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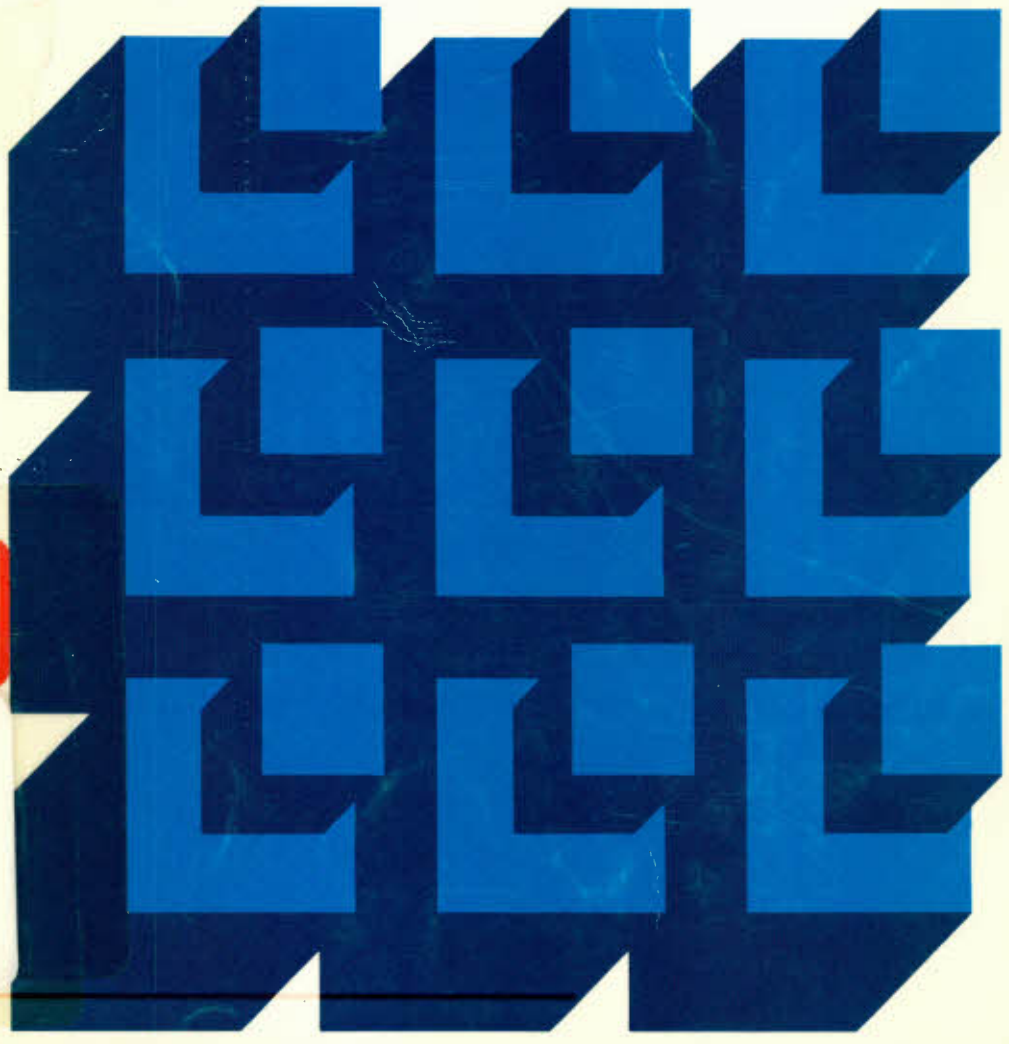

DISCUSSION PAPER NO. 348

The Canada-U.S. Free Trade Agreement: Possible Implications on Canada's Health Care Systems

by

Pran Manga

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RÉSUMÉ

L'auteur du présent document tente de spéculer sur les effets possibles de l'Accord canado-américain de libre-échange sur les politiques et les programmes de soins de santé au Canada. Il souligne et déplore que jusqu'ici, ces questions n'aient fait l'objet d'aucun débat ou discussion. Il démontre que l'Accord de libre-échange risque d'entraîner certains effets en comparant les caractéristiques essentielles des régimes de soins de santé au Canada et aux États-Unis. Il souligne les rôles différents que jouent les gouvernements dans le financement des soins de santé. Il analyse aussi la place qu'y occupe le secteur privé. Il relève également les principales différences dans la politique sur les soins de santé des deux pays. À son avis, il n'y a pas lieu de considérer l'Accord comme une menace à notre régime d'assurance-maladie en tant que politique ou programme de soins de santé. Il aura toutefois des effets sur d'autres aspects de notre régime de soins de santé reliés à l'assurance, et sur certains programmes et politiques non reliés à l'assurance-santé. L'auteur laisse entendre que l'Accord de libre-échange pourrait avoir des conséquences dans des domaines tels que la gestion à but lucratif par le secteur privé des institutions et des programmes de soins de santé, la propriété privée des institutions, les traitements et salaires des professionnels de la santé, l'industrie des foyers de convalescence, le marché des soins dentaires, les équipements médicaux ainsi que les secteurs pharmaceutiques et biologiques. Dans certains cas, les effets éventuels sont incertains et dans d'autres, ils ne seront peut-être pas aussi favorables ou positifs que le supposent les partisans du libre-échange. Il y a enfin des cas où les effets pourraient être vraiment salutaires. Quoi qu'il en soit, le sujet mérite d'être encore longuement discuté et débattu.

ABSTRACT

The discussion paper attempts to speculate on the possible effects of the Canada-U.S. Free-Trade Agreement on Canada's health care policies and programs. The lack of debate and discussion on these issues is noted and decried. The possible effects of the free-trade deal are founded on a comparison of the basic features of the health care systems in Canada and the United States. The differences in the role of the government in financing health care services and the extent and nature of the role of the private sector are emphasized. The principal differences in health policy are also described. It is suggested that the free-trade deal need not be viewed as a threat to Medicare as a health policy or as a program. However, the Canada-U.S. Free-Trade Agreement will also have effects on other medicare related aspects of our health care system and on certain non-medicare health programs and policies. The paper suggests some possible effects of the free-trade deal vis-à-vis private for-profit management of health care institutions and programs, private ownership of health care institutions, wages and fees of health care professions, the nursing home industry, the dental care market, the medical devices and the pharmaceutical and biological sectors. In some instances the possible effects are simply uncertain and in others, they may not be as benign or as positive as advocates of the free-trade deal may suppose. In yet other instances, the effects may well be salutory. In any case, it is a subject that deserves much additional discussion and debate.

CONTENTS

FOREWORD

Over the years the Economic Council of Canada has expressed concern for the health care needs of Canada's population, particularly as that population is progressively aging. In 1986 the Council sponsored a colloquium on health care and published its proceedings, Aging With Limited Health Resources. In 1987 the Council published a study prepared by Dr. Lou Auer, a senior staff economist, on Canadian Hospital Costs and Productivity. This discussion paper follows up on these initiatives, and compares the health care delivery systems in Canada and the United States.

The paper is timely for two reasons. The first is that health care costs in all major industrial countries have been rising as a percentage of gross national expenditure, and hospital and health care administrators have been looking to other countries' practices and policies for indications as to where efficiencies and savings might be found. The second is that when this study was commissioned the bilateral trade negotiations with the United States were underway. The Council drew in part on the study's findings in providing advice to governments on the trade issue in the Twenty-Fourth Annual Review, Reaching Outward, which was published in October 1987. Two months later, on January 2, 1988, Canada and the United States signed a Free Trade Agreement, which if given legislative endorsement, will measurably affect Canada's economic performance, and Canadian/U.S. commercial relations for years to come.

Canadians everywhere have noted the differences in the health care delivery systems on each side of the border, and have expressed the view very clearly that the agreement must not endanger Canada's universal medicare system in any way. The trade agreement meets this objective. In fact, apart from the phased elimination of trade barriers on medical equipment and pharmaceuticals, and provisions governing temporary entry into each other's country for certain medical and allied professionals, the Agreement does not touch directly on matters of health care. Both countries continue to be bound by the GATT Subsidies Code, which excludes domestic programs such as hospital and medical insurance from its definition of a countervailable subsidy. There are however some health-related areas where the Agreement may indirectly have an impact. These are discussed in this study.

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Judith Maxwell
Chairman

April 1988

INTRODUCTION

What is the potential impact of the Canada-U.S. Free Trade Agreement (CUSFTA) on Canada's health care system? This subject has not yet been seriously studied or analysed in Canada but with the release of the draft agreement (CUSFTA, 1988), this question is becoming increasingly important and relevant to the debate and discussion about the advantages and risks of the free trade agreement itself. Opponents of the free trade agreement have voiced fears that our welfare state policies will have to be radically altered and harmonized to those prevailing in the United States. They did not believe the Prime Minister's assurances that our health and social programmes were "not on the bargaining table" or Pat Carney's, the then Minister for International Trade, statement as late as November 24, 1987 that "there is nothing in the agreement that involves social programs... in any way at all." The actual agreement released about a fortnight later, in the view of these opponents of free trade, show that their scepticism and doubts were valid. At the very least it cannot be said that the CUSFTA does not have anything to say about health and social programs in Canada. For example, chapter fourteen of the Agreement clearly allows for free trade in management services for a wide range of institutional and non-institutional health care

services. More recently, Adam Zimmerman warned that the CUSFTA could mean much pressure from the United States for Canada to bring its social, tax and other policies in line with those in the United States. A supporter of bilateral free trade with the U.S., and Chairman of Noranda Forest Inc., and Canadian co-chairman of the influential Canadian-American Committee, Mr. Zimmerman's warning cannot be easily dismissed as uninformed and mere fear-managing, as presumably one could with some vociferous opponents of the free trade agreement. He had met with Sam Gibbons, chairman of the foreign trade sub-committee of the ways and means committee, the main group in the House of Representatives dealing with the free trade deal. Gibbons' message was that Canadians should not do things "any different up there" and that according to Zimmerman "may affect our tax policy, our social policy, all kinds of things." (Toronto Star, March 28, 1988, p. A5).

It is clear from the nature of the issue that what is required is "educated" or "informed" opinion on the matter. The analysis of the CUSFTA must of necessity be speculative and conjectural. There is no past experience with free trade between Canada and the U.S. to draw on for the purposes of the questions that are being pursued here. International trade theory does address the issue of the harmonization of tax and financial policies but hardly ever focuses on the issues of harmonization of the expenditure side of the fiscal budget, specially welfare state policies and programs, or the regulatory activities of the state that concern such

policies or programs. Past and existing free trade or common market experience between other countries are so subject to their own historical and geopolitical specificities that not much of value may be learnt from them vis-à-vis the CUSFTA. Thus analytically, experientially and methodologically the issues that need to be debated and discussed are unfamiliar and therefore more difficult to deal with.

The purpose of this discussion paper is to speculate about the implications for the health care system in Canada of the bilateral free trade agreement between the United States and Canada. This speculation is "informed" by one's understanding of the health care system in Canada and the Untied States, its similarities and differences, and the pressures for change that both systems are facing currently. Thus the section dealing the possible effects of the CUSTFA on Canada's health care system, is preceded by a brief and selective description of the basic features of the health care system in the United States and Canada.

HEALTH CARE EXPENDITURE IN CANADA AND THE UNITED STATES

Health policy analysts in Canada are particularly wont to compare the health care expenditure in Canada with that of the United States. The most noted difference is the trend in the total health care expenditure as a proportion of gross national product, as reflected in Table 1. In 1960, the figure for Canada

Table 1

Total Health Expenditures, Canada and the United States, as a Per Cent of Gross National Product, 1960-1985

Year	Canada	United States
1960	5.5	5.3
1965	6.1	5.8
1970	7.1	7.2
1975	7.24	8.30
1976	7.25	8.45
1977	7.26	8.53
1978	7.32	8.43
1979	7.22	8.55
1980	7.52	9.08
1981	7.73	9.40
1982	8.61	10.22
1983	8.81	10.48
1984	8.71	10.36
1985	8.62	10.63

was 5.5 and for the United States, 5.3. The gap narrowed over the next decade and the two countries had spent roughly the same proportion of their gross national product on health care in 1970, a year in which almost all of the provinces had established Medicare (that is, universal, comprehensive, publicly-financed hospital and medical insurance schemes). By 1971, Medicare was a reality everywhere in Canada. As shown in Table 1, Canada was able to maintain its health care expenditure as a per cent of gross national product between 7.1 and 7.3 throughout the 1970s. The American experience is notably different, especially for the first five years of the 1970s. Both countries experienced a rise in the health care expenditure in relation to the gross national product since 1980, though again the increase is noticeably greater for the United States. The steep jump in the share of health care expenditures in relation to GNP in 1982 for both Canada and the United States is largely due to the deepening of the recession that gripped both countries in the early eighties. The recession affects negatively the GNP figure (i.e. the denominator) and at the same time leaves the growth in health care expenditures more or less unaffected. Hence the ratios shown in Table 1 in 1982 shows a very marked increase from 1981 to 1982 as compared to other year by year increases. In 1985, the respective figures for Canada and the United States are 8.6 and 10.6. The change-over in the figure from a pro-U.S.A. advantage to one that is decidedly in Canada's favour is attributed to a number of factors. Very briefly, one major reason for our relatively better performance is that Medicare confers substantial powers to

provincial governments in controlling expenditures through their near total control over hospital budgets and their role in determining fee schedules. The same control over spending makes it easier for Canadian governments to regulate both the introduction and the diffusion of medical technology. As well, administrative costs account for at most 2.5 per cent of total health spending in Canada, whereas in the United States, the comparable figure is 8.5 per cent, or more than 3 times the Canadian figure. This difference is accounted for by the economies of scale in administering one large (i.e., province-wide) "health insurance" scheme in contrast to the myriad of private commercial and self-insurance schemes that exist in the United States. The administrative efficiency save Canadians over $2 billion annually.

Tables 2A and 2B present data on the total health expenditure in terms of the principal categories of expenditure. There are essentially two categories of expenditures, the largest of the two constituting 87 per cent to total expenditure is personal health care. It is made up of institutional and related services, professional services, and drugs and appliances. The other category is a composite of public health, capital expenditure, health research and administration. Tables 3A and 3B show the per capita expenditure for the various categories in the United States and Canada. In 1985, the overall per capita costs in the United States are $1,721 (U.S.), in contrast to $1,567 (Canadian). A closer examination of Tables 3A and 3B shows that the biggest

Table 2-A

Total Health Expenditures by Category,
United States, 1975-1985

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985
	(Billions of U.S. dollars)										
Total expense	132.7	150.7	169.8	189.6	214.4	248.1	287.0	323.6	357.0	390.1	425.0
Personal health care	117.1	132.8	149.1	167.4	189.5	219.7	254.7	286.5	314.6	340.9	371.4
Institutional and related services	62.5	72.2	81.1	91.3	104.4	122.0	143.0	161.9	176.2	187.2	201.9
Hospitals	52.4	60.9	68.1	76.2	87.0	101.6	119.1	135.2	146.8	155.3	166.7
Nursing homes	10.1	11.3	13.0	15.1	17.4	20.4	23.9	26.7	29.4	31.9	35.2
Professional services	35.7	40.2	46.0	51.7	58.2	67.9	78.9	89.3	99.4	110.8	122.5
Physicians	24.9	27.6	31.9	35.8	40.2	46.8	54.8	61.8	68.4	75.4	82.8
Dentists	8.2	9.4	10.5	11.8	13.3	15.4	17.3	19.5	21.7	24.5	27.1
Other professionals	2.6	3.2	3.6	4.1	4.7	5.7	6.8	8.0	9.3	10.9	12.6
Drugs and appliances	15.1	16.4	17.8	19.6	21.8	23.9	26.0	27.9	30.7	33.5	36.0
Drugs and medical supplies	11.9	13.0	14.1	15.4	17.1	18.8	20.7	22.1	24.5	26.5	28.5
Eyeglasses and appliances	3.2	3.4	3.7	4.2	4.7	5.1	5.3	5.8	6.2	7.0	7.5
Other personal health care	3.8	4.0	4.2	4.8	5.1	5.9	6.8	7.4	8.3	9.4	11.0
Other health costs	15.6	17.9	20.7	22.2	24.9	28.4	32.3	37.1	42.4	49.2	53.6
Prepayment administration	4.0	5.1	7.5	7.5	8.6	9.2	10.6	13.5	17.1	22.6	26.2
Public health	3.2	3.8	4.0	5.0	5.9	7.3	8.5	9.3	9.9	10.9	11.9
Construction	5.1	5.3	5.3	5.3	5.7	6.5	7.6	8.4	9.2	8.9	8.1
Research	3.3	3.7	3.9	4.4	4.7	5.4	5.6	5.9	6.2	6.8	7.4

Source National Health Expenditures, 1985, by Dan Waldo, Helen Lazenby, and Katherine R. Levit, in Health Care Financing Review, Fall 1986, Health Care Financing Administration, United States Department of Health and Human Services, Baltimore, Maryland, October 1986, Volume 8, No. 1.

Table 2-8

Total Health Expenditure by Category, Canada, 1975-1985

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984 (a)	1985 (b)
	(Millions of dollars)										
Total expense	12,239.3	14,088.4	15,494.2	17,251.7	19,430.4	22,719.4	26,642.5	31,172.7	34,697.0	37,420.2	39,793.3
Personal health care	10,702.0	12,362.9	13,567.9	15,184.4	17,110.3	19,750.8	23,174.2	27,147.3	30,393.5	32,787.3	34,980.6
Institutional and related services	6,733.6	7,897.6	8,605.9	9,545.2	10,642.4	12,297.8	14,461.9	17,077.9	18,905.9	20,023.3	21,096.8
Hospitals	5,447.9	6,355.9	6,804.0	7,400.9	8,137.8	9,322.9	11,020.4	13,092.7	14,457.5	15,259.3	16,086.8
Other institutions	1,193.9	1,423.9	1,654.6	1,966.1	2,287.7	2,700.4	3,101.7	3,617.7	4,045.2	4,309.9	4,482.2
Home care	37.3	51.4	60.3	70.3	90.8	120.2	156.6	145.2	156.4	167.6	203.6
Ambulances	54.5	66.5	87.0	107.8	126.1	154.2	183.3	222.4	246.8	286.5	324.2
Professional services	2,658.0	3,018.8	3,388.9	3,833.6	4,351.2	4,998.6	5,761.5	6,689.6	7,594.1	8,313.5	8,953.6
Physicians	1,926.7	2,165.3	2,390.0	2,681.2	3,015.1	3,441.0	3,977.4	4,651.8	5,322.3	5,809.7	6,249.3
Dentists	596.6	699.8	827.6	954.1	1,106.0	1,288.0	1,462.3	1,656.4	1,831.1	2,013.5	2,177.9
Chiropractors	66.5	77.4	87.8	98.3	116.6	139.3	172.1	209.9	243.5	269.0	281.2
Optometrists	34.3	39.0	43.1	50.0	55.3	63.4	72.4	83.5	96.7	110.3	123.6
Podiatrists	13.3	14.6	14.8	15.7	17.4	20.1	21.7	27.6	30.0	31.7	32.3
Osteopaths	1.3	1.4	1.5	1.4	1.5	1.4	1.5	1.6	1.6	1.3	1.4
Private duty nurses	14.0	13.5	14.6	15.5	15.0	15.6	15.6	17.6	18.5	21.0	24.8
Physiotherapists	5.1	7.8	9.6	17.4	24.3	29.7	38.3	41.3	50.4	56.9	63.1
Drugs and appliances	1,310.4	1,446.5	1,573.1	1,805.6	2,116.7	2,454.4	2,950.8	3,379.8	3,893.5	4,450.5	4,930.1
Prescribed drugs	578.7	667.1	745.0	822.2	918.5	1,042.6	1,331.0	1,575.9	1,764.5	1,927.8	2,178.4
Non-prescribed drugs	512.5	529.6	543.3	658.3	834.3	997.2	1,102.7	1,182.2	1,393.2	1,712.8	1,868.9
Eyeglasses	170.6	196.6	225.3	255.3	276.6	311.3	392.8	471.2	553.4	606.0	656.4
Hearing aids	14.9	13.6	15.7	20.2	28.1	30.3	35.8	43.9	54.1	64.5	70.0
Other appliances and prostheses	33.7	39.6	43.7	49.6	59.2	72.9	88.5	106.6	128.4	139.3	156.5
Other health expense	1,537.3	1,725.5	1,926.4	2,067.3	2,320.1	2,968.6	3,468.3	4,025.3	4,303.5	4,633.0	4,812.7
Prepayment administration	209.8	208.3	242.9	247.6	280.1	317.4	407.4	400.9	436.3	511.0	530.2
Public health	487.0	599.6	684.4	674.0	759.9	889.0	1,048.7	1,239.6	1,330.9	1,525.5	1,674.0
Capital expenditure	610.6	648.9	672.5	761.2	831.7	1,235.2	1,408.9	1,716.2	1,786.4	1,785.7	1,757.6
Health research	97.6	111.0	136.0	158.6	183.4	216.3	247.3	277.1	318.9	340.5	356.5
Miscellaneous health costs	132.3	157.6	190.6	226.0	264.9	310.7	356.0	391.5	431.0	470.2	494.4

(a) Provisional.

Table 3-A

Total Health Expenditure by Category, United States, 1975-1985

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985
	(U.S. dollars per person)										
Total expense	590.04	664.76	742.46	821.49	920.17	1,054.40	1,206.90	1,347.21	1,472.16	1,594.20	1,721.34
Personal health care	520.68	585.80	651.95	725.30	813.30	933.70	1,071.07	1,192.76	1,297.32	1,393.13	1,504.25
Institutional and related services	277.90	318.48	354.61	395.58	448.07	518.49	601.35	674.02	726.60	765.02	817.74
Hospitals	232.99	268.64	297.77	330.16	373.39	431.79	500.84	562.86	605.36	634.65	675.17
Nursing homes	44.91	49.85	56.84	65.42	74.68	86.70	100.50	111.16	121.24	130.36	142.57
Professional services	158.74	177.33	201.14	224.00	249.79	288.57	331.79	371.77	409.90	452.80	496.15
Physicians	110.72	121.75	139.48	155.11	172.53	198.90	230.45	257.29	282.06	308.13	335.36
Dentists	36.46	41.46	45.91	51.13	57.08	65.45	72.75	81.18	89.48	100.12	109.76
Other professionals	11.56	14.12	15.74	17.76	20.17	24.22	28.60	33.31	38.35	44.54	51.03
Drugs and appliances	67.14	72.34	77.83	84.92	93.56	101.57	109.34	116.15	126.60	136.90	145.81
Drugs and medical sundries	52.91	57.34	61.65	66.72	73.39	79.90	87.05	92.02	101.03	108.30	115.43
Eyeglasses and appliances	14.23	15.00	16.18	18.20	20.17	21.67	22.29	24.15	25.57	28.61	30.38
Other personal health care	16.90	17.64	18.36	20.80	21.89	25.07	28.60	30.81	34.23	38.41	44.55
Other health costs	69.36	78.96	90.51	96.19	106.87	120.70	135.83	154.45	174.85	201.06	217.09
Prepayment administration	17.79	22.50	32.79	32.50	36.91	39.10	44.58	56.20	70.52	92.36	106.12
Public health	14.23	16.76	17.49	21.66	25.32	31.02	35.74	38.72	40.82	44.54	48.20
Construction	22.68	23.38	23.17	22.96	24.46	27.62	31.96	34.97	37.94	36.37	32.81
Research	14.67	16.32	17.05	19.06	20.17	22.95	23.55	24.56	25.57	27.79	29.97
Population (millions)	224.9	226.7	228.7	230.8	233.0	235.3	237.8	240.2	242.5	244.7	246.9

Source Population, National health expenditures, 1985, op. cit.; other data, Table 85.

Table 3-8

Total Health Expenditure by Category, Canada, 1975-1985

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984(a)	1985(b)
	(Dollars per person)										
Total expense	534.54	612.06	665.13	733.04	817.49	943.88	1,093.42	1,264.29	1,393.20	1,488.17	1,567.90
Personal health care	470.90	537.10	582.44	645.19	719.88	820.55	951.08	1,101.03	1,220.40	1,303.92	1,378.27
Institutional and related services	296.28	343.11	369.43	405.58	447.76	510.91	593.52	692.64	759.13	796.31	831.24
Hospitals	239.71	276.13	292.08	314.47	342.38	387.32	452.28	531.01	580.52	606.85	633.84
Other institutions	52.53	61.86	71.03	83.54	96.25	112.19	127.29	146.72	162.43	171.40	176.60
Home care	1.64	2.23	2.59	2.99	3.82	5.00	6.43	5.89	6.28	6.66	8.02
Ambulances	2.40	2.89	3.73	4.58	5.31	6.41	7.52	9.02	9.91	11.39	12.78
Professional services	116.95	131.15	145.48	162.89	183.07	207.67	236.45	271.31	304.93	330.62	352.78
Physicians	84.78	94.07	102.60	113.93	126.85	142.96	163.24	188.67	213.71	231.05	246.23
Dentists	26.25	30.40	35.53	40.54	46.53	53.51	60.02	67.18	73.53	80.08	85.81
Chiropractors	2.93	3.36	3.77	4.18	4.90	5.79	7.06	8.51	9.78	10.70	11.08
Optometrists	1.51	1.69	1.85	2.12	2.32	2.64	2.97	3.39	3.88	4.39	4.87
Podiatrists	.59	.63	.63	.67	.73	.83	.89	1.12	1.20	1.26	1.27
Osteopaths	.06	.06	.06	.06	.06	.06	.06	.06	.06	.05	.06
Private duty nurses	.62	.59	.63	.66	.63	.65	.64	.71	.74	.84	.98
Physiotherapists	.23	.34	.41	.74	1.02	1.23	1.57	1.68	2.02	2.26	2.49
Drugs and appliances	57.66	62.84	67.53	76.72	89.05	101.97	121.10	137.08	156.34	176.99	194.25
Prescribed drugs	25.46	28.98	31.98	34.94	38.64	43.32	54.63	63.92	70.85	76.67	85.83
Non-prescribed drugs	22.55	23.01	23.32	27.97	35.10	41.43	45.25	47.95	55.94	68.12	73.64
Eyeglasses	7.51	8.54	9.67	10.85	11.64	12.93	16.12	19.11	22.22	24.10	25.86
Hearing aids	.66	.59	.68	.86	1.18	1.26	1.47	1.78	2.17	2.56	2.76
Other appliances and prostheses	1.48	1.72	1.87	2.11	2.49	3.03	3.63	4.32	5.15	5.54	6.16
Other health expense	67.64	74.96	82.69	87.84	97.61	123.33	142.34	163.26	172.80	184.25	189.63
Prepayment administration	9.23	9.05	10.43	10.52	11.78	13.19	16.72	16.26	17.52	20.32	20.89
Public health	21.43	26.05	29.38	28.64	31.97	36.94	43.04	50.28	53.44	60.67	65.96
Capital expenditure	26.87	28.19	28.87	32.35	34.99	51.32	57.82	69.61	71.73	71.01	69.25
Health research	4.29	4.82	5.84	6.74	7.72	8.99	10.15	11.24	12.81	13.54	14.05
Miscellaneous health costs	5.82	6.85	8.18	9.60	11.14	12.91	14.61	15.88	17.31	18.70	19.48

(a) Provisional.

difference in per capita expenditure occurs in the categories of prepayment administration (for the United States it was $106 [U.S.] per capita in 1985, compared to $21 [Canadian] in Canada), followed by a sizable difference in the per capita expenditure on professional services ($496 [U.S.], compared to $353 [Canadian]). The American per capita expenditure on institutional care too is higher than for Canada (adjusting the figures by the then current rate), though there is little difference in the per capita spending on drugs and appliances.

The higher per capita spending for professional services in the United States is probably due to higher fee schedules and less to differences in the overall supply or composition of professional manpower or the volume and quality of services provided in the two countries.

Tables 4A and 4B illustrate the composition or the distribution of the total health expenditure in terms of the above-mentioned categories. The data indicate that we in Canada have always spent a greater proportion of our aggregate health expenditure for institutional and related services but the opposite is true for professional services. Table 5A and 5B show the per cent increase in total and personal health care expenditure over preceding year over the period 1975 to 1985. In both Canada and the United States, the growth in health care expenditure exceeded the inflation rate throughout this period though in both countries,

Table 4-A

Total Health Expenditure by Category, United States, 1975-1985

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985
	(Percentage distribution)										
Total expense	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00
Personal health care	88.2	88.1	87.8	88.3	88.4	88.6	88.7	88.5	88.1	87.4	87.4
Institutional and related services	47.1	47.9	47.8	48.2	48.7	49.2	49.8	50.0	49.4	48.0	47.5
Hospitals	39.5	40.4	40.1	40.2	40.6	41.0	41.5	41.8	41.1	39.8	39.2
Nursing homes	7.6	7.5	7.7	8.0	8.1	8.2	8.3	8.3	8.2	8.2	8.3
Professional services	26.9	26.7	27.1	27.3	27.1	27.4	27.5	27.6	27.8	28.4	28.8
Physicians	18.8	18.3	18.8	18.9	18.8	18.9	19.1	19.1	19.2	19.3	19.5
Dentists	6.2	6.2	6.2	6.2	6.2	6.2	6.0	6.0	6.1	6.3	6.4
Other professionals	2.0	2.1	2.1	2.2	2.2	2.3	2.4	2.5	2.6	2.8	3.0
Drugs and appliances	11.4	10.9	10.5	10.3	10.2	9.6	9.1	8.6	8.6	8.6	8.5
Drugs and medical sundries	9.0	8.6	8.3	8.1	8.0	7.6	7.2	6.8	6.9	6.8	6.7
Eyeglasses and appliances	2.4	2.3	2.2	2.2	2.2	2.1	1.8	1.8	1.7	1.8	1.8
Other personal health care	2.9	2.7	2.5	2.5	2.4	2.4	2.4	2.3	2.3	2.4	2.6
Other health costs	11.8	11.9	12.2	11.7	11.6	11.4	11.3	11.5	11.9	12.6	12.6
Prepayment administration	3.0	3.4	4.4	4.0	4.0	3.7	3.7	4.2	4.8	5.8	6.2
Public health	2.4	2.5	2.4	2.6	2.8	2.9	3.0	2.9	2.8	2.8	2.8
Construction	3.8	3.5	3.1	2.8	2.7	2.6	2.6	2.6	2.6	2.3	1.9
Research	2.5	2.5	2.3	2.3	2.2	2.2	2.0	1.8	1.7	1.7	1.7

Source Table 85.

Table 4-8

Total Health Expenditure by Category, Canada, 1975-1985

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984(a)	1985(b)
						(Percentage distribution)					
Total expense	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00
Personal health care	87.4	87.8	87.6	88.0	88.1	86.9	87.0	87.1	87.6	87.6	87.9
Institutional and related services	55.0	56.1	55.5	55.3	54.8	54.1	54.3	54.8	54.5	53.5	53.0
Hospitals	44.5	45.1	43.9	42.9	41.9	41.0	41.4	42.0	41.7	40.8	40.4
Other institutions	9.8	10.1	10.7	11.4	11.8	11.9	11.6	11.6	11.7	11.5	11.3
Home care	.3	.4	.4	.4	.5	.5	.6	.5	.5	.4	.5
Ambulances	.4	.5	.6	.6	.6	.7	.7	.7	.7	.8	.8
Professional services	21.7	21.4	21.9	22.2	22.4	22.0	21.6	21.5	21.9	22.2	22.5
Physicians	15.7	15.4	15.4	15.5	15.5	15.1	14.9	14.9	15.3	15.5	15.7
Dentists	4.9	5.0	5.3	5.5	5.7	5.7	5.5	5.3	5.3	5.4	5.5
Chiropractors	.5	.5	.6	.6	.6	.6	.6	.7	.7	.7	.7
Optometrists	.3	.3	.3	.3	.3	.3	.3	.3	.3	.3	.3
Podiatrists	.1	.1	.1	.1	.1	.1	.1	.1	.1	.1	.1
Osteopaths	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
Private duty nurses	.1	.1	.1	.1	.1	.1	.1	.1	.1	.1	.1
Physiotherapists	.0	.1	.1	.1	.1	.1	.1	.1	.1	.2	.2
Drugs and appliances	10.7	10.3	10.2	10.5	10.9	10.8	11.1	10.8	11.2	11.9	12.4
Prescribed drugs	4.7	4.7	4.8	4.8	4.7	4.6	5.0	5.1	5.1	5.2	5.5
Non-prescribed drugs	4.2	3.8	3.5	3.8	4.3	4.4	4.1	3.8	4.0	4.6	4.7
Eyeglasses	1.4	1.4	1.5	1.5	1.4	1.4	1.5	1.5	1.6	1.6	1.6
Hearing aids	.1	.1	.1	.1	.1	.1	.1	.1	.2	.2	.2
Other appliances and prostheses	.3	.3	.3	.3	.3	.3	.3	.3	.4	.4	.4
						(~~U.S.A.~~)					
Other health expense	12.6	12.2	12.4	12.0	11.9	13.1	13.0	12.9	12.4	12.4	12.1
Prepayment administration	1.7	1.5	1.6	1.4	1.4	1.4	1.5	1.3	1.3	1.4	1.3
Public health	4.0	4.3	4.4	3.9	3.9	3.9	3.9	4.0	3.8	4.1	4.2
Capital expenditure	5.0	4.6	4.3	4.4	4.3	5.4	5.3	5.5	5.1	4.8	4.4
Health research	.8	.8	.9	.9	.9	1.0	.9	.9	.9	.9	.9
Miscellaneous health costs	1.1	1.1	1.2	1.3	1.4	1.4	1.3	1.3	1.2	1.3	1.2

(a) Provisional.

Table 5-A

Total Health Expenditure by Category, United States, 1975-1985

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985
	(Percentage increase over preceding year)										
Total expense	14.10	13.56	12.67	11.66	13.08	15.72	15.68	12.75	10.32	9.27	8.95
Personal health care	15.48	13.41	12.27	12.27	13.20	15.94	15.93	12.49	9.81	8.36	8.95
Institutional and related services	16.82	15.52	12.33	12.58	14.35	16.86	17.21	13.22	8.83	6.24	7.85
Hospitals	16.44	16.22	11.82	11.89	14.17	16.78	17.22	13.52	8.58	5.79	7.34
Nursing homes	18.82	11.88	15.04	16.15	15.23	17.24	17.16	11.72	10.11	8.50	10.34
Professional services	15.91	12.61	14.43	12.39	12.57	16.67	16.20	13.18	11.31	11.47	10.56
Physicians	17.45	10.84	15.58	12.23	12.29	16.42	17.09	12.77	10.68	10.23	9.81
Dentists	10.81	14.63	11.70	12.38	12.71	15.79	12.34	12.72	11.28	12.90	10.61
Other professionals	18.18	23.08	12.50	13.89	14.63	21.28	19.30	17.65	16.25	17.20	15.60
Drugs and appliances	9.42	8.61	8.54	10.11	11.22	9.63	8.79	7.31	10.04	9.12	7.46
Drugs and medical sundries	8.18	9.24	8.46	9.22	11.04	9.94	10.11	6.76	10.86	8.16	7.55
Eyeglasses and appliances	14.29	6.25	8.82	13.51	11.90	8.51	3.92	9.43	6.90	12.90	7.14
Other personal health care	15.15	5.26	5.00	14.29	6.25	15.69	15.25	8.82	12.16	13.25	17.02
Other health costs	4.70	14.74	15.64	7.25	12.16	14.06	13.73	14.86	14.29	16.04	8.94
Prepayment administration	-14.89	27.50	47.06	.00	14.67	6.98	15.22	27.36	26.67	32.16	15.93
Public health	18.52	18.75	5.26	25.00	18.00	23.73	16.44	9.41	6.45	10.10	9.17
Construction	8.51	3.92	.00	.00	7.55	14.04	16.92	10.53	9.52	-3.26	-8.99
Research	17.86	12.12	5.41	12.82	6.82	14.89	3.70	5.36	5.08	9.68	8.82

Source Table 85.

Table 5-8

Total Health Expenditure by Category, Canada, 1976-1985

	1976	1977	1978	1979	1980	1981	1982	1983	1984(a)	1985(b)
	(Percentage increase over preceding year)									
Total expense	15.11	9.98	11.34	12.63	16.93	17.27	17.00	11.31	7.85	6.34
Personal health care	15.52	9.75	11.91	12.68	15.43	17.33	17.14	11.96	7.88	6.69
Institutional and related services	17.29	8.97	10.91	11.50	15.55	17.60	18.09	10.70	5.91	5.36
Hospitals	16.67	7.05	8.77	9.96	14.56	18.21	18.80	10.42	5.55	5.42
Other institutions	19.26	16.20	18.83	16.36	18.04	14.86	16.64	11.82	6.54	4.00
Home care	37.80	17.28	16.70	29.10	32.41	30.20	-7.27	7.69	7.16	21.54
Ambulances	21.98	30.78	23.99	16.97	22.27	18.84	21.34	10.97	16.10	13.17
Professional services	13.57	12.26	13.12	13.50	14.88	15.26	16.11	13.52	9.47	7.70
Physicians	12.38	10.38	12.18	12.45	14.13	15.59	16.95	14.41	9.16	7.57
Dentists	17.29	18.27	15.28	15.93	16.46	13.53	13.27	10.55	9.96	8.16
Chiropractors	16.31	13.43	11.94	18.62	19.54	23.54	21.92	16.02	10.45	4.57
Optometrists	13.71	10.53	16.01	10.51	14.81	14.20	15.22	15.83	14.11	12.00
Podiatrists	9.50	1.33	6.52	10.87	15.14	8.17	27.12	8.47	5.85	1.87
Osteopaths	2.37	5.43	-1.58	3.91	-6.44	10.26	1.11	2.70	-16.42	6.97
Private duty nurses	-3.59	8.26	5.75	-3.18	4.21	-.06	12.93	5.16	13.61	18.05
Physiotherapists	51.95	22.35	81.93	39.92	22.15	28.78	7.94	21.90	12.94	10.91
Drugs and appliances	10.39	8.75	14.78	17.23	15.95	20.23	14.54	15.20	14.30	10.78
Prescribed drugs	15.29	11.67	10.36	11.72	13.51	27.66	18.40	11.97	9.25	13.00
Non-prescribed drugs	3.33	2.60	21.16	26.73	19.53	10.57	7.21	17.85	22.94	9.11
Eyeglasses	15.23	14.64	13.31	8.31	12.57	26.18	19.96	17.43	9.52	8.31
Hearing aids	-8.80	15.58	28.31	39.32	7.68	18.18	22.65	23.19	19.26	8.50
Other appliances and prostheses	17.43	10.24	13.58	19.44	23.11	21.35	20.46	20.44	8.53	12.29
Other health expense	12.24	11.64	7.32	12.23	27.95	16.83	16.06	6.91	7.66	3.88
Prepayment administration	-.70	16.59	1.92	13.15	13.32	28.35	-1.60	8.82	17.13	3.76
Public health	23.12	14.15	-1.53	12.76	16.99	17.96	18.20	7.37	14.62	9.73
Capital expenditure	6.28	3.63	13.20	9.26	48.51	14.07	21.81	4.09	-.04	-1.57
Health research	13.69	22.52	16.68	15.64	17.91	14.33	12.06	15.10	6.77	4.70
Miscellaneous health costs	19.17	20.91	18.55	17.23	17.28	14.59	9.97	10.10	9.10	5.15

(a) Provisional.

the growth in expenditure was moderated considerably in the last three years (1983 to 1985 inclusive).

THE ROLE OF GOVERNMENT AND PRIVATE SECTORS IN FINANCING HEALTH SERVICES

It is well known that the public sector in Canada plays a much greater role in financing health care expenditures than in the United States. In Canada, federal, provincial, and local governments paid for about 75 per cent of the total health expenditure in 1984 and in 1985. Indeed, the share of total expenditure paid for by the three levels of government has been approximately 75 since the full implementation of Medicare in 1970-71. As can be seen in Tables 6A and 6B, private expenditure and Workers' Compensations Board expenses (which can properly be construed as private expenditure paid by employers) constitutes about 25 per cent of total health expenditures. In Table 6A, the figures for the provincial government include the federal contributions to provinces. Provinces also transfer sums to local government for health care purposes. The figure for the local government share includes this transfer. In 1984 and 1985, the provincial government share of total health expenditure is thus 70.1 minus 28.4 (federal contribution to provinces), plus 0.6 (provincial transfer to local government) or 43.3 per cent. In Canada, thus, provinces are the biggest source of funds for health expenditures, followed by the federal government with 31.5, made up 28.4 per cent for its contributions to provinces and 3.1 for

Table 6-A

Total Health Expenditure by Sector, Canada and Provinces, 1975-1985

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984(a)	1985(a)
	(Percentage distribution)										
All sectors: total expenses (b)	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00
Federal government direct expenses	3.2	3.1	3.0	2.8	2.7	2.6	2.7	2.8	2.9	3.1	3.1
Federal contributions to provinces	27.7	28.3	30.0	31.1	31.4	30.2	29.0	27.8	27.7	28.0	28.4
Provincial government expense	71.2	72.0	71.9	71.5	70.8	69.8	70.3	70.7	70.7	70.2	70.1
Provincial transfers to local government	.6	.6	.5	.6	.6	.7	.7	.8	.6	.6	.6
Workers' compensation expense	1.0	1.0	1.0	1.0	1.0	.9	1.0	1.0	.9	.9	.9
Local government expense	1.1	1.1	1.1	1.0	1.4	1.6	1.8	1.5	1.7	1.8	1.8
Private expense	23.5	22.8	23.0	23.7	24.1	25.0	24.2	23.9	23.7	24.0	24.1

(a) Provisional.

(b) In this table, the item "All sectors: total expense" does not include the item "Federal contributions to provinces", nor the item "Provincial transfers to local government" since they are subsumed in the item "Provincial government expense."

Table 6-8

Deflated (c) Health Expenditure by Sector, Canada, 1975-1985

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984 (a)	1985 (b)
	(Dollars per person)										
All sectors: total expense (b)	888.67	930.18	951.55	987.92	1,001.83	1,046.43	1,093.42	1,160.96	1,218.89	1,256.90	1,280.96
Federal government direct expense	28.19	28.65	28.88	27.89	27.18	27.69	29.41	32.77	35.55	38.58	39.21
Federal contributions to provinces	246.05	263.02	285.80	307.24	314.73	316.50	316.80	322.73	337.82	352.24	363.31
Provincial government expense	633.07	669.62	684.11	705.95	709.52	730.88	768.41	821.01	862.10	882.73	898.38
Provincial transfers to local government	5.36	5.19	4.44	5.77	5.93	7.10	7.25	8.89	6.87	7.27	7.69
Workers' compensation expense	8.78	9.36	9.40	9.94	9.53	9.37	11.24	11.44	11.39	11.72	12.13
Local government expense	9.59	10.47	10.12	9.80	14.35	16.72	19.62	17.79	21.03	22.41	23.15
Private expense	209.04	212.09	219.04	234.34	241.25	261.77	264.75	277.95	288.82	301.47	308.09

(a) Provisional.

(b) In this table, the item "All sectors: total expense" does not include the item "Federal contributions to provinces", nor the item "Provincial transfers to local governments" since they are subsumed in the item "Provincial government expense."

(c) Deflated in accordance with the implicit deflator of the Gross Domestic Product, 1981 = 100.

direct expenses. The concept of private expense in Tables 6A and 6B include both direct payment by individuals and the purchase of private insurance (for such services as dental care, pharmaceuticals, semi-private and private hospital insurance coverage).

The comparable figure for the United States is summarily shown in Table 7. Private expenditure accounts for 58.6 per cent of total health expenditure in 1984. In 1980, it was 57.4, indicating that there was a decrease in the share of total expenditure paid for publicly, from 42.6 to 41.4 over the period 1980 to 1984. The reversal in the trend over this period will be explained later in the chapter. It is also apparent from Table 7 that there has been a gradual reduction in the share of private expenditure since 1960. The large reduction between 1965 to 1970 is due, no doubt, to the introduction of Medicare and Medicaid in 1966.

Unlike Canada, the public share of 41.4 of health care expenditure is largely accounted for by federal government expenditure. Also, local government expenditure in the United States accounts for about 4 to 5 per cent of overall health costs, in contrast to a mere 1.2 per cent in Canada. The principal reason for this difference is that American local governments are still responsible for the care for the poor and the indigent, a responsibility which Canadian municipalities no longer have to bear since the introduction of Medicare. The role of State

Table 7

National Health Expenditures: Aggregate, as a Per Cent of GNP, and by Source for Selected Years

Year	Health expenditures (in billions)	Percentage of GNP	Percentage of distribution of funds	Private	Public
1950	$ 12	4.4	100	72.8	27.2
1960	26	5.3	100	75.3	24.7
1965	41	6.1	100	73.8	26.2
1970	75	7.6	100	63.0	37.0
1975	132	8.6	100	57.5	42.5
1980	247	9.4	100	57.4	42.6
1984	387	10.6	100	58.6	41.4

Source Adapted from Levit et al., "National health expenditures, 1984," in Health Care Financing Review, Fall 1985.

government in the financing of health expenditures is decidedly lower than is the case for provinces in Canada.

Table 8 illustrates the distribution of personal health expenditures (which constitute about 87 of total health expenditures), by source of payment, over 1950 to 1984. The data highlights three well-noted trends in the financing of personal health care in the United States. Direct payment for personal health care costs by patients accounted for 65.5 per cent of total health care expenditure in 1950. The figure declined gradually until 1965 because of the growth in private health insurance from a mere 9.1 per cent in 1950 to 24.2 per cent in 1965. The share of total expenditure accounted for by government hardly changed over this period. The introduction of Medicare and Medicaid in 1966 raised the government share of expenditures from 22.0 per cent to 34.3 per cent and reduced the share accounted for by direct payment by patients from 51.6 in 1965 to 40.5 by 1970. The enrichment of these programs and the introduction of the universal end-stage renal dialysis program in the early 1970s raised the federal share to 39.5 and dropped the share of direct payments by patients to 32.5 per cent by 1975. There was very little change in the share of personal health care expenditure accounted for by private insurance. Since 1975, the government share of personal health care has remained constant and the share accounted for by private insurance has increased from 26.7 in 1975 to 31.3 in 1984. Correspondingly, direct payment by patients accounts for 27.9 per cent of total personal health cost expenditure, compared to

Table 8

Per Cent Distribution of Personal Health Care Expenditures by Source of Funds for Selected Years

Year	Total	Direct payment	All third parties	Private Insurance	Other private	Government
1059	100	65.5	34.5	9.1	2.9	22.4
1960	100	54.9	45.1	21.1	2.3	21.8
1965	100	51.6	48.4	24.2	2.2	22.0
1970	100	40.5	59.5	23.4	1.7	34.3
1975	100	32.5	67.5	26.7	1.3	39.5
1980	100	28.5	71.5	30.7	1.2	39.6
1984	100	27.9	72.1	31.3	1.2	39.6

Source Adapted from Levit et al., op. cit.

32.5 per cent in 1975. Altogether, private expenditure consisting of direct payment, private insurance, and payments by voluntary and charitable organizations accounts for 60 per cent of total spending of personal health care, a figure almost 2.5 times that in Canada.

The extensive role of the government in financing health care services in Canada is also reflected in areas of health expenditure other than personal health care services. Thus most of the expenditure on health research in Canada is publicly financed. In the United States, a significant portion of health research is financed by the private sector. Private sector spending accounts for about 20 per cent of capital spending in Canada, very little of it in the form of corporate investment. In the United States, the private sector accounts for more than 50 per cent of total capital spending, the major part of which is investments by profit and non-profit corporations. The bulk of overhead or administrative expenditure is private expenditure in the United States, while virtually all of the administrative costs in Canada are public. The existence of pharmacare programs for the elderly and dentacare programs for children in most provinces in Canada, and the Canada Assistance Plan, which covers a wide range of nonMedicare health services, and the relative absence of such schemes in the United States, means that the government's share of the expenditure on dental and pharmaceutical care is considerably higher in Canada than in the United States. This pattern no doubt also holds true for nursing home care, as many

provinces have universal programs that provide nursing home care along much the same principles that characterize Medicare in Canada. This difference in the role of the public sector in financing health care also holds true for other extended care services as home care services. It is also true of the financing of the educational costs of health manpower, including doctors, nurses, and a variety of technical and professional health care workers.

Not surprisingly, the pervasive and marked difference in the role of the government in the financing of health care services is reflected in major health policy differences in the two countries. Since these health policy differences are generally well-known and extensively described in the extant literature on the health care system of Canada and the United States, only a few salient observations on the matter are offered in the next section. However, a few observations about important features of the private health insurance sector in the United States are warranted at this point.

An increase in the share of personal health care expenditure paid by private insurance over the years was noted earlier and detailed in Table 8. About 90 per cent of civilian privately-insured population under 65 years of age is covered by employment-related group insurance. There is a growth in the numbers of employers who choose to self-insure, that is, pay employee claims directly rather than purchase insurance coverage

through the commercial insurance sector. Self-insurance exempts employers from State laws mandating specific insurance benefits. Employees also avoid premium taxes and earn tax-free interest on such health insurance funds. In 1965, self-insured plans accounted for a mere 4 per cent of total private benefit payments but since 1977, the figure has been about 20 per cent of privately-insured payments. Over the past decade, there has been a rapid increase in partially self-funded health insurance schemes. Under such schemes, employers set aside enough funds for expected claims/payments and buy commercial insurance for the risk of additional payments that could arise.

In the United States, more than two-thirds of all insured persons rely exclusively on private insurance coverage, since most are not eligible for public programs such as Medicare or Medicaid, or government provision of health services to the military, Indians, or prisoners. Also, while the elderly are entitled to Medicare benefits, about two-thirds of the elderly purchase private insurance coverage to supplement their Medicare benefits and protect themselves against the deductibles, co-insurance, and limits they are subject to under Medicare. Despite this "double" coverage, the elderly paid, on average, 25 per cent of their health expenses out-of-pocket.

The private insurance industry is still dominated by two types of insurers: the non-profit Blue Cross and Blue Shield plans and commercial insurance companies. Health maintenance organizations

are gaining in popularity and have nearly tripled their enrollment from 6 million in 1977 to 17 million in 1984. HMO's offer a comprehensive package of health care services on a prepaid basis. It is estimated that about 12 million Americans are enrolled in preferred provider organizations.

It is apparent from the foregoing that employers play a dominant role in the provision of private health insurance in the United States. Indeed, more than a third of those on Medicare (over 65 years of age) who had supplementary private insurance coverage were covered through plans sponsored by their current or former employers. Health policy reforms in the United States are thus of special concern to employers. Employers' premium contributions as a percentage of total labour compensation have increased at a 0.5 per cent annual rate from 1970 to 1982 (Chollet, 1984). The majority of medium and large employers pay the entire cost of private health insurance coverage for their employees, and a substantial number pay for dependents as well. By 1977, two-thirds of all private insurance premiums were paid by employers and the figure at present is likely to be higher.

There are sound economic reasons for the popularity and dominance of employment-related group health insurance. Administrative and marketing economies make group plans less expensive than direct individual purchase from a third-party insurer. More importantly, premiums paid by employers on behalf of their employees are tax-exempt. This tax expenditure was

estimated to be $33 billion in 1983, a loss of tax revenue almost equal to the expenditure under Medicaid (a federal-state program for the poor) for the noninstitutionalized population (Taylor and Wilensky, 1983).

SALIENT DIFFERENCES IN HEALTH POLICY: CANADA AND THE UNITED STATES

Canadians have opted for and have consistently displayed a strong preference for a universal hospital and medical insurance program. As well, a universal scheme was to be comprehensive, that is, provide all medically necessary services and essentially publicly financed (that is, an elimination of financial barriers through prices, deductibles, coinsurance, premiums, etc.). The programs were to be provided on uniform terms and conditions and publicly administered. This fundamentally egalitarian policy was also to assure freedom of choice for patients in terms of their choice of doctors and hospitals, and physicians were free to choose the mode of practice and method of reimbursement. The program was to be provincially administered but the portability of benefits and the essential similarity of the insurance programs made Medicare a national program.

In the United States, a national health insurance scheme was considered on numerous occasions and, despite occasional majority public support for such an idea, it never came to fruition. The reasons are many and complicated. They are rooted in ideological

conflict, alignment of powerful pressure groups, the complex nature of public policy making in the American government and, not least because there was always less support for a universal program than for coverage of "deserving" population groups, especially the aged, the poor, or certain categories of the poor. Thus, in the United States, the passage of Medicare (federally supported hospital and medical insurance program for the elderly) and Medicaid (a federal-state cost-shared program for the poor) finally came about when large Democratic majorities in the House of Representatives and the Senate and a Democratic President combined to overcome heavy opposition by the medical profession and a variety of corporate interests, especially the private insurance groups. At the time, these programs were also seen by many as the first "stage" towards an eventual national health insurance program.

This prospect is now more remote than ever. In the recent years, the once strong advocates of a national health insurance program have resorted to proposing very specific piecemeal legislation to improve the access to health care services of those who currently are not covered by private insurance schemes or the categorical public schemes such as Medicare and Medicaid. For example, the AFL-CIO, in February 1987, urged Congress to mandate all employers to provide health insurance covering basic services, a policy they opposed during the Nixon and Ford administrations. As well, there are several other suggestions to improve the protection offered by existing private and public schemes.

In 1984, almost 35 million Americans under the age of 65 had no health insurance. The most recent estimate pegs that number at 37 million. About 70 per cent of this group are workers or are dependents of those workers. Firms that do not offer any health benefits tend to be small or not unionized, or hire seasonal workers, or employ large number of low-wage employees. This year, Senator Kennedy has proposed a bill that would make all employers provide health insurance to (only) full-time employees. Under the bill, business would pick up 80 per cent of the premium for policies whose deductible could not exceed $250 for individuals or $500 for a family. Other proposals to improve accessibility to health care services include federal expansions of Medicaid eligibility, and private sector efforts to increase private insurance coverage of the employed population.

In February 1987, President Reagan announced his support for a catastrophic medical care program that would expand the Medicare program to cover hospital and physician costs after a Medicare beneficiary has spent $2,000 for services. This support came after a highly controversial and heated debate about the virtues of private or public insurance solutions to the problem - the problem being that many Americans cannot afford the high costs of health care (especially if a long stay in a hospital or nursing home is involved) once their private and public insurance protection is exhausted, that is, when costs greatly exceed the maximum insurance protection.) (Almost all private or public health insurance schemes in the United States incorporate

deductibles and coinsurance and many also stipulate maximum benefits). It is essential to note that catastrophic insurance is aimed at filling part of the gap in insurance coverage for the Medicare population only. If enacted, it is estimated to benefit about 800,000 Medicare beneficiaries annually.

In the recent years, Congress also debated on ways to improve access to emergency services and on ways to assure continued health insurance for those who experience a change in jobs or family status.

Issues such as these, i.e., coverage for the unemployed or the employed, and catastrophic insurance protection for the elderly are, of course, non-issues under Medicare in Canada. Canadian debates about improving access to care via public insurance focus on health care services not covered by Medicare, for example, home care services, nursing home care, dental care and pharmaceuticals. When a universal program for certain health care services was not justifiable for social, economic, and political reasons, Canadians too have opted for categorical public programs such as dentacare and pharmacare. Public insurance or entitlement programs have been extended beyond the services covered by Medicare everywhere in Canada though the nature, the design, and the extent of this expansion varies from one province to the next. Canadian health policy has focused almost exclusively on expanding access to health care services through universal or categorical public plans. The market preference for categorical programs and for

private sector solutions typifies and contrasts the American health policy orientation from that in Canada.

It is important, too, to recall that in the first four years of the Reagan administration, a major attempt was made to reduce the costs under Medicare and Medicaid. It is estimated that the cutbacks have resulted in "savings" to the government of about 5 per cent of program expenditure annually for both programs. The "cutbacks" include the increase in premiums, deductibles and coinsurance rates, the deinsuring of select services, and the tightening up of eligibility (in the case of Medicaid). In times of fiscal crisis, it seems that categorical programs are more likely to fall prey to deficit cutting initiatives than universal programs; and those that benefit the poor are more susceptible to cost-cutting measures than those that benefit the elderly and the non-poor. It is those cutbacks in Medicare and Medicaid, and budgetary reductions for health research cuts in the subsidization of medical education, and reductions in the transfers to state and local governments for health expenditures that led to a reduction in the share of public spending as a proportion of total health expenditure from 42.6 per cent in 1980 to 41.4 per cent in 1984. The support for catastrophic insurance coverage for Medicare beneficiaries is a belated recognition that Medicare does not afford a sufficient protection against health costs for the elderly. Much to the chagrin of conservatives, the President's support for this initiative is also seen as a preference for a public solution over a private insurance approach to the problem.

The problem of access, especially of the poor, to health care services remain largely unanswered in the United States. Medicaid is an unsatisfactory response to it. It has proven to be a costly program, and there is an abundance of evidence that major inequities in access to care and poor quality of care are problems that are very difficult to address, let alone correct, given the American reluctance to seriously countenance a national health insurance scheme.

The contrast between the American and Canada health policies is all the more poignant when one recognizes that contrary to expectation, Canadians spend significantly less on health care than Americans. The quality of care is as good or better than in the United States. Inequalities in access to health care are very much less in Canada than in the United States. Canadians are among the healthiest people in the world - ranking in the top ten for all of the major health indicators. Canada has been better able to contain health care costs than the United States, calling into question the widely-held belief in both countries that a universal first-dollar health insurance scheme will inevitably and inexorably lead to unaffordable increases in expenditure.

While Canadians can be justly proud of their achievements in the area of health care services, it is widely recognized that there are lessons for both countries in examining the other's health policy and program experience. Just as the Americans can learn that a universal scheme such as Medicare can assure equitable

access to high quality of services at affordable aggregate costs while at the time same preserving freedom of choice for patients and providers, Canadians have much to learn from the American experiments with alternative ways of organizing health care delivery systems and methods of reimbursing hospitals.

The most significant of these developments in the United States is presented in the next section and select comparisons of the performance of the delivery systems between Canada and the United States are offered.

HEALTH CARE DELIVERY IN THE UNITED STATES: LESSONS FOR CANADA

In the 1960s and early 1970s, the Canadian health care delivery system was quite similar to that in the United States. The health policies in Canada were motivated mainly by the pursuit of the objective of equitable access to care, rather than health care organizational objectives. The status quo was maintained as far as medical decision-making and the organization of the health services were concerned. Medicare and the many other policies it engendered essentially meant public financing of care but "private delivery" of services.

The degree of similarity between the United States and Canada in terms of delivery systems has been significantly reduced over the past decade to fifteen years. Cost containment has become the

dominant concern of both government and employers in the United States. It was not until the early 1980s that the combined effects of inflation, recession, soaring costs of employee health benefits, Medicare insolvency, and fiscal crises produced decisive action by both government and business. There is a greater emphasis on providing care in the most cost-effective setting. New methods of payment for health care providers, i.e., physicians and hospitals, have been introduced and are based on incentives intended to discourage the use of costly resources. New schemes of private insurance have been introduced to foster price competition. Health Maintenance Organizations (HMOs) are flourishing and new organizational entities such as emergency care or urgent care centers, birthing centers, hospices, preferred-provider organizations, independent practice associations, and surgicenters are taking hold. The boundary between financing and delivery of health care is becoming less distinct as a variety of vertically integrated systems are emerging. There are also mergers between large enterprises in numbers and on a scale not seen before. Private, for-profit hospitals and the number of beds in private hospitals as a proportion of total bed supply is growing again after a gradual decline for several decades. Currently, about 13 per cent of all hospitals in the United States are for-profit, proprietary hospitals. In 1910, the figure was around 50 per cent. Today, about 70 per cent of the hospital beds in the United States remain non-profit. The American health care delivery system is in a

state of flux and compared to what is occurring there, the Canadian health care delivery system seems "frozen" and static.

One of the most interesting development is the Medicare prospective payment legislation introduced in 1983, despite a concerted opposition by doctors, hospitals, and some labour groups. Under this system, Medicare payment for hospital inpatient services is based on 467 diagnosis-related groups (DRGs). Hospitals know in advance how much Medicare will pay for the treatment of a patient with a particular diagnosis. Previously, under a cost-based retrospective system, hospitals were reimbursed for whatever they spent. Under the DRG prospective payment system, hospitals have a powerful incentive to scrutinize tests and procedures and avoid unnecessary or useless ones, discharge patients as soon as possible, and encourage greater use of outpatient services or day surgery. It also encourages hospitals to be selective about the patients they admit, monitor physician practice patterns, and generally control operating costs.

This reimbursement system is one of the factors that has brought about a remarkable reduction in hospital utilization in the United States. For example, the average length of stay of patients age 65 and over (Medicare patients) fell from 11.1 to 10.1 over a five-year period - 1977 to 1982 - but then dropped to 8.8 days at the end of 1984. There has been a reduction in the admission rates and staffed beds. Average annual employment in hospitals

fell by 73,000 from 1983 to 1984, and a further 73,000 in 1985. This is in an industry in which employment has grown at a very rapid pace, averaging 5.9 per cent annually over the period 1960 to 1984, or nearly 3 times the rate of employment growth for the private economy as a whole. The health industry's employment in relation to the economy grew from 3.1 to 7.4 between 1960 and 1984. (The Canadian figures are approximately the same as for the United States.) In contrast to the United States, employment is increasing in Canadian hospitals. In Canada, while admission rates have declined somewhat since the mid-1970s, lengths of stay have increased somewhat, resulting in a relatively stable patient-days per thousand population. Occupancy rates are steady at 83 per cent. Very little change has occurred in the 1980s in the admission rates or average length of stay, both of which are much higher in Canada than in the United States. The DRG payment mechanism won't be fully implemented until 1988 and they still do not apply to anyone under 65 (i.e., applies only to Medicare patients). Yet from 1983 to 1984, Medicare expenditures grew by only 8.6 per cent, then the smallest increase in the history of the program. From 1984 to 1985, the rate of increase was only 5.5 per cent.

One of the criticisms made of the DRG payment system is that there is a powerful incentive to discharge Medicare patients "quicker and sicker." They are, but the question is, are they harmed by that? In a study on this matter, it was concluded that accelerated discharges did not harm the patients' health. It

should be noted too that there are Medicare "Ombudsmen" to help patients file appeals against inappropriate or too early discharges.

There are, of course, other complaints about the DRG method of reimbursing hospitals. There is a fear that some hospitals will practice "cream skimming", that is, choose less sick or less complicated patients, in order to save on costly cases. There are complaints that particular DRG categories are too heterogeneous allowing for both over and under remuneration unfairly and thereby encourage physicians to categorize their patients in particular diagnostic groups.

The virtues and risks from a DRG system remains to be fully assessed. In Canada there it no DRG-based system of reimbursement in place, though this issue has certainly been studied and could be further assessed in conjunction with the management information system project being undertaken by the Canadian Hospital Association.

There are, of course, other reasons for the decline in hospital utilization in terms of admission rates and average lengths of stay. Over the past five to seven years, many private plans have introduced or raised the deductible (a $200 to $500 deductible is common) and imposed a co-payment, typically around 20 per cent, up to a total of $1,000 to $5,000 per year. Medicare in the United States has also increased co-payments. There is also a

deductible, per admission, of $520. The deductible is expected to raise about 5 per cent of the total Medicare expenditure in 1987.

In the United States, several hospitals have closed over the past three years. There is a glaring overcapacity in hospital beds. The occupancy rate in U.S. hospitals was over 80 per cent in 1970; in 1985, it was no more than 69 per cent. The Canadian figure stayed fairly constant around 83 per cent over the same period. There has been a rapid growth in day surgery in the United States, much more so than in Canada. Hospitals in the United States have been very active in developing home health care programs. Other programs that hospitals have promoted and developed in order to cut down hospital utilization include hospices, nursing homes, rehabilitation units, and birth centers. Several hospitals have also set up wellness, health education, and fitness centers.

Another major - indeed striking - development in the United States is the recent rapid growth of HMOs. Enrollment in HMOs has increased from 10 to 21 million subscribers between 1981 and 1985. Most analysts expect continued rapid growth. HMO enrollees annually pay 10 to 40 per cent less than those enrolled in fee-for-service health insurance plans. The HMO hospitalization rate is considerably lower than the fee-for-service plans. This is attributed to incentives to reduce unnecessary hospitalization, emphasis on preventive care, and broader ambulatory coverage. Fee-for-service surgeons are twice as likely to perform a coronary

bypass as HMO surgeons. Similar differences occur in the case of caesarean sections, chest x-rays, electrocardiograms, and a variety of other tests and procedures.

There are three types of HMOs. The most common is called the "staff model" HMO in which physicians are directly employed by the organization, usually on a salaried basis. The second is known as "individual practice association" (IPA) wherein the HMO makes contractual arrangements with doctors who treat HMO members in their own offices. These doctors are paid a "capitation" fee and not on a fee-for-service basis. The third is sometimes called a "group" or "network" HMO and involves a contractual arrangement between the HMO and two or more group medical practices. Again, the capitation form of reimbursement is common in such network HMOs. It is important to note that HMOs are one of the favoured approaches to reforming the health care delivery system in the United States and it has been encouraged by favourable tax reforms.

There are yet other delivery models in the United States that attempt to offer a "managed" patient care and represent an alternative to the traditional fee-for-service solo practice. In a PPO (preferred-provider organization, a group-insurance buyer (usually the employer) agrees to steer employees to particular hospitals or doctors in return for a volume discount. Doctors have formed such PPOs to gain a market share of group insurance buyers, considering that corporations are the largest buyers of

private insurance, covering more than 130 million American workers and their dependents. A new "managed care" model called the Primary Care Network (PCN) is also emerging. Patients get an HMO-style full coverage without co-payment or deductibles. They are required to sign on or designate a PCN physician as a "case manager" who must clear them to see specialists or enter a hospital. The doctor, usually a general practitioner or family physician, is the sole "gatekeeper" in the system. PCN doctors are paid on a fee-for-service basis but receive only 80 per cent of this directly. The balance goes into a reserve for specialists and hospital admissions. At year-end, any money remaining in the fund is divided up amongst the PCN doctors. Thus far, PCN patients are using 20 per cent fewer hospital days than the average for other insured groups. Also, PCN coverage costs employers approximately 17 per cent less than traditional indemnity plans.

The changes in the organization and design of the health care delivery system have been and will remain far more important in controlling health care costs than the regulatory approval fashionable in the United States in the 1970s. Certificate of Need (CON), Health Systems Agencies (HSAs), and Professional Standard Review Organizations (PSROs) seek to control health care costs and abuses through public review of capital expansion, utilization rates, expenditure limits, and medical standards. Thus far, the benefits of these policies do not seem to be overwhelming.

From what is apparent in the United States, it is clear that a market-driven health care system can cut down waste and inefficiency, but it is a mixed blessing. While many of the hospitals are half-empty, those that serve the poor are full or overcrowded. Their average lengths of stay are much higher than the national average because poor patients are usually sicker at the time of admission. The "Medicaid mills" deliver a distinctly inferior quality of care to the poor in truly dismal clinics in inner cities and depressed rural areas. Market-driven medicine ignores and, in fact, flees from the poor. Much of the working poor and lower middle class are not entitled to Medicaid benefits nor have private insurance coverage and can properly be considered "medically indigent," that is, they can afford the basic necessities of food, shelter, and clothing, but a sizable medical expense would impoverish them. Almost everywhere in the United States, fees to physicians under Medicaid are lower than under Medicare or private insurance. Poor patients are dumped or shunted off to public hospitals. In one hospital, 24 per cent of patients transferred from private, for-profit, or non-profit hospitals were in unstable condition. Private hospital executives see nothing wrong in this practice, arguing that public hospitals ought to take indigents because they are publicly funded. A two-tier or multi-tier system is very much a reality in the United States, with marked differences in standards and quality of care that the majority of Canadians would find unacceptable.

BILATERAL FREE TRADE IMPLICATIONS
FOR CANADA'S HEALTH CARE SYSTEM

What effects, if any, will a bilateral free trade agreement between the United States and Canada have on Canada's health care system? This question has received little, if any, attention by the federal and provincial governments, or by health and social policy analysts generally. There are no formal studies of the issue. There is even a dearth of "educated" or "informed" opinions from Canadian health economists or health policy analysts. This is not to say that there are no opinions at all. The Prime Minister has stated on several occasions that our social policies are not a matter for negotiation and implied that therefore, our health care system will remain intact (for example, see his statement in the Commons debate of March 16, 1987, Gazette, p. 4176). On the other hand, groups opposed to free trade fear that a bilateral free trade would jeopardize the continuation of social programs, including Medicare. In a recent advertisement in all of the major newspapers in Canada, the Canadian Labour Congress declared a free trade deal is "a certifiable threat to such valued social programs as pensions, unemployment insurance, and Medicare."

In what follows, a number of issues and considerations that bear on this question are presented. The discussion is brief and the issues are not presented in any particular order of importance. Also, it will be obvious that much of what is concluded here is

speculative and amounts to opinions rather than results of in-depth study and analysis. In the nature of things, this is all that can be done at this point.

A THREAT TO MEDICARE?

In what way can a free trade deal with the United States pose a threat to Medicare? Those who believe that Medicare will be threatened rarely explain why and how the threat will materialize. It can be argued that the non-existence of a publicly-financed health insurance program is "proof" of a general subsidization of all employers in Canada. This would be opposed by the U.S. corporate sector which, as was shown earlier, is the largest buyer of private health insurance coverage for their employees. Indeed, the largest supplier of Chrysler is not U.S. steel or any other supplier of parts but Blue Cross and Blue Shield. Each car produced in Detroit costs General Motors about $650 per worker/per year worth of health care or related costs. Does a "level playing field" require that we get rid of Medicare and imitate the United States? It is highly unlikely that this would happen. As was seen earlier, publicly-financed health care services in the United States are not insignificant. They account for 40 per cent of all health care expenditures. As well, corporate and employee purchase of private health insurance is subsidized by tax expenditures under the U.S. tax system. It can hardly be suggested that governments do not subsidize health care consumption in the United States. Finally, general revenue

financing of health expenditures in Canada does not mean that Canadian employers pay nothing for Medicare. They may pay very little directly; their contribution may be said to be factored into the corporate tax rates. In most provinces, employers do pay for some health care costs quite directly, through workmen's compensation boards, and in three provinces and one territory, for their employee health insurance premiums.

Any agreement that suggests Canadian employers are "more heavily" subsidized than American ones will inevitably run into very complex and ultimately futile comparison of corporate tax rates and structure, the definition of subsidy (which is quite difficult to define in that it is subject to some basic political premises and assumptions).

Most importantly, Medicare in Canada embodies an egalitarianism - a political and social value choice - that is quite different from that evident in the United States. Our universal health insurance scheme manifests not only important ideas of how we organize our income and wealth redistribution policies but how we pursue the principle of equality of opportunity. The principle of equality of opportunity is enshrined in both American and Canadian constitutions. Canadian negotiators on the bilateral free trade agreement must press home the point that in our view the notion of a "level playing field" is not limited to the "economic game" of trading goods and services across the Canada-U.S. border, but incorporates the

notion that all our citizens have as equal chance as practically possible to step on the "level playing field" to play the economic game. The welfare state in Canada is not merely about doing something for those who are battered, bruised and otherwise lose on the economic "playing field," level or otherwise. It would be ironic indeed for the Americans to argue for a notion of a "level playing field" that requires us to give up on our social policies that pursue the objectives of equality of opportunity. It would be an abject capitulation of our sovereignty to concede to any American demands that call for the demise of Medicare, or to cite another example, universal and free public education for Canadian children.

It might be noted that in other "free trade" blocs, health insurance policies of member countries remained virtually unchanged. There is no good reason to expect otherwise were a Canada-U.S. free trade agreement to occur. Also, as was suggested earlier, the American public favours a national insurance scheme and therefore is not likely to urge a radical change in Canada. The corporate sector in the United States, however, might, for reasons cited above.

OTHER MEDICARE-RELATED ISSUES

But Medicare as a policy and a program is not the whole of Canada's health care policy or of its health care system. Under the CUSFTA there will be a greater openness to private, for-profit

management of hospitals in Canada. In and of itself, this is not necessarily a threat to Medicare. As well, it is not certain whether the large, multi-national corporations would find Canada a hospitable country to expand into. As long as provincial treasuries and Ministers of Health control hospital budgets, they have the power to regulate the profit margins of private management firms and through this control, effectively regulate the number of hospitals open to private, for-profit management. Beyond controlling the budgets of hospitals, provincial ministries of health will have to make sure that private managers of public hospitals do not violate in any way the principles of Medicare. Thus the codes and regulations that govern hospitals in how they provide services to the public should not change and must be vigorously enforced. In short, it should be possible for provincial governments to ensure that Canadians do not experience anything untoward just because there may be a change from public to private management of some public health care institutions and programs. A vigilant and watchful provincial administration is not the only defence against the possible abuse of patient's rights and privileges under Medicare. The health care professions, notably nurses and physicians, are also in a position to monitor this aspect of the private management of public institutions. So are patients' rights groups.

But perhaps this is too sanguine a view. While it can reasonably be expected that provincial ministries of health will monitor closely the conduct of private management and enforce the

principles of medicare, there are a few provinces which are not at all reluctant to violate in one way or another the basic principles of Medicare. This is apparent from recent history and current developments. Worse, these very same provinces have also been the keenest to promote as much privatization of the health care system as possible.

At present, there is very little private for-profit management of health care institutions in Canada. The best known case is that of the Hawkesbury General Hospital in Ontario which contracted out the whole management to a subsidiary of the American Medical International (AMI) Corporation. With the CUSFTA the extent and range of private management of Canadian health care institutions and programs is likely to grow but it is very difficult to know by how much and in what areas. The federal government appears not to be concerned about free trade in the private management of health care institutions or programs, and has pointed out that private management of Canadian institutions is already permissible without the CUSFTA. If so, why does the CUSFTA detail such already existing free trade in Chapter fourteen? Is it merely to put into the agreement what already exists? It is quite likely that it is the American negotiators who insisted that the free trade deal cover such services as private management of health care institutions. The U.S.A. has the foremost and largest firms in this field and the Americans have always wanted to expand its exports in services.

In summary, it is difficult to know what the terms of Chapter fourteen of the CUSFTA mean or imply for Canada's health care system. Private management of our programs and institutions are likely to grow, but the size and impact of this growth is difficult to gauge. It is, of course, a development that should be monitored and assessed carefully should the CUSFTA become a reality.

It is the same control over budgets of hospitals that would make the introduction of privately-owned, for-profit hospitals economically impractical in Canada. Private, for-profit hospitals cannot take hold in Canada since provinces effectively disallow private health insurance coverage for services covered under Medicare. Could Canadians buy private health insurance in the United States and be served by private hospitals in both Canada and the United States? While this is possible, it is quite unlikely and, without doubt, would be very costly to Canadian consumers. It is difficult to see how even the very rich Canadians would be better off than under the status quo. At present, for the rare medical treatment not readily available in Canada, Canadians do have fairly easy access to the American health care system, if and when needed. Also, with the growing excess capacity in both countries, there is little incentive for American investment in private hospitals in Canada.

Would American firms build private hospitals in Canada to serve their U.S. clients or members? The only reason to do so would be

to take advantage of the lower costs of treating American patients in Canada. While this may be so at the moment, the longer-term relative costs are far from obvious: with the growing surplus of doctors and hospital beds in the United States, and the introduction of the managed care systems described earlier, to say nothing of the opposition to the importation of services from Canada by U.S. physicians and labour groups, this idea is rather unlikely to materialize. Strangely enough, it was raised last year, in the form of large American corporation working to lease a wing of a major Canadian teaching hospital for its American clients.

A free trade deal between Canada and the United States will not mean a free flow of health care labour. It appears that under the CUSFTA, physicians, nurses, and other professionals would be no more freer to locate and practice in the United States than they are now. Thus a free trade deal per se is not likely to affect the relative wages and fees of the professions in the health care system.

THE NURSING HOME INDUSTRY

There is extensive private, for-profit sector involvement in the provision of nursing home care in Canada. In Ontario, the private sector accounts for more than 90 per cent of nursing home care beds. There are large nursing home chains in the United States that might find expansion into Canada worthwhile inasmuch as this

sector is still quite profitable (though not as profitable as it was in the 1970s). There is also likely to be a growth in demand for nursing home beds with an aging population. A growth in investment by U.S. firms is not problematic, however, as long as the nursing home policies and regulations of the provinces are maintained. Is there any reason to believe that they may change just because U.S. nursing home chains may enter and/or expand in some provinces in Canada? American firms have not been well disposed towards government regulations and control in the nursing home industry. They are likely to resist and indeed alter existing Canadian controls and regulations.

DENTAL CARE MARKETS

A free trade deal with the U.S. is not likely to make an important difference to the dental care market in Canada. Some of the imported dental care goods and supplies will enter Canada duty-free and should benefit importers, distributors, dentists, and consumers, though the overall impact on the latter is likely to be rather small. A free trade deal is also likely to accelerate the emerging trend in Canada towards prepaid dental care plans that are more common in the United States. This trend, however, could benefit both the employers and employees who at present are subscribers of private dental insurance schemes that entitle the beneficiaries access to fee-for-service dentists. Walk-in dental clinics or store-front dentistry is also likely to

expand, with the American ownership and management of such dental care delivery system increasing over time.

HOME CARE, EXTENDED CARE AND COMMUNITY-BASED SERVICES

It is difficult to see how a free trade deal will impact on home care, extended care, and community-based services. It is unlikely to do so, though, there are sizable private firms in the United States that concentrate in providing home care services. Provincial programs and regulations and their integration with other publicly-provided services makes a major U.S. push in these services quite unlikely. As well, the profitability of such services is not known and, in any case, is subject to manipulation by the provincial governments.

Up to this point, we have focused on the provision of different classes of services. The overall conclusion or conjecture, to put it more accurately, is that a free trade agreement is not likely to affect Canada's policies or health care services in any major way. In the next two sections, we focus on two sectors of the health care industry which involve the production and trade in goods and therefore, are more likely to be affected by a free trade deal between Canada and the United States.

HEALTH CARE COSTS

It is rather unlikely that the CUSFTA will help to reduce health care costs in Canada. The health care industry is highly labour-intensive, a component of cost that is not affected by the agreement. Most imported equipment, drugs and supplies enter Canada duty free, while on many goods the current levels of tariffs are rather low. As well, the reduction in tariffs may not lead to lower prices for imports.

THE MEDICAL DEVICES SECTOR

North America represents the largest geographically-concentrated market for advance medical products. In 1985, it accounted for an estimated 36 per cent of the world market. However, the Canadian market is relatively small, accounting for no more than 3 per cent of the world market. The medical devices industry in Canada is made up of a large number of firms though for the vast majority of the firms, medical devices represent a relatively small part of their total activity. Imports account for 75 per cent of the total medical devices and products expenditure in Canada. Not surprisingly, distributors outnumber manufacturers, and many of the latter import complementary lines. About 47 per cent of the firms in this sector are Canadian-owned; 43 per cent are entirely foreign-owned, with the remaining 10 per cent having minority Canadian participation. Among the manufacturers, 68 per cent is totally Canadian-owned and 21 per cent is totally foreign-owned,

whereas among the distributors, 39 per cent are Canadian-owned and 54 per cent are entirely foreign-owned.

It is quite likely that a free trade deal with the United States will dash any hopes that Canadians may have had in expanding and broadening the manufacturing of medical devices in Canada through an import-substitution strategy. The factors that have always worked against such hopes include the limited size of the domestic market, economies of scale in the manufacturing of devices, lack of marketing capabilities of Canadian firms, the low level of research and development expenditure in this industry in Canada (especially compared to the United States), and now with a free trade deal, the reduction of tariffs and possibly nontariff barriers to imports from the United States. In the case of medical devices, the proportion of imports allowed into Canada duty-free is quite high (about one-third of the total imports). Many products are still subject to tariffs, however, in the range of 10 to 15 per cent. The absence of tariff protection may adversely affect the investment decisions of American firms contemplating the manufacturing of medical devices in Canada. By the same token, it should make Canada more attractive to nonU.S. foreign investment, for example, German, Swiss, British, and Japanese investors. The net effect is, of course, difficult to determine. It is often thought (at least in Canada) that we maintain a favourable regulatory environment for medical devices manufacturing and distribution. The corresponding process in the United States is seen by the industry to be more complex, costly,

and time-consuming. As well, the U.S. regulations do not allow the export of devices unless approved for their domestic market.

THE PHARMACEUTICAL AND BIOLOGICAL SECTORS

A number of very large multinational corporations dominate the industry world-wide. The active ingredients for the drug products are usually manufactured in the country of origin and recently, in certain countries offering very favourable tax treatment. Concentration is increasing and there is a concomittant centralization of research and development efforts as well, as both the time and cost of bringing new drugs onto the market increase.

In Canada, there are about 130 manufacturing establishments in the pharmaceutical industry. Only 15 per cent of its assets of $1.3 billion are Canadian-owned and concentrated largely in small firms. Of the leading 30 pharmaceutical companies in Canada, only two are Canadian-owned; the rest are subsidiaries of foreign-owned multinationals. These firms account for about 80 per cent of the Canadian market. The biological products sub-sector is made up of very few firms and is largely Canadian-owned, with substantial participation by governments. Biological products account for 2 per cent of the total Canadian market for pharmaceuticals and biological products. About 84 per cent of the manufacturing establishment in the pharmaceutical and biological sectors are to be found in Ontario (50 per cent) and Quebec (34 per cent).

The United States and Canada import very little in the way of (completed) dosage products (less than 10 per cent of their domestic needs). Rather, firms in Canada import active ingredients, then formulate and package them for the local market, a step which accounts for 60 per cent of the total manufacturing value added. Canadian firms export about 7 per cent of their shipments, of which about 30 per cent goes to the United States (that is, slightly more than 2 per cent of the total shipment is exported to the United States). More than two-thirds of the import into Canada are active ingredients, with about 60 per cent originating in the United States.

The industry is noted for its continuous high profits. In Canada, after-tax profit on capital employed averaged 15 per cent over the 1978-82 period. In 1983, its research and development expenditure was 3.5 per cent of the value of its shipment and as such, is one of the lowest among the industrialized countries, which generally devoted 8 to 15 per cent of the value of their sales on research and development. The Canadian market is small, representing about 1.5 per cent of world consumption. Most production runs in Canada are short and most plants operate on no more than one shift; thus the cost of capital must be spread over a smaller output. Canada lacks a basic pharmaceutical fine chemical (fermentation) industry. This is a major constraint to the development of an advanced biotechnology-based industry. There is little chance that the industry will attain the size and critical mass required to engage in drug discovery. It has been

suggested that the threshold of research spending, below which a firm stands little chance of sustaining development of novel products, exceeds $35 million annually. As was noted earlier, Canada has to import most of the required active ingredients, underscoring the fact that it lacks a vertically integrated pharmaceutical industry. The Canadian-owned generic segment is considered competitive in international markets. The reasons for this include their very low research and development expenditure, lower marketing costs, and the importation of active ingredients at lower costs from countries such as Italy, Hungary, and Argentina instead of the United States, United Kingdom, or Germany. However, they are constrained from effective international market penetration because they lack an international marketing structure, and a variety of nontariff barriers. The largely Canadian-owned generic segment cannot sell their compulsory licensed products (copy of brand name) in the major industrialized countries which have strong patent protection systems. All of the above suggests that a free trade deal between the United States and Canada will at best preserve the status quo. It is difficult to see any permanent and long-term increase in domestic manufacturing of pharmaceuticals in Canada.

SUMMARY

It would appear from the foregoing that a free trade deal is not likely to have a major impact on Canada's health care system. It

should leave intact our principal health policies such as Medicare. However, it could have possibly adverse effects in certain non-medicare areas. It will also lead to an expansion of the private management of Canadian health care institutions and programs. The consequences of this expansion, it was argued, will depend very much on the willingness and ability of the provinces to ensure that the policies and regulations governing the delivery of health services in Canada are met, no matter who manages them. Whether the CUSFTA is benign in this respect is not certain. The free trade deal will affect some health care products markets, specifically pharmaceuticals and devices. Both of these sectors are already open to considerable trade between the United States and Canada (usually imports from the United States to Canada). The reduction in tariffs could lead to yet further increases in imports from the United States. While no comment was made about employment in those sectors, it seems unlikely that a free trade deal would affect very much the employment levels in either sector.

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