$467.3 million in 1988 to \$1.2 billion in 1998—an annual increase of 10.1 per cent. While the industry experienced double-digit rates of growth from 1988 to 1995, the rates declined from 1995 to 1998.

A similar pattern of expenditure growth is demonstrated when the data are adjusted by population (see Table 35).

**Table 35**  
**Total Private Per Capita Sources of Funding for Other Health Spending, Annual Growth Rates, 1988–98**

	1988	1991	1995	1998
Total Private Sources of Funding	28.61	45.21	68.83	65.37
Average annual per cent change		16.5	11.1	-1.7
Out-of-Pocket	5.06	7.77	12.31	12.98
Average annual per cent change		15.4	12.2	1.8
Private Health Insurance	17.44	28.54	45.78	40.25
Average annual per cent change		17.8	12.5	4.2
Non-Consumption Health Expenditures	6.12	8.91	10.74	12.14
Average annual per cent change		13.3	4.8	4.2

Source: Canadian Institute for Health Information.

1 R. Deber et al., *The Public-Private Mix in Health Care: Striking A Balance—Health Care Systems in Canada and Elsewhere*. Papers commissioned by the National Forum on Health, vol. 4. Health Action Lobby, Canadian Institute for Health Information and Health Canada, *The Evolution of Public and Private Health Care Spending in Canada, 1960 to 1997* (Ottawa: Canadian Institute for Health Information, 1999). R. Deber, *Getting What We Pay For: Myths and Realities About Financing Canada's Health Care System*. A background paper prepared for the "Dialogue on Health Reform: Sustaining Confidence in Canada's Health Care System," 2000. *International Funding Perspectives: One Size Does Not Fit All*, (Ottawa: Canadian Medical Association, forthcoming publication). Canadian Healthcare Association, *The Private-Public Mix in the Funding and Delivery of Health Services in Canada: Challenges and Opportunities* (Ottawa: Canadian Healthcare Association, 2001).

2 The issue of the level of out-of-pocket expenditures, and/or the use of co-payments and deductibles with private insurance has raised questions about one's ability to pay and its distributive impact on access to needed care. See R.G. Beck and J.M. Horne, *An Analytical Overview of the Saskatchewan Copayment Experiment in Hospital and Ambulatory Care Settings*, Report for the Ontario Council of Health, 1978. R.G. Evans, M.L. Barer and G.L. Stoddart, *Who Are the Zombie Masters, and What Do They Want?* (Toronto: The Premier's Council on Health, Well-Being and Social Justice, 1994).

3 Canadian Institute for Health Information.

4 For the same reasons that are outlined in Chapter 5, there is no developed or generally accepted deflator to adjust current levels of private funding, by category, for price increases. As a result, the data are only adjusted by population.

5 For accounting purposes, employees' out-of-pocket payouts that are reimbursed by the employer's supplementary health benefit plan are included under the category of private Health Insurance. The remaining out-of-pocket expense (e.g., deductible, co-payment) is captured under the out-of-pocket category. As well, employers' assistance plans (EAPs) are accounted for in the public sector under the sub-category of occupational health (under other health spending). Estimates for the private sector are not yet available.

6 That being said, it is important to keep in mind some of the incentives that have been built into programs that have been introduced by governments to cover the costs associated with care provided by other institutions.

7 Facility fees are considered to be a form of out-of-pocket payment.

8 The SHS, conducted by Statistics Canada, found that the average household spending for physician care after inflation decreased from \$21 in 1978 to \$13 in 1998 (or 38.1 per cent). However, if one looks only at those households that reported spending on physician care, their spending after inflation increased from \$124 in 1978 to \$232 in 1998 (87.1 per cent). See Statistics Canada, *Household Spending on Health Care, Health Reports*, vol. 12, no.1 (Ottawa: Statistics Canada, 2000) cat. no. 82-003.

9 D. Menon, "Pharmaceutical Cost Control in Canada: Does it Work?" *Health Affairs*, vol. 20, no. 3, 2001.

10 Introduced in 1997, the Private Financing Initiative (PFI) was developed to encourage greater financial participation by the private sector in underwriting capital-intensive projects. To date, the evidence as to whether this policy provides better value for money than direct investments by the National Health Service is less than clear.

## “Share” and Share Alike: How Are Private Revenues Raised?

In contrast to Chapter 6, which focused on how total, public and private dollars are spent, this section focuses solely on how private revenues are raised. As was the case with total, public and private health expenditures, limitations exist because of an inability to adjust current dollars for price movements (i.e., increases or decreases).

Given this restriction, total and per capita private sources of funding health care are converted into their respective shares for each funding category. While year-over-year increases that were presented in the previous chapter are important, by looking at shares we will get a clearer sense of the distribution of total private spending by each sub-section (i.e., out-of-pocket, private health insurance and non-consumption health expenditure). Table 36 presents a summary of the breakdown of private sources of funding.

As mentioned previously, it is also important to keep in mind that shares of spending exist in relation to other categories. As a result, some categories may be increasing at a rate that is deemed to be appropriate, but may fall (rise) in relation to total, out-of-pocket, private insurance and/or non-consumption health expenditures due to the rate of acceleration (deceleration) of growth in other categories.<sup>1</sup>

Although private funding for hospitals increased by 30 per cent from 1988 to 1998 (see Table 22), as a share of total private revenues it has declined from 17.3 per cent to 11.1 per cent. At the same time, the categories of out-of-pocket expenditures, private health insurance claims and non-consumption health expenditures showed a similar trend.

As identified in Chapter 7, the category of other institutions is in the unique position of deriving all private sources of funding from out-of-pocket revenues. From 1988 to 1998, out-of-pocket payouts were in line with the overall increase in private sources of funding.

Physicians’ share of private revenues for all three categories remained almost constant. Interestingly, physicians appear to live within two funding vacuums; that is, while 99 per cent of what physicians earn comes from the public purse, 98 per cent of private sources of funding comes from individuals’ own pockets.

Other professionals continued to occupy the largest share of total, out-of-pocket and private health insurance revenues over the 10-year period. In contrast to physicians, other professionals derived 90 per cent of their revenues from the private sector. Over the 10-year period, out-of-pocket

expenditures and private health insurance claims accounted for approximately the same proportion, at 46 per cent.

In the case of prescribed drugs, private health insurance occupied an increasing proportion of funding. However, out-of-pocket sources continued to play a large role in offsetting costs. That being said, this is the only category (except for other health spending) whose share in each category rose from 1988 to 1998.

Given the definition of capital, it is not surprising to see that all sources of private funding fall under non-consumption health expenditures—and account for a small proportion of total private health revenues. Despite this fact, it is important to keep in mind that only 11 per cent of total capital expenditures were generated through the private sector.

Finally, for other health spending, the shares for each sub-component tended to rise from 1988 to 1998—with out-of-pocket sources showing a small increase. As was the case with the category of capital, the private sector generated only 15 per cent of revenues.

In summary, this analysis raises several points. First, depending on how deeply you mine through the data, a number of different patterns are revealed with regard to the respective roles of the public and private sectors. For example, individuals almost exclusively account for private sources of funding for other institutions and physician services, while we increasingly rely upon private health insurance for hospitals, other professionals and prescribed drugs.

The second point has as much to do with where we currently stand vis-à-vis the overall financial architecture of the health care system as it does with where we want to go. In other words, given the current configuration and level of private sector involvement in funding different components of the health care system, legitimate questions arise about what roles out-of-pocket sources and private health insurance might or should play.

Given that paying for services out of pocket requires a non-recoverable payment at the time of the service, there are always concerns that a growing or substantial role for out-of-pocket revenues may compromise access to care by those who can least afford it. This is an important point when one realizes that in 1998 out-of-pocket expenditures represented 55 per cent of total private sources of funding in the health care system (see Table 21).

Given the current distribution between public and private expenditures, and how private spending breaks down in

**Table 36****Share of Private Sources of Funding, by Category of Expenditure, 1988–98**

	1988	1991	1995	1998
<b>Hospitals</b>				
Per cent share of total private sources	17.3	16.5 (↓)	13.5 (↓)	11.1 (↓)
Per cent share of out-of-pocket	9.2	8.3 (↓)	6.0 (↓)	5.3 (↓)
Per cent share of private health insurance	7.4	7.0 (↓)	5.8 (↓)	6.3 (↑)
Per cent share of non-consumption health expenditures	68.3	71.4 (↑)	68.0 (↓)	63.1 (↓)
<b>Other Institutions</b>				
Per cent share of total private sources	11.5	12.1 (↑)	11.9 (↓)	11.1 (↓)
Per cent share of out-of-pocket	22.5	24.9 (↑)	24.8 (↓)	22.8 (↓)
Per cent share of private health insurance	0.0	0.0	0.0	0.0
Per cent share of non-consumption health expenditures	0.0	0.0	0.0	0.0
<b>Physicians</b>				
Per cent share of total private sources	0.7	0.6 (↓)	0.6 (→)	0.7 (↑)
Per cent share of out-of-pocket	1.4	1.3 (↓)	1.2 (↓)	1.4 (↑)
Per cent share of private health insurance	0.02	0.03 (↑)	0.02 (↓)	0.03 (↑)
Per cent share of non-consumption health expenditures	0.0	0.0	0.0	0.0
<b>Other Professionals</b>				
Per cent share of total private sources	41.8	40.0 (↓)	39.7 (↓)	41.6 (↑)
Per cent share of out-of-pocket	48.6	45.7 (↓)	45.3 (↓)	45.9 (↑)
Per cent share of private health insurance	49.8	48.3 (↓)	45.2 (↓)	45.8 (↑)
Per cent share of non-consumption health expenditures	0.0	0.0	0.0	0.0
<b>Prescribed Drugs</b>				
Per cent share of total private sources	18.5	19.5 (↑)	21.4 (↑)	24.8 (↑)
Per cent share of out-of-pocket	16.0	16.8 (↑)	18.7 (↑)	20.9 (↑)
Per cent share of private health insurance	30.3	30.2 (↓)	31.2 (↑)	34.7 (↑)
Per cent share of non-consumption health expenditures	0.0	0.0	0.0	0.0
<b>Capital</b>				
Per cent share of total private sources	3.2	2.3 (↓)	2.2 (↓)	1.8 (↓)
Per cent share of out-of-pocket	0.0	0.0	0.0	0.0
Per cent share of private health insurance	0.0	0.0	0.0	0.0
Per cent share of non-consumption health expenditures	21.6	16.3 (↓)	18.3 (↑)	19.2 (↑)
<b>Other Health Spending</b>				
Per cent share of total private sources	7.0	8.7 (↑)	10.7 (↑)	9.0 (↓)
Per cent share of out-of-pocket	2.4	3.1 (↑)	4.0 (↑)	3.7 (↓)
Per cent share of private health insurance	12.5	14.5 (↑)	17.8 (↑)	13.1 (↓)
Per cent share of non-consumption health expenditures	10.1	12.3 (↑)	13.7 (↑)	17.7 (↑)

The arrows indicate whether the percentage share has increased (↑), decreased (↓) or remained the same (→) over the last five-year period. Numbers may not add up to 100 due to rounding.

Source: Canadian Institute for Health Information. Charts do not include totals for the sub-category of non-prescribed drugs (which includes over-the-counter drugs and personal health supplies).

terms of out-of-pocket expenditures and private health insurance, a key policy question remains and requires further consideration. Have we structured the health care system appropriately for today, and more importantly, for tomorrow? That is, to what degree have we aligned the funding of health care with the health care system's overall structure for today and, more urgently, for the foreseeable future? Furthermore, based on what we know, is private sector funding growing by default, design or by gravitational pull?

As an example, given the demographics of Canada's population and continued technological innovation in the system, greater reliance will be placed on care delivered outside of the hospital (e.g., community-based care, home care, long-term care, nursing home and rehabilitation) and on the role of drug therapy. As a consequence, it is important to focus on building the system in such a way that it facilitates continued access and that will not place a prohibitive financial burden on Canadians.

1 See footnote 1, p. 21.

## Where Does Canada Stand Internationally?

In Canada, as in other Western countries, the issue of maintaining the financial integrity of the system is a top-of-mind public policy challenge.<sup>1</sup> That being said, how does Canada rank with other OECD member countries when it comes to a number of generally accepted measures of health care spending?<sup>2</sup>

As a macroeconomic measure of resources allocated to health care systems, health care expenditures as a percentage of GDP expresses a society's willingness to devote resources to health care.<sup>3</sup> When it comes to total, public and private health care expenditures as a percentage of GDP for the most recent year available on a comparative basis, one sees that Canada is ranked sixth, eighth and third among the 29 reporting OECD countries (see Table 37). Interestingly, when placed among the G7 nations (which are italicized in the tables), Canada is ranked fourth, third and second, respectively. It should also be noted that Canada places above the OECD unweighted average for each expenditure category.

In addition to comparing health expenditures in relation to GDP, Tables 38 and 39 use two different methodologies to calculate health expenditures adjusted for population and international currencies. Table 38 presents the data by converting per capita health expenditures into a single currency using the U.S. exchange rate.<sup>4</sup> Table 39 equalizes the purchasing power of international currencies (known as purchasing power parities or PPPs) in U.S. dollars.<sup>5</sup>

Table 38 shows that Canada ranks fourteenth, sixteenth and ninth in terms of total, public and private per capita spending among the 29 OECD countries. At the same time, Canada ranks fifth, sixth and fourth among the G7 nations. Canada also ranks slightly above the OECD unweighted average in all three categories.

Of the three categories, Canada is ranked in the top 10 for private per capita expenditures only. In terms of public spending, Table 38 confirms the finding that Canada's spending on health care, on a comparative basis, has been restrained.

Alternatively, Canada's ranking in Table 39 is virtually identical to that on Table 37: Canada ranks fifth, eighth and third in terms of total, public and private per capita

**Table 37**  
**Total, Public, Private Health Care Expenditures (HCE) as a Percentage of GDP, OECD Countries, 1998**

Country	Total HCE as a per cent of GDP	Rank of 29	Public HCE as a per cent of GDP	Rank of 29	Private HCE as a per cent of GDP	Rank of 29
Australia	8.6	8	6.0	12	2.6	9
Austria	8.0	15	5.8	14	2.3	13
Belgium	8.6	8	6.1	11	2.5	10
<b>Canada</b>	<b>9.3</b>	<b>6</b>	<b>6.5</b>	<b>8</b>	<b>2.8</b>	<b>3</b>
Czech Republic	7.1	19	6.5	8	0.6	28
Denmark	8.3	12	6.8	6	1.5	23
Finland	6.9	21	5.3	21	1.6	18
<i>France</i>	<i>9.4</i>	<i>4</i>	<i>7.3</i>	<i>3</i>	<i>2.1</i>	<i>16</i>
<i>Germany</i>	<i>10.3</i>	<i>3</i>	<i>7.8</i>	<i>1</i>	<i>2.5</i>	<i>10</i>
Greece	8.4	10	4.7	25	3.6	2
Hungary	6.8	22	5.2	22	1.6	18
Iceland	8.4	10	7.0	5	1.3	25
Ireland	6.8	22	5.2	22	1.6	18
<i>Italy</i>	<i>8.2</i>	<i>13</i>	<i>5.5</i>	<i>18</i>	<i>2.7</i>	<i>7</i>
<i>Japan</i>	<i>7.4</i>	<i>18</i>	<i>5.8</i>	<i>14</i>	<i>1.6</i>	<i>18</i>
Korea	5.1	28	2.4	29	2.8	3
Luxembourg	6.0	26	5.5	18	0.5	29
Mexico	5.3	27	2.6	28	2.8	3
Netherlands	8.7	7	6.0	12	2.7	7
New Zealand	8.1	14	6.3	10	1.9	17
Norway	9.4	4	7.1	4	2.3	13
Poland	6.4	25	4.2	26	2.2	15
Portugal	7.7	17	5.1	24	2.5	10
Spain	7.0	20	5.4	20	1.6	18
Sweden	7.9	16	6.6	7	1.3	25
Switzerland	10.4	2	7.6	2	2.8	3
Turkey	4.8	29	3.5	27	1.4	24
<i>United Kingdom</i>	<i>6.8</i>	<i>22</i>	<i>5.7</i>	<i>17</i>	<i>1.1</i>	<i>27</i>
<i>United States</i>	<i>12.9</i>	<i>1</i>	<i>5.8</i>	<i>14</i>	<i>7.1</i>	<i>1</i>
Average (unweighted)	7.9	29	5.7	29	2.2	29

Numbers may not add up due to rounding.  
Source: OECD Health Data, 2001.

spending among the 29 OECD countries. At the same time, Canada ranks third, third and second among the G7 nations. Once again, Canada ranks above the OECD unweighted average in all three categories.

While Canada's health care system is ranked in the top 10 in terms of public per capita health spending, it also ranks near the top of the class (in third place) in terms of the amount of private spending per person. Only the United States and Switzerland are ahead of it, ranked first and second, respectively. There is also some separation between Canada and the countries that are ranked below it. It is interesting to note that, while the U.S. system is a predominantly privately funded health care system, it spends more on a public per capita basis than does Canada.

Based on Tables 38 and 39, Canada's ranking is strikingly different. In the former, differences in national currencies are reflected through the exchange rate and no attempt has been made to equalize prices for a defined basket of goods and services. Thus, where system efficiencies can be reflected through (lower) prices, they are captured using this approach. Alternatively, the PPP approach holds price levels constant, thus any differences in spending are attributed to the volume of care provided. Together, Tables 38 and 39 suggest that Canada has purchased a relatively high volume of health services (using PPPs) for a relatively low price (using the U.S. exchange rate).<sup>6</sup>

Table 40 shows the public-private distribution of health spending among the 29 reporting OECD countries. Standing at 70.1 per cent, Canada ranks twentieth in terms of its public share, and tenth for its private share. Interestingly, Canada ranks fifth among G7 nations in terms of its public share. As well, while Canada ranks below the OECD unweighted average in terms of its public share (70.1 per cent versus 72.4 per cent), it ranks above the private share at 29.9 per cent.

While other countries devote a similar share of total (per capita) spending on health, their ranking in terms of the public-private distribution is strikingly different. For example, Belgium, France, Germany, Ireland,

Norway and Sweden devote a higher share of public spending than Canada does. In contrast, while the United States allocated the highest private share of health spending, it also devotes a significant sum from public sources.

For the most part, Canada's health care system is portrayed as a universal single-payer system. The reality, however, is that this characterization only extends to hospitals and physician services (i.e., those within the bounds of the Canada Health Act). There is clearly more to the overall picture than just a publicly funded health care system (see Tables 37-40). In fact, based on the public-private distribution in Canada, and in comparison to other countries, one observes that the private sector plays an active role in terms of financing the provision of care.<sup>7</sup>

**Table 38**  
**Total, Public and Private Per Capita Health Care Expenditures (HCE),**  
**\$ U.S. Exchange Rate, OECD Countries, 1998**

Country	Total Per Capita HCE	Rank of 29	Public Per Capita HCE	Rank of 29	Private Per Capita HCE	Rank of 29
Australia	1,718	16	1,202	18	516	11
Austria	2,100	13	1,508	11	593	7
Belgium	2,112	12	1,503	12	609	6
<b>Canada</b>	<b>1,850</b>	<b>14</b>	<b>1,297</b>	<b>16</b>	<b>553</b>	<b>9</b>
Czech Republic	392	24	360	24	32	29
Denmark	2,730	4	2,236	4	494	12
Finland	1,737	15	1,324	15	412	15
France	2,324	8	1,807	8	517	10
Germany	2,697	5	2,044	6	653	5
Greece	965	22	544	23	421	14
Hungary	318	26	243	25	75	27
Iceland	2,484	7	2,085	5	399	16
Ireland	1,577	19	1,211	17	366	17
Italy	1,702	17	1,145	19	556	8
Japan	2,242	9	1,759	10	483	13
Korea	351	25	162	27	189	24
Luxembourg	2,571	6	2,376	2	195	23
Mexico	234	28	112	28	122	25
Netherlands	2,172	10	1,491	13	681	4
New Zealand	1,132	20	872	20	260	21
Norway	3,108	3	2,356	3	752	3
Poland	264	27	172	26	91	26
Portugal	859	23	575	22	284	19
Spain	1,043	21	798	21	241	22
Sweden	2,146	11	1,798	9	348	18
Switzerland	3,857	2	2,821	1	1,019	2
Turkey	149	29	107	29	42	28
United Kingdom	1,636	18	1,363	14	273	20
United States	4,165	1	1,866	7	2,299	1
Average (unweighted)	1,746	29	1,281	29	465	29

Numbers may not add up due to rounding.  
Source: OECD Health Data, 2001.

In sum, while Canada appears to be in line with the comparator countries in terms of total health spending in relation to GDP, it shows different mixtures of public and private funding, by category of expenditure.

The degree to which our system differs from other countries in terms of the public-private distribution is illustrated in Table 41, which shows the degree of public funding for physicians, acute hospitals and pharmaceuticals and medical non-durables (which are prescription drugs and medical non-durables, including over-the-counter drugs), all of which account for 61 per cent of total health spending in Canada.<sup>8</sup>

Canada has made a very strong commitment to the degree of public funding for physician services (ranked first out of 11 OECD countries reporting) and in-patient care (ranked ninth out of 12). Public funding for out-patient care (ranked ninth out of 12), and pharmaceuticals and medical non-durables (ranked 12th out of 13 OECD reporting countries) is more variable and is below the OECD unweighted average.

An examination of the international context raises a key policy question of what the levels and balance should be between the public and private sectors. Should this mean more public money or a redistribution from the private to the public sector, coupled with continued structural renewal of the health care system? Or does this mean we should examine how other countries involve

the private sector? If so, what impact would this have on the delivery structure of the system, and would it affect how Canadians access the system?

**Table 39**  
**Total, Public, Private Per Capita Health Care Expenditures (HCE), \$ U.S. Purchasing Power Parity, OECD Countries, 1998**

Country	Total Per Capita HCE	Rank of 29	Public Per Capita HCE	Rank of 29	Private Per Capita HCE	Rank of 29
Australia	2,085	10	1,459	12	627	5
Austria	1,894	13	1,359	15	534	10
Belgium	2,050	11	1,460	11	591	8
<b>Canada</b>	<b>2,360</b>	<b>5</b>	<b>1,655</b>	<b>8</b>	<b>705</b>	<b>3</b>
Czech Republic	937	24	861	22	76	29
Denmark	2,132	8	1,746	7	386	16
Finland	1,510	18	1,152	19	359	17
France	2,043	12	1,588	9	455	12
Germany	2,361	4	1,790	5	572	9
Greece	1,198	22	675	24	523	11
Hungary	717	26	548	25	168	29
Iceland	2,113	9	1,773	6	340	19
Ireland	1,534	17	1,177	18	356	18
Italy	1,824	14	1,227	17	596	6
Japan	1,795	15	1,408	14	387	15
Korea	740	25	342	27	398	13
Luxembourg	2,246	6	2,076	2	170	26
Mexico	419	28	201	29	218	24
Netherlands	2,150	7	1,476	10	674	4
New Zealand	1,440	20	1,109	20	331	20
Norway	2,452	3	1,859	4	593	7
Poland	524	27	343	26	182	25
Portugal	1,203	21	806	23	398	13
Spain	1,194	23	912	21	276	22
Sweden	1,732	16	1,451	13	281	21
Switzerland	2,853	2	2,087	1	754	2
Turkey	316	29	227	28	89	28
United Kingdom	1,510	18	1,258	16	252	23
United States	4,165	1	1,866	3	2,299	1
Average (unweighted)	1,707	29	1,238	29	469	29

Numbers may not add up due to rounding.  
Source: OECD Health Data, 2001.

**Table 40****Public and Private Health Care Expenditures (HCE) as a Percentage of Total Health Expenditures, OECD Countries, 1998**

Country	Public HCE as a per cent of Total	Rank of 29	Private HCE as a per cent of Total	Rank of 29
Australia	70.0	21	30.0	9
Austria	71.8	18	28.2	12
Belgium	71.2	19	28.8	11
<b>Canada</b>	<b>70.1</b>	<b>20</b>	<b>29.9</b>	<b>10</b>
Czech Republic	91.9	2	8.1	28
Denmark	81.9	6	18.1	24
Finland	76.3	13	23.7	17
<i>France</i>	<i>77.7</i>	<i>8</i>	<i>22.3</i>	<i>22</i>
<i>Germany</i>	<i>75.8</i>	<i>14</i>	<i>24.2</i>	<i>15</i>
Greece	56.3	26	43.7	4
Hungary	76.5	11	23.5	18
Iceland	83.9	3	16.1	27
Ireland	76.8	10	23.2	19
<i>Italy</i>	<i>67.3</i>	<i>23</i>	<i>32.7</i>	<i>7</i>
<i>Japan</i>	<i>78.5</i>	<i>7</i>	<i>21.5</i>	<i>23</i>
Korea	46.2	28	53.8	2
Luxembourg	92.4	1	7.6	29
Mexico	48.0	27	52.0	3
Netherlands	68.6	22	31.4	8
New Zealand	77.0	9	23.0	21
Norway	75.8	14	24.2	15
Poland	65.4	25	34.6	5
Portugal	66.9	24	33.1	6
Spain	76.4	12	23.1	20
Sweden	83.8	4	16.2	26
Switzerland	73.2	16	26.4	14
Turkey	71.9	17	28.1	13
<i>United Kingdom</i>	<i>83.7</i>	<i>5</i>	<i>16.7</i>	<i>25</i>
<i>United States</i>	<i>44.8</i>	<i>29</i>	<i>55.2</i>	<i>1</i>
Average (unweighted)	72.4	29	27.6	29

Numbers may not add up due to rounding.

Source: OECD Health Data, 2001.

**Table 41****Physician, In-Patient Care, Out-Patient Care and Pharmaceuticals as a Percentage of Total Health Care Expenditures, OECD Countries, 1998**

	MD per cent Public	Rank of 11	In-Patient Care per cent Public	Rank of 12	Out-Patient Care per cent Public	Rank of 12	Rx per cent and Med. Non-Dur. Public	Rank of 13
Australia	76.9	6	78.8	11	52.3	11	53.1	9
Austria	—	—	—	—	—	—	—	—
Belgium	—	—	—	—	—	—	—	—
<b>Canada</b>	<b>98.7</b>	<b>1</b>	<b>86.3</b>	<b>9</b>	<b>57.5</b>	<b>9</b>	<b>31.2</b>	<b>12</b>
Czech Republic	—	—	—	—	—	—	—	—
Denmark	61.5	10	94.0	4	74.7	3	47.5	11
Finland	81.2	4	92.1	5	72.2	4	48.1	10
France	—	—	91.2	6	68.4	5	57.5	8
Germany	66.0	8	86.5	8	63.6	7	69.2	3
Greece	—	—	—	—	—	—	—	—
Hungary	—	—	—	—	—	—	—	—
Iceland	74.6	7	100.0	1	55.1	10	62.6	6
Ireland	—	—	—	—	—	—	81.9	1
Italy	—	—	—	—	—	—	—	—
Japan	82.1	3	89.7	7	81.3	2	62.0	7
Korea	—	—	—	—	—	—	—	—
Luxembourg	96.1	2	97.4	3	87.2	1	80.5	2
Mexico	—	—	—	—	—	—	—	—
Netherlands	61.9	9	81.7	10	65.2	6	63.5	5
New Zealand	—	—	—	—	—	—	—	—
Norway	—	—	100.0	1	—	—	—	—
Poland	—	—	—	—	—	—	—	—
Portugal	—	—	—	—	—	—	—	—
Spain	—	—	—	—	—	—	—	—
Sweden	—	—	—	—	—	—	—	—
Switzerland	78.3	5	77.6	12	62.4	8	63.9	4
Turkey	—	—	—	—	—	—	—	—
United Kingdom	—	—	—	—	—	—	—	—
United States	32.0	11	—	—	31.4	12	17.2	13
Average (unweighted)	73.6		89.6		64.3		56.8	

Numbers may not add up due to rounding.

Source: OECD Health Data, 2001.

- C. Ham, *Health Care Reform: Learning from International Experience* (Buckingham: Open University Press, 1997). R.B. Saltman, J. Figueras and C. Sakellariades (eds.), *Critical Challenges for Health Care Reform in Europe* (Buckingham: Open University Press, 1998). D. Drache and T. Sullivan, *Health Reform—Public Success, Private Failure* (London: Routledge, 1999). C. Scott, *Public and Private Roles in Health Care Systems—Reform Experiences in Seven OECD Countries* (Buckingham: Open University Press, 2001).
- It is important to keep in mind that it is always a challenge to develop a series of standardized health expenditure indicators across a number of countries. Given the different ways in which health expenditures are captured and reported, careful attention is paid to the methodology to ensure that the figures are comparable. That being said, the combination of funding and delivery mechanisms can influence how a country tracks health expenditures. As a result, international comparisons should be treated with some caution.
- The National Forum on Health stated that "Gross Domestic Product (GDP) represents the sum total of resources available in society to pursue health and other societal goals. The sum of these goals, "well-being," is the purview of public policy in its broadest sense and is the product of the decisions which individuals, communities and governments make every day." National Forum on Health, *Canada Health Action: Building on the Legacy*, Synthesis Reports and Issues Papers, 1996, p. 9.
- To account for international currencies, all figures are converted into a single currency (i.e., U.S. dollars). This is done through the use of daily averages of spot rates quoted for the U.S. dollar on national markets expressed as national currency units per U.S. dollar. OECD, *Health Data Definitions*, 2001.
- Purchasing power parities (PPPs) means that a given sum of money, when converted into different currencies at the PPP rates, will buy the same basket of goods and services in all countries. As a result, PPPs effectively eliminate differences in price levels (that may be due to system efficiencies) between countries. For more information, please see OECD, *Health Data Definitions*, 2001, R. Deber, B. Swan, "Canadian Health Expenditures: Where Do We Really Stand Internationally?" *Canadian Medical Association Journal*, vol. 160, no. 12.
- R. Deber, B. Swan, "Canadian Health Expenditures: Where Do We Really Stand Internationally?" *Canadian Medical Association Journal*, vol. 160, no. 12.
- As of 1998, Canadians allocated \$25.1 billion (or \$830 per person, of which more than 50 per cent was on an out-of-pocket basis) through private sources in health care.
- Canadian Institute for Health Information, *National Health Expenditure Trends, 1975–2000(f)*. Of note, Canada lies above the mean for physicians, is close to the mean for in-patient care, and is well below the mean for pharmaceuticals and medical non-durables.

## Conclusions

The report covers a significant amount of territory when it comes to reviewing the past 20-year health expenditure and revenue history in Canada. However, there are three important points to keep in mind.

First, depending on which category of expenditure or revenue is being reviewed, different patterns emerge in different magnitudes. This makes it very difficult to generalize from one category to the next. It also underscores the difficulty one encounters in trying to determine whether two related sectors are substituting for one another or complementing each other—when in fact they may be doing both at different times.

Second, as we continue the dialogue about the future of Canada's health care system, we must keep in mind not only the kind of policy proposals that are on the table, but how we get from where we are to where we need to go. This begs the question of policy implementation, and how we can financially align sectors of the health care system that are fundamentally different (for example, physicians and other professionals). If primary health care reform or a publicly financed home care or pharmaceutical program is a high public policy priority, how do we bring together diverse sectors in a more financially seamless structure? We need to think about how we might align incentives in the system more advantageously.

Finally, perhaps the most difficult issue is where we should draw the respective lines for the public and private sectors when it comes to funding health care. Should we examine the (more balanced) funding relationships that exist among other OECD countries? If we were to do so, what would be the effects of a higher or lower proportion of private sector funding on our ability to achieve the public policy objectives that we have set out for our health system, such as equitable access, cost effectiveness, income protection, patient choice and clinical autonomy? Furthermore, if the private sector were to play a greater role in funding health care, how sensitive should we be to the possibly uneven distribution of services that may occur as a result? Conversely, where there is an active role for the private sector to play, should we aim to strengthen the role of the public sector?

These are questions that are not easily answered. However, they must be addressed as part of the ongoing—and increasingly critical—debate on health care funding. Reviewing the data on public and private health care expenditures in Canada and examining the patterns and relationships that exist among the spending categories is vital work. It is only through doing so that we can determine where we have come from, where we may be headed, and how we can best steer our way through the many challenges that lie ahead.

## Definitions for Categories of Expenditures

**Hospitals:** Institutions where patients are accommodated on the basis of medical need and are provided with continuing medical care and supporting diagnostic and therapeutic services. Hospitals are licensed or approved as hospitals by a provincial/territorial government, or are operated by the Government of Canada and include those providing acute care, extended and chronic care, rehabilitation, convalescent care and psychiatric care, as well as nursing stations or outpost hospitals.

**Other Institutions:** Include residential care types of facilities (for the chronically ill or disabled, who reside at the institution more or less permanently) and which are approved, funded or licensed by provincial or territorial departments of health and/or social services. Residential care facilities include homes for the aged (including nursing homes), facilities for persons with physical disabilities, developmental delays, psychiatric disabilities, alcohol and drug problems, and facilities for emotionally disturbed children. Facilities solely of a custodial or domiciliary nature and facilities for transients or delinquents are excluded.

**Physicians:** Expenditures include primarily professional fees paid by provincial/territorial medical care insurance plans to physicians in private practice. Fees for services rendered in hospitals are included when paid directly to physicians by the plans. Also included are other forms of professional incomes (salaries, sessional, capitation). The physician expenditure category does not include the remuneration of physicians on the payrolls of hospitals or public sector health agencies; these are included in the appropriate category (e.g., hospitals or other health spending).

**Other Professionals:** Services, at the aggregate level, represent expenditures for the services of privately practising dentists, denturists, chiropractors, massage therapists, orthoptists, osteopaths, physiotherapists, podiatrists, psychologists, private duty nurses and naturopaths. Discrete identification of many of the professions included under other professional services is often possible only when they are reported by provincial medical insurance plans. The category has been disaggregated at the national level in the CIHI data tables to provide information on the following sub-categories:

- *Dental Services*—expenditures for professional fees of dentists (includes dental assistants and hygienists) and denturists, as well as the cost of dental prostheses, including false teeth and laboratory charges for crowns and other dental appliances.
- *Vision Care Services*—expenditures for the professional services of optometrists and dispensing opticians, as well as expenditures for eyeglasses and contact lenses.
- *Other*—expenditures for chiropractors, massage therapists, orthoptists, osteopaths, physiotherapists, podiatrists, psychologists, private duty nurses and naturopaths.

**Drugs:** At the aggregate level, include expenditures on prescribed drugs and non-prescribed products purchased in retail stores. This category has been disaggregated at the national level in the data tables to provide information on the following sub-categories:

- *Prescribed Drugs*—substances sold under the Food and Drug Act that require a prescription.
- *Non-Prescribed Drugs*—include two sub-components; over-the-counter drugs and personal health supplies.
  - *Over-the-Counter Drugs*—therapeutic drug products not requiring a prescription.
  - *Personal Health Supplies*—include items used primarily to promote or maintain health (e.g., oral hygiene products, diagnostic items such as diabetic test strips and medical items such as incontinence products).

**Capital:** Includes expenditures on construction, machinery and equipment of hospitals, clinics, first-aid stations and residential care facilities.

**Other Health Spending:** At the aggregate level, includes expenditures on home care, medical transportation (ambulances), hearing aids, other appliances and prostheses, public health, prepayment administration, health research and miscellaneous health care. This category has been disaggregated at the national level in the CIHI data tables to provide information on the following sub-categories:

- *Prepayment Administration*—expenditures related to the cost of providing health insurance programs by either government or private health insurance firms.
- *Public Health*—expenditures for items such as measures to prevent the spread of communicable disease, food and drug safety, health inspections, health promotion activities, community mental health programs, public health nursing and all costs for the infrastructure to operate health departments.
- *Health Research*—expenditures for research activities designed to further knowledge of the determinants of health, health status or methods of providing health care, evaluation of health care delivery or of public health programs. The category does not include research carried out by hospitals or drug companies in the course of product development. These amounts would be included with the hospital or drug categories, respectively.
- *Other*—expenditures for items such as home care, medical transportation (ambulances), hearing aids, other appliances, training of health workers, voluntary health associations, and occupational health to promote and enhance health and safety in the workplace.

Source: Canadian Institute for Health Information, *National Health Expenditure Series, 1975–2000(f)*, pp. 53–54.

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