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# Greed is Not Enough: Reforming Medicare

Expenditures on health care systems around the world are about to reach their highest level ever as a percent of their countries' gross domestic product (GDP). The reason will have much less to do with rising health care spending than declining GDP.

Canada's health spending is expected to reach its all time high this year. Questions will arise again as to whether the system is sustainable and what to do about containing costs.

One important measure of sustainability is how much is your country spending in comparison to others.

In relation to other G7 member countries, Canada devotes approximately the same proportion of its GDP to health care as the group does on average, significantly less than the US, the same as France and Germany and more than Japan and Britain. Part of this spending is from taxpayers and a portion is out of pocket or from private insurance. Canada on average has approximately the same proportion of public and private expenditures as does its competitors. We do not put any more or less of a burden on taxpayers to pay for our health care system than do our competitors. Neither of these trends has changed for two decades.

How then might we make the system more effective, efficient and accessible?

The Canadian health system is mandated by the Canada Health Act (CHA) to control three sub-sectors: hospitals, physicians and administration and *not* other sub-sectors such as dental care, pharmaceuticals, long-term care, medical devices and so forth.

Research from the Canadian Institute for Health Information demonstrates that government spending on hospitals and on physician services has declined as a share of total health expenditures overtime. At present 28 per cent of total health expenditures go to hospitals (down from 45.2 percent in 1976), and 13.4 per cent of expenditures went to physician services (down from 15.4 per cent in 1991). As a percentage of GDP this CHA sub-sector has remained stable for over thirty years. The major source of Canadian health care expenditure increases is the private for-profit sector that is still a significant part of our system.

Spending on drugs is expected to represent 17.4% per cent of the total health expenditures in Canada, up from 9 per cent in 1984. Over time there has been an increasing quantity of new more expensive drugs of dubious efficacy prescribed.

It is often argued that higher drug costs pay for themselves by saving on hospital costs, at least

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for those health conditions for which surgery and management with pharmaceuticals are competing therapies. However, aside from anecdotal evidence on a few new drugs, there is little known about the cost saving of the new drugs or their relative therapeutic efficacy over the existing drugs. According to a recent of study of 1035 new drugs applications that received approval by the Food and Drug Administration in the United States between 1989 and 2000, in 85 percent of the cases the new drugs do not provide significant improvement over currently marketed therapies. According to the National Institute for Health Care Management (NIHCM), brand manufacturers have flooded the market with product line extensions (known as "ever-greening" in the industry) in response to perverse incentives related to changes in patent laws and advertising regulations. Moreover, the claim that increasing drug costs have lowered hospital costs runs afoul of the timing of these so-called effects. The alleged beneficial effects of many new and expensive drugs on health and thus health care use is problematic because the fall in inpatient use in Canada is both prior, and contemporaneous with the rapid escalation of expenditures on drugs.

There is no better cost containment health policy option for Canada than to introduce a single-payer drug plan. This would allow the public sector to assess which drugs are worth the money spent on them, negotiate the right price for them and distribute them, as we do hospital beds and physician services to those in need, for less money than we spend as a nation now. Or we could go farther and introduce a crown corporation to produce, distribute and purchase the drugs we need as a nation.

Two tier system alternatives like those proposed by Dr. (profit) Day, former president of the Canadian Medical Association, will result in higher costs, lower quality and longer waiting lists, except for those wealthy enough to cut in line, often to get services they don't know they don't need. In a time of economic crisis, (or any other time for that matter), why would you spend a $1.10 for something you can get for a $1.00?

This is an epochal moment in our history. Massive public resources will be used to rescue the for-profit sector from its structural flaws. It is time to begin to build a better world based on what we know works for us. Structural flaws, greed and blind faith, such as led to the present financial crisis, rarely provide the basis for good public policy.

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