Who Pays for Privatization?
An Analysis of Out-of-Pocket Health Care Spending in Canada, 1969-1996

by

Stacey Todd

A Thesis Submitted to
the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements for the Degree of

MASTER OF ARTS

Department of Sociology
University of Manitoba
Winnipeg, Manitoba

THE UNIVERSITY OF MANITOBA

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ABSTRACT

This thesis explores whether out-of-pocket health care spending has increased since 1969, and how out-of-pocket health care spending is distributed throughout the population. Family Expenditure Surveys (FAMEX) between 1969 and 1996 were analyzed. Descriptive statistics and multiple regression results are reported. This study found that since the 1990s Canadians are spending more out-of-pocket on health care. Furthermore, socio-demographic characteristics affect households' out-of-pocket health care spending. Households in British Columbia and the three prairie provinces spend more out-of-pocket on health care than do households in the eastern provinces. Lower income households spend the least amount on health care, yet their spending represents a greater proportion of their income. Between 1969 and 1996 out-of-pocket health spending has increased the most for people aged 65 and over. Out-of-pocket health spending increases as household size increases. However, per person health spending is highest for households with one or two members. The findings are discussed in a political economy perspective, recognizing the political and economic factors which shape health care policy.

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TABLE OF CONTENTS

LIST OF TABLES

CHAPTER 1

INTRODUCTION

Health care in Canada has always been a hotly debated topic, between business and governments, between the federal and provincial governments, and between the public and governments. The importance of health care to Canadians is evident by the large proportion of provincial spending that is devoted to health care. Furthermore, health care spending is given priority over other social services in both federal and provincial budgets.

Health care policy in Canada has undergone many changes throughout the century, not only in terms of financing but also in regards to regulation. These changes have resulted in public concern over government support for Medicare. A May 2000 poll by Angus Reid found that 76% of respondents said that health care was experiencing a major funding crisis, and 58% believed that the federal government had not provided the necessary leadership to ensure the system works (Canadian Press, 2000: B2). Public concern over the future of Medicare in Canada reflects years of cuts to health care spending by the federal government, as well as the federal government's reduced ability to ensure provinces meet the five principles outlined in the Canada Health Act (CHA). Nevertheless, Canadians still remain committed to the principles outlined in the CHA (Mahoney, 2001: A4).

Even with a national health care program, Canadians have always had some out-of-pocket expenses for health care services and products. However, national data point to the increasing role of private health expenditures in financing health care. Private health

spending can take two forms: third party payment (insurance companies) and out-of-pocket expenditures. This thesis is concerned with out-of-pocket health spending by Canadian households.

PURPOSES OF THE STUDY

The purposes of this study are as follows:

- to highlight the political nature of health care policy;
- to assess whether out-of-pocket health care spending has increased as the federal government has withdrawn from the financing and regulation of health care delivery;
- to examine out-of-pocket health care spending by different groups of Canadians; and
- to assess the appropriateness of using quantitative data analysis to study privatization and out-of-pocket health care spending.

Chapter 2 of this thesis outlines recent changes to health care policy and their implications for privatizing the costs of health care. Instances of privatization and arguments for and against the private provision of health care services are then examined. Chapter 3 outlines the theory of political economy to place health care policy in a political and economic framework. It is argued that health care policy as one component of the welfare state, is subject to the same demands of capital as other social programs. As a result, in an era of globalization and the "powerless" state, health care is targeted as a way to reduce government spending in the interests of capital.

The hypotheses that are tested in this thesis are presented in Chapter 4. Chapter 5 outlines the datasets used in this study, and deals with measurement issues. Chapter 6

displays both the descriptive findings and the results of the multiple regression model. The results, placed in a political economy perspective, are discussed in Chapter 7, as are issues relating to data quality and limitations of the study. Finally, in Chapter 8, implications that arise from this thesis are presented.

SIGNIFICANCE OF THE STUDY

In a review of health care reform in Saskatchewan and Manitoba, it was found that there is very little research on the impact of privatization (Howard & Willson, 2000: 4). In fact, the federal government does not even collect such data (Russell, 2000: A12). Hence, this study contributes to research on privatization, specifically on the privatization of health care costs. While there is data which points to a trend of health care spending shifting more to the private sector from the public sector, there is little data which points to the effects of privatization of health care costs on Canadian individuals. Furthermore, the Canadian Institute for Health Information (CIHI) recognizes a need to examine the type and amount of services purchased by income level (CIHI, 1999: B4). The differential impact of health care policy on various groups of Canadians is clearly needed if the outcomes of health care policy are to be effectively evaluated.

The goal of this study is to contribute to the research being conducted on the effects of privatization, in particular on the literature regarding the privatization of health care costs. In addition, the effects of health care policy on individual Canadians will be examined, with particular attention being paid to groups who have the least access to society's resources. While health care costs are only one aspect of health care

privatization, the results of this study can point to the effect of health care policy on Canadian citizens, as well as determine whether the effects of health care policy are distributed equitably throughout society.

CHAPTER 2

CANADIAN HEALTH CARE POLICY

While there is disagreement about the extent of the withdrawal of the federal government in financing Medicare (Deber, 2000: 26, 29-30), there is little doubt that today the federal government has much less control over how provinces allocate health care spending. This chapter outlines the changes to health care policy that have occurred since the inception of Medicare, and outlines the consequences of these changes in terms of the federal government's role as overseer of the Canadian Medicare system.

The conflict between the provinces and federal government over the financing and control of health care originates with the British North American Act of 1867. Under this Act, the control of hospitals was given to the provinces, and as such health care was viewed as a provincial responsibility (Deber, 2000: 11). The varying degrees of provincial abilities to fund health care, however, necessitated the financial involvement of the federal government to ensure that citizens in different provinces had access to comparable health care services.

After years of conflict between the federal and provincial governments and the Canadian Medical Association (CMA), the Hospital Insurance and Diagnostic (HIDS) Act was fully operational by July 1958 and the Medical Care Act was implemented on July 1, 1968. By 1971, all provinces and territories took part in Medicare. Under these two Acts, the federal and provincial governments shared the costs of hospital and physician services on a 50-50 basis. It is important to note that only physician and hospital services were included under these Acts. As will be discussed later, the services

of other health care providers, nursing homes, home care, and prescription drugs were not subject to the federal-provincial health spending split. As a consequence, provinces tended to cover only those services which would be partially reimbursed by the federal government's contributions.

In order for the provinces to receive the federal government's contribution to health care, provinces had to meet four criteria. First, each provincial health plan had to be administered on a non-profit basis by a public authority, accountable to the provincial government. Second, the plan had to be comprehensive. The provincial health plan had to insure all services which are "medically necessary" (the consequences of this term will be discussed in more detail below). Third, the plan had to be universal in that all services are available to all citizens, regardless of their province of residence. Fourth, the plan must be portable. Provinces must cover their citizens while they are temporarily out of the province.

If a province did not meet any of these four principles, the federal portion of health care funding would be reduced. Madore (1996) points out that since federal contributions were proportional to provincial government expenditures, the provincial governments had nothing to gain from imposing user charges. Thus, the 50-50 funding arrangement ensured that all four principles of the Medical Care Act would be met by the provinces. With the federal and provincial governments assuming an equal portion of the health care bill, there was no incentive for the provinces to deviate from the principles.

Changes to the funding of Medicare have greatly reduced the ability of the federal government to enforce the principles laid out in the Medical Care Act. In 1977, the Established Programs Financing (EPF) Act replaced the 50-50 cost-sharing arrangement

between the federal government and the provinces. The EPF was a method of block funding based on cash and tax transfers for post-secondary education and health funding. In order to receive the cash transfer portion of the EPF, provinces still had to meet the principles outlined in the Medical Care Act. The tax transfer, however, had no such strings attached (Badgley, 1987: 51). While the provinces were in favour of the financing arrangement as it allowed greater provincial control over the allocation of resources, the provinces charged that the federal government was providing inadequate resources to fund health care. In response, the federal government accused the provinces of diverting money from the EPF payments away from health care (Badgley, 1987: 51). In 1983 the federal government applied anti-inflation guidelines to the post-secondary education portion of the EPF, lowering the base for future EPF calculations (Rachlis & Kushner, 1994: 37).

Perhaps the most important aspect of the EPF was the weakened ability of the federal government to ensure the standards of Medicare were being met. As discussed above, with the 50-50 cost sharing arrangement, provinces had no reason to deviate from the standards of Medicare, knowing that the federal government's contribution would be proportionately reduced. With the introduction of the EPF, federal funding was no longer linked to provincial government expenditures on health. The method for the federal government to reduce its contributions to provinces that violated the principles of the Medical Care Act was eliminated. As a result, there was a proliferation of user fees and extra-billing in most provinces (Madore, 1996: 4).

The federal government's concern over the erosion of the principles of Medicare resulted in the Canada Health Act (CHA) in 1984 in which the federal government re-

affirmed the four founding principles and introduced the principle of accessibility. The principle of accessibility states that citizens must have reasonable and uniform access to insured health services, free of financial barriers. Thus, by virtue of the requirement of accessibility, the Act specifically prohibits direct or indirect financial barriers. The federal government recognized, however, that with shrinking EPF payments they would have little power to enforce the principles outlined in the CHA. As a remedy, the Act contained two penalties for non-compliance with the principles of Medicare. First, the federal government would withhold one dollar for each dollar collected through user fees and extra-billing. Second, the Act also provides for the federal government to impose discretionary penalties, which could range from no fines to withholding EPF or other transfer payments.

EPF transfers were further reduced in 1986 when the formula for EPF growth was changed from equaling growth in the GNP, to GNP growth minus two percent. In 1990 and 1991 the EPF contribution was frozen for five years, and in 1995 it equaled GNP growth minus three percent (Rachlis & Kushner, 1994: 38). During the Mulroney years, the provinces lost $30 billion for health care alone (Fuller, 1998: 75).

In 1996 the CHA was linked to a new method of block funding. The EPF transfers were combined with the Canada Assistance Plan (CAP) to form the Canada Health and Social Transfer (CHST). Thus, welfare was added to the EPF payment. At the same time, however, the CHST transfer was reduced by approximately the same amount as the previous CAP payments (Deber, 2000: 25). In effect, the provinces now had to pay for welfare without a federal government contribution. The CHST payment a province receives is determined by a mix of cash transfers and tax points. As with the

EPF payments, the mix of cash and tax transfers is important. As the value of tax points increases due to inflation and economic growth, the federal government transfers less cash to the provinces. Prior to the September 2000 Health Accord, which increases the CHST payments by a total of $21.1 billion over the course of five years, it was expected that between 2005 and 2010 no province in the country would be getting EPF payments (Rachlis & Kushner, 1994: 38). With the new infusion of money, the federal government says that provinces and territories can now rely on stable and predictable funding through 2005-2006 (Intergovernmental Affairs, 2000). The provinces, however, are still calling for more money from the federal government. They argue that much of this new money must be spent on diagnostic equipment and program evaluations. According to the provinces, more money is needed to cover costs such as prescription drugs and home care, and to settle labour disputes with health care workers (Meissner, 2001).

As with the EPF payments, the federal government has the power to reduce a province's CHST if it is in violation of the CHA. Theoretically, the amount of money that could be withheld for the violation of national standards can equal the whole CHST transfer. In practice, the federal government has withheld monthly transfers to Alberta ($420,000), Manitoba ($49,000), Newfoundland ($8,000), and Nova Scotia ($6,000) for facility fees collected by private clinics, fees which the federal government considers user fees (Madore, 1996: 10). However, discretionary penalties have never been imposed on provinces and territories for non-compliance with the five principles outlined in the CHA (Russell, 2000: A12). As the federal Auditor General writes, "Ottawa has adopted a

non-intrusive approach towards the provinces' adherence to the CHA" (Russell, 2000: A12).

The 2000 Health Accord does not provide the federal government with a greater regulatory role in the delivery of health care. First, the $21.1 billion the provinces and territories will share over the next five years will be included in the CHST cash transfer. In effect, each province's share of the new infusion of money could be spent on post-secondary education and other social programs, which have also experienced funding cuts in the 1990s. Second, while the cash transfer will be subject to the conditions and penalties outlined in the CHA, the Accord re-affirms provincial autonomy over the allocation of health spending. Indeed, "provinces and territories will determine the priorities within their own systems" and "the purpose of performance measurement is for all governments to be accountable to their public, not to each other" (Canadian Intergovernmental Conference Secretariat, 2000). While provincial and territorial governments will receive more money in the CHST payments for the next five years, the federal government has again left spending decisions to the provinces and territories.

Because of the complex financing arrangements for the CHST, it is difficult to ascertain how much money Ottawa gives to the provinces for health care spending. Deber (2000) argues, however, that tax points are often ignored when calculating the amount of money that has been cut from federal transfers. She claims that federal transfers for health care amounted to 39% of provincial health care expenditures in 1975, 45% in 1979, and 33% in 1995 (Deber, 2000: 29-30). While health care financing from the federal government has decreased only 6% between 1975 and 1995, new technology, more expensive drugs, and an aging population have placed greater demands on the

health care system. Furthermore, cuts to health care reached a peak in the 1995 budget when the Chretien government cut provincial transfer payments from $18 billion to $12 billion (Armstrong et al., 2000: 4).

The federal government has not only become less involved in health care funding, it also has less control over how the provinces spend money transferred to them in the CHST. As a result, the federal government has less authority in ensuring the provinces meet the principles outlined in the CHA. The next section discusses the role of private payment in health care expenditures.

PRIVATE HEALTH CARE EXPENDITURES

Aggregate statistics point to the increasing role of private expenditures in funding health care. In 1975, 76% of the total health care bill was publicly funded, while 24% was paid for by private insurance or out-of-pocket. By 1997, the split was 68% public and 32% private (Fuller, 1998: 75). Aggregate figures, however, do not tell us whether the increase in private spending was a result of the increased use of non-insured services, or whether services were being shifted from the public insurance plan to the responsibility of individuals. Available evidence supports both explanations.

Evans et al. (2000) point out that the problem with Medicare is not that it covers too much, but rather that it covers too little. Even with a national health insurance program, Canadians have always had some out-of-pocket health care expenses. In fact, hospital and physician visits are the only services that Canadians can expect to be covered by Medicare. When the HIDS Act and the Medical Care Act were passed, the

federal government matched provincial expenditures on hospital and physician services on a 50-50 basis. Thus, provinces insured these services since they knew that 50% of what they spent would be reimbursed by the federal government. Other providers such as physiotherapists and chiropractors, however, were not covered under the 50-50 cost-sharing agreement with the federal government.

Health care in Canada focuses on physician and hospital services, to the exclusion of other health providers. Canadians who wish to visit other health care providers have always been expected to pay for these services, either out of their own pocket or through an extended health insurance plan. In addition, the costs of extended health services such as nursing homes, residential care, and home care have either been completely or partially the responsibility of individuals. Coverage for optometric services, dental care, and drugs varies from province to province, but again these costs have been primarily the responsibility of individuals. When discussing privatization, therefore, it is important to remember that parts of Canada's health care system have always been paid for privately.

Because some non-insured services have never been covered by Medicare, they are open to the effects of what Evans et al. call "passive privatization," i.e., shifting of costs from the public to the private sphere as a result of changes to the structure and delivery of health care services (Evans et al., 2000: 8). Between 1991 and 1996, 30% of acute care beds were closed in British Columbia. In Winnipeg 21% of hospital beds were closed between 1992 and 1995. As a result hospital stays were shortened and many inpatient surgeries became outpatient procedures (Roos, 2000: 411). This meant that drug and supply costs that are routinely covered by Medicare during a hospital stay have increasingly become the responsibility of individuals as hospital stays have become

shorter (Evans et al., 2000: 8). Added to the effects of "passive privatization" have been increases in drug costs. Between 1987 and 1996, the cost of prescription drugs increased by 93%, compared to a 23.1% increase in the Consumer Price Index (Fuller, 1998: 191). Thus, there has been an increase in both the utilization and costs of this type of non-insured services.

Evidence also supports the hypothesis that increased private health expenditures have resulted from provinces introducing user fees and de-listing medical services from the provincial health plans, a practice which allows private clinics to open without a province being in violation of the principles outlined in the CHA. While the CHA specifically prohibits direct or indirect financial barriers to accessing health care services, citizens are only entitled to free access to insured services that are deemed "medically necessary." Furthermore, individual provinces are free to determine which services are covered under their own insurance plan. Thus, there is great variation between provinces in what is considered to be a medically necessary procedure. By de-listing services, provinces encourage the opening of private clinics because the CHA does not prohibit charging fees for health services that are not medically necessary. Furthermore, most provinces allow semi-private clinics to offer services covered by the provincial insurance plan. In Alberta, for example, the presence of non-hospital private clinics increased by 43% between 1993 and 1998 (Plain, 2000: 7). Patients of these clinics are required to pay a facility fee, a fee which the federal government considers a user fee, a direct violation of the CHA.

Provinces have also gotten around the term "medically necessary" by changing its definition. For example, some procedures are medically necessary but are not

immediately needed. By including the time frame in the definition of medically necessary, provinces can allow private clinics to offer a wider range of services, even though the services are still covered by the provincial plan (Evans et al., 2000: 33). As an example, a private clinic in Alberta is allowed to charge patients for an immediate magnetic resonance imaging (MRI) scan. It is argued that if the patient does not require an immediate scan, the procedure is not medically necessary (Evans et al., 2000: 49).

In some instances, the federal government has given its approval to the operation of private providers in the health care system. Under Medicare physicians are able to work in the private system or the public system, but not both. Flood and Archibald (2000) argue that restrictions limiting the ability of physicians to receive both public and private payment have served to limit the development of a private system (p. 11). However, as a requirement to allow overnight private hospitals to open in Alberta, the federal government gave the province of Alberta permission to allow physicians to work in both the private and the public health system as long as all public services are paid for by the provincial health plan. Doctors, however, are free to charge for services that are not covered by the provincial plan. As Alberta Health wrote, "Without Health Canada's agreement on the principle that it is acceptable for physicians to work in both public and private sectors, the existing private clinic policy would not have been possible to implement" (Plain, 2000: 21).

Some health care analysts (Deber, 2000; Evans et al., 2000; Fuller, 1998) argue that the increased role of private spending and private clinics is part of a broader movement towards privatizing the health care system. The next section will discuss

privatization and present arguments for and against the privatization of health care services.

PRIVATIZATION

The Webster dictionary defines private as "not for public use or participation" and "owned or controlled by a person or group rather than the public or government." Applied to health care, this definition clearly stresses the individual in terms of rights and control over health care services. In essence, then, privatization entails the shifting of rights and control from the public to individuals. This shift, however, can take many different forms.

As a forward to a special addition on privatization in *Studies in Political Economy*, Armstrong et al. (1997) outline the various manifestations of privatization. First, the most obvious form of privatization is the selling of government assets and corporations. Examples include the sale of former crown corporations such as Air Canada and the Manitoba Telephone System. Armstrong et al. point out that this often occurs regardless of whether the state benefits from the sale. A second form of privatization is the contracting out of services. For example, McDonald's and Marriott took over the operation of food services in some hospitals, and workers with term contracts replace civil servants. Third, services that were once provided by the public sector are shifted to the household. For example, Aronson and Neysmith (1997) found that over 90% of seniors displaced from long-term care institutions were cared for by family members. This care-work is primarily provided by women (Aronson & Neysmith,

1997: 49). Finally, and of primary interest to this study, is the shifting of payment from the public to the individual. More and more services, from health care to garbage pick-up, are being funded from individuals' out-of-pocket spending, rather than through the tax system. The arguments for and against privatization of health care services will now be examined.

Medicare is criticized as being unable to meet the health needs of Canadians in a new medical era of technological advances. Physicians, especially, point to long waiting lists for medical procedures and insufficient technology such as MRIs as leading to long delays for medical tests. All too often, Canada's technological assets are compared with the U.S. This comparison is made despite the fact that researchers such as Marmor and Mashaw (1994) believe that the Unites States has over-invested and over-used some technologies. Thus, some hospitals have invested in equipment which stands idle most of the time, or is used without good medical reason, in an attempt to generate revenue from insured patients (Marmor & Mashaw, 1994: 472). It is also problematic to compare the technological assets of the American system with that of the Canadian system in that technology in Canada is available for use by anyone who needs it. The lavish amount of technology in American clinics and hospitals, on the other hand, is open only to those patients who can afford the procedures, or who have an insurance company or health maintenance organization (HMO) willing to foot the bill.

Critics of Medicare such as the Fraser Institute argue that a publicly funded health care system rations care by long waiting lists. The think-tank found that in 1999

Canadian waiting times for surgical procedures increased to 14 weeks[1] (Zelder & Wilson, 2000). However, the data used to calculate waiting times was based on only a 25% specialist response rate. The data collected by the Fraser Institute is suspect since it is not known how representative the respondents' opinions are of medical specialists in general. Notwithstanding these criticisms of the methods used, the Fraser Institute advocates the introduction of a private tier in health care delivery, rather than increased public spending. This, despite evidence from Manitoba that the introduction of a private tier in which doctors work in both the public and private sphere increased waiting times in the public sphere (DeCoster et al., 2000: 35).

Manitoba data point out that for all procedures (except cataract surgery in which doctors can work in the private and public sphere), waiting time for surgery is less than 60 days, and for many procedures patients waited about 30 days. DeCoster et al. point out that a 30 day wait is not inappropriate given that patients should take time to weigh the risks and benefits of a surgical procedure (DeCoster et al., 2000: 34). Another finding of the Manitoba study was that while waiting times have increased, the number of procedures performed has also increased. It appears, then, that health care funding has not been able to keep up with demand created by an aging population.

Marmor and Mashaw (1994) point out that all countries have waiting lists for elective procedures and most countries have waiting lists for essential procedures as well. However, in Canada medical tests and procedures are rationed according to the availability of resources, whereas in systems such as the United States, medical treatment

[1] The Fraser Institute measures waiting times from the time a patient is referred by their general practitioner until the time of surgery. This approach has been criticized because some patients put off making an appointment with a specialist, may delay a decision on surgery, or may cancel specialist and surgical appointments.

is rationed according to one's ability to pay. Indeed, the study of waiting times in Manitoba found that there were similar waiting times for Manitobans, regardless of income, gender, or age. Evans (2000) also reasons that a distinction needs to be made between dying while on a waiting list and dying because of being on a waiting list. In many cases where the patient is too old or ill to undergo surgery, the patient is placed on a waiting list as a humane gesture. It has been speculated that more people die because of inappropriate coronary by-pass surgery in California than because they have been placed on waiting lists in Canada (Evans, 2000: 43).

Furthermore, waiting lists are not necessarily the result of inadequate resources. Pope's (1991) study of waiting lists in the UK found that delays for medical procedures and tests are often a reflection of administrative problems and labour shortages, rather than a lack of technology and facilities, a finding supported by DeCoster et al. in their study of waiting times in Manitoba (DeCoster et al., 2000: 36).

Proponents of privatization, such as the Fraser Institute and Gratzer (1999), argue that by allowing the private sector to deliver health care services, there will be increased efficiency. They argue that introducing a second-tier that can be used by people who can afford to pay for health care services will actually improve accessibility for people who rely on the state-funded health care system. By allowing private clinics to siphon patients from the public waiting list, the waiting lists will become shorter. However, this reasoning does not take into account that most physicians operating in the private sphere are also operating in the public sphere. Thus, Fuller (1998) points out that by accepting patients who are willing to pay for their services, the queue in the public system becomes longer while the physician gives priority to patients who are willing to pay a higher price

for the services than what the physician would receive from the government fee schedule. Supporting this claim is a study on waiting times for ophthalmologists. It was found that waiting times were longer where there are private clinics and the same practitioner sees patients from both the public and private system (DeCoster et al, 1999).

Evans et al. (2000) and Deber (2000) also challenge the claim that a two-tiered system would improve the public delivery of health care services. They point out that a two-tiered system necessitates an upper and a lower tier. The lower tier must be inferior, or at least perceived as such by the public, or else no one would pay for the services offered in the upper tier. Furthermore, claims that the public system would improve with the addition of an upper tier are undermined by the fact that privatization advocates are also strongly in favour of lower taxes and paying off the deficit (Evans et al., 2000: 46).

Some critics of Medicare such as Gratzer (1999) support a private system, paid for by medical savings accounts (MSAs) which would be more responsive to consumers' needs. Much like the argument for user fees, the rationale for MSAs is based on the belief that citizens unnecessarily over-use health care services because it is "free." MSAs would allow patients to choose what products and services they would like to receive, while at the same time keeping them within a budget. The logic for MSAs, however, is based on the erroneous assumption that health care, like automobiles, can be treated as a commodity. Evans (1984) argues that health care is not a commodity and as such is not subject to the laws of supply and demand.

Evans defines health care as "that set of goods and services which consumers/patients use solely or primarily because of their anticipated (positive) impact on health status." Thus, it is not health care, but rather health status that is a commodity

which has value to its users (Evans, 1984: 5). People who pay for medical procedures are doing so in the hope of improving their health or well-being. Patients who want medical procedures performed in the absence of ill health are considered to be sick (hypochondriacs, for example). Another problem with treating health care as a commodity is that unlike other commodities which have fairly predictable costs and can be budgeted for, the need for health care is not predictable and the costs can be enormous.

Evans, however, argues that the most important reason for not treating health care as a commodity is the insufficient medical knowledge of most patients. It is because of this lack of medical knowledge that the provision of health care has always been regulated by governments, even in countries where the private provision of services is extensive (Evans, 1984: 69). On their own, patients are not able to correctly identify their health care needs. Patients may purchase unneeded medical tests, or go without needed procedures. Studies have shown that patients are not very good at distinguishing between necessary and unnecessary care (Deber, 2000: 38). When an economic disincentive applies to seeking health care, it has been found that necessary care is as likely to be deterred as unnecessary care, increasing avoidable complications from diseases such as diabetes and hypertension (Deber, 2000: 38). Clearly, there is a risk that people who want to "save" their MSA do so at the risk of their health and well-being. Furthermore, while patients have a lack of medical knowledge, doctors have extensive training in this area. Because of this asymmetry in knowledge, patients rely on the judgments of the physician. Thus, the error of MSAs rests on the assumption that they would result in greater consumer choice. As Evans (1984) notes, patients rely on the advice of physicians when evaluating the need for medical services; patients are not

sovereign consumers. The role of physicians in creating demand for health services is ignored in MSA plans.

Insufficient medical knowledge of patients also brings up important questions when the service is provided privately and the physician stands to gain financially by their treatment recommendations, as is now the case in Alberta. It is because of these financial incentives that in the U.S. and Canada doctors are not allowed to own or operate a pharmacy. In Japan where this is not the case, consumers spend 40 percent more on drugs than do Americans. It has also been found that in the U.S. physicians who own diagnostic equipment have their patients undergo more medical tests and charge a higher price for each examination (Plain, 2000: 14). The introduction of financial incentives into doctor-patient relationships clearly places more responsibility on the patient as they must now balance financial costs versus their physician's advice.

Deber (2000) points out a number of practical problems with the MSA scheme. First, under these plans a certain amount of each person's allowance would need to be spent on catastrophic insurance. However, in countries such as Singapore which has implemented MSAs, people over the age of 75, the disabled, or people with severe pre-existing conditions are unable to purchase catastrophic insurance (p. 36). The second problem with MSAs concerns the fact that it is a small proportion of the population who use the majority of health care services. The unhealthy would deplete their accounts, while the healthy could spend their surplus on superfluous (health-promoting) treatments. Finally, Deber points out that if people are allowed to carry over their MSA balance for future health care needs, necessary health services may be put off. In conclusion, Deber writes, "under the guise of empowering consumers, these sorts of models would transfer

resources from the sick to the well, raise expenditures, diminish appropriateness, and leave the sickest without insurance" (Deber, 2000: 37). Rather than consumer choice, the underlying goal of MSAs is an expanded role for the private provision of health care services. MSA schemes, like other forms of privatization, place the responsibility of paying for health care needs on individuals, rather than treating health care as a shared responsibility.

The most cited reason for allowing for-profit, private clinics to deliver health care services is the ability of the private sector to contain costs. Rachlis (2000), however, points out that in fact the introduction of private clinics and hospitals actually results in increased costs. A report by the Consumers' Association of Alberta estimates that the cost of a private operation is 50-100% higher than a public, non-profit operation (Rachlis, 2000: 3). The high costs of a private operation are especially interesting because private clinics tend to take easier, less-risky patients. Thus, not only would the costs of services increase, but also the public plan would be left with the most risky patients. As Rachlis points out, the whole point of public health insurance is to create a large, balanced risk pool, thereby averaging out the cost of health care services.

American studies comparing the costs between public and private hospitals confirm the findings by the Consumers' Association of Alberta. One study by Woolhandler and Himmelstein (1997) found that U.S. for-profit hospitals were 25% more expensive per case than U.S. public facilities. Furthermore, administrative charges in for-profit facilities were increasing faster than administrative charges in public facilities. In another American study, Silverman et al. (1999) found that health spending was higher and increased faster in communities where all beds were for-profit compared with

communities where all beds were non-profit. Clearly the evidence does not support the assertion that health care services can be delivered cheaper by the for-profit sector.

Some observers contend, however, that the higher costs in the private sector are due to higher quality care. Again, the evidence does not support this claim. One U.S. study found that for-profit HMOs rated lower than non-profit HMOs on all 14 quality indicators (Himmelstein & Woolhandler, 1999). Furthermore, the authors estimated that there would be an additional 5,925 breast cancer deaths per year in the United States if all HMOs were for-profit. Another U.S. study published in the *New England Journal of Medicine* reported that patients receiving care at for-profit facilities had 20% higher death rates and were 26% less likely to be placed on a waiting list for renal transplants than patients receiving care in non-profit facilities (Garg et al., 1999).

American studies must be interpreted with caution. Like the Canadian health care system, the American system is a mix of private and public financing. However, the American system of health care financing is much more complex than the Canadian system (Evans, 2000: 25). In Canada and the U.S. health care is delivered privately. But in Canada all Canadian citizens are insured under their provincial health plan. In the U.S. in 1997, 70% of the population was covered by private insurance plans, 25% of the population was covered under public insurance (Medicare for those over the age of 65 or Medicaid for some of the low-income population), and 16% of the American population had no health insurance (Evans, 2000: 26). Adding to the complexity of health financing in the American system is the increased prevalence of HMOs. Nevertheless, Canadian studies have also arrived at the same conclusion; health care delivered by the private

sector is often more expensive, delivers less quality care, and is contrary to societal goals of equitable and accessible health care.

CHAPTER 3

THEORETICAL FRAMEWORK

This chapter outlines the political economy perspective, which guides this thesis. Medicare is one aspect of the Canadian welfare state. As such, the functions of the welfare state will be examined with particular attention paid to the state's role in financing health care delivery. In addition, the political, economic, and hegemonic forces guiding privatization will be discussed as they relate to the welfare state in general and Medicare in particular.

Burke and Stevenson (1998) point out that health care is a political issue. First, they note that governments regulate health care workers and finance hospitals. Second, Canadians' expectations for medical care have made Medicare a political issue that politicians have learned cannot be ignored. Finally, and as discussed earlier, there are the complex funding arrangements that exist between the federal and provincial governments. Given the political nature of Medicare, it is important to view the delivery of health care services in terms of the conflicts and contradictions of welfare states in capitalist societies (Burke & Stevenson, 1998: 598). Thus, health care delivery in Canada leads to conflict arising out of contradictory ideologies, which characterize health care as either a commodity sold on the market or as a decommodified public good provided by governments. The conflict surrounding health care is not unique in this regard. Indeed, all services delivered by the welfare state are surrounded by the same ideological conflicts. What is unique, however, is the broad support that universal health care receives from the Canadian public.

THE WELFARE STATE IN CAPITALIST ECONOMIES

"Political economy is a concept referring to the inter-dependent workings and interests of political and economic systems, especially in complex industrial societies" (Johnson, 2000: 228). Political economists, then, cannot separate the economic system from the political system. In the Marxist tradition, political economy views the role of the state as that of active promoter of the interests of the capitalist class. Thus, inequalities created in the economic sphere are reinforced in the political sphere. Both health status and access to health care are fundamentally connected to the distribution of resources and power. It is therefore important to examine the influences of the capitalist mode of production and the state in determining both health and health care policy.

The only goal in capitalist economies is the relentless and insatiable drive for profits. All activities are thus organized to meet this goal. The collective needs of the public are not a part of this equation so long as these do not increase profits. Gough (1975) however points out that the profit motive shapes rather than determines the form of capitalist development. To argue otherwise would ignore the role of class struggle in influencing state policy (Gough, 1975: 56-57).

Marxist analysis of the welfare state in capitalist economies rests on two assumptions. First, the state, while acting in the interests of the capitalist class, has relative autonomy (Swartz, 1977: 314). This separation is necessary if the state is to effectively manage the interests of capital as a whole. Without the state to promote political unity, the conflict arising from competing economic interests would threaten the power of the capitalist class. The second assumption of Marxist theorists is that class

conflict shapes the form of capitalist development. Gough (1975) points out that the state therefore has a dual role. On the one hand, the state must organize the interests of the capitalist class. On the other hand, the state must disorganize the working class if the interests of the capitalist class are to be achieved. This dual role is achieved by placating the demands of the working class without interfering with the capitalist mode of production and distribution. The concessions gained by the working class and the degree of state autonomy from the capitalist class depends on the strength of the working class and the economic condition of capital at the time (Swartz, 1977: 315). However, it must be noted that the state provision of services does not mean that capital's interests have not been met. Indeed, the fact that working class unrest has been undermined serves to contribute to capital accumulation.

There are two main Marxist perspectives in regards to the origin of health care policy in Canada. The debate centers around whether Medicare was a concession arising from working class militancy or whether it was recognized that Medicare was functional for capitalist class interests. Swartz (1977) argues that Medicare was the result of working class struggle. In order to advance the long-term economic and political interests of the capitalist class, health care was a concession to the working class. Walters (1982), however, argues that at the time Medicare was implemented, there was very little working class militancy. Instead, she argues that a universal health insurance plan was adopted because it was functional for capital. As such, there was very little opposition to health insurance on the part of the capitalist class. There are a few reasons why the capitalist class would not be opposed to a health insurance scheme. First, by socializing the costs of health care, employers would not be responsible for providing an

expensive fringe benefit. Second, workers in better health would have better work productivity. Clearly, there were some benefits to capital by adopting a state-financed health care plan.

Coburn (1999) argues that the competing perspectives of Swartz and Walters are not incompatible. First, he points out that Swartz and Walters' differing viewpoints are partly due to methodology, specifically how working class militancy was measured. Swartz focused not only on unions, but also on political parties such as the Cooperative Commonwealth Federation (CCF). Walters, however, focused exclusively on union activism. Second, Coburn argues that due to the particular stage of capitalism at the time Medicare was implemented, both perspectives are correct. At the time of the Medicare debate there was a great deal of competition between monopoly and competitive capital. Monopoly capital (characterized by organized labour) benefited from the introduction of health insurance, while the smaller competitive firms opposed state sponsored health care on ideological grounds—intervention in the market. However, because of the greater power of labour, the state had to pay much more attention to balancing the needs of capital and labour (Coburn, 1999: 843). Thus, the demands of labour and the absence of great opposition to health insurance were both important in the implementation of Medicare.

Navarro (1976) also points out that there is no clear-cut dichotomy between the social needs of capital and the social demands of labour. Any specific policy can meet the needs of both capital and labour (p. 452). Thus, a national health insurance plan met the needs of labour by eliminating the requirement to pay directly for hospital or physician services, to buy private insurance on the market, or to rely on employers for

health insurance. Capitalists also gained by not having to provide an expensive fringe benefit, making Canadian firms more competitive on the international markets. Chrylser, for example, estimated that in 1998 it paid $700 U.S. on health benefits for each car made in the U.S., but only $233 U.S. for each car made in Canada (Armstrong et al., 2000: 24).

Furthermore, the introduction of welfare policies served as a legitimation function for the state. Indeed, Waitzkin (2000) points out that state expenditures usually rise when the classless nature of the state is being questioned (p. 45). As will be discussed later, Medicare also served to reinforce the values of private enterprise and individualism.

Political sociologists such as Esping-Andersen (1998) and Coburn (1999) argue that Canadian welfare policies have done little to alter the balance between capital and labour. A common definition of the welfare state is that the state accepts responsibility for a certain level of support for its citizens (Esping-Andersen, 1998: 133). However, Esping-Andersen argues that this basic definition obscures important differences between welfare states. As such, he created a typology which rates countries according to the degree of decommodification and social stratification of state policies. Decommodification refers to the extent to which a person is free from the constraints of the market. Employers oppose state policies which threaten to decommodify workers because workers are no longer completely dependent on an employer for either income or services such as health insurance. In the United States, for example, where workers may receive health benefits through their employer, 30% of adult male workers would like to change jobs but are afraid of losing their health insurance (Navarro, 1998: 673). Social stratification refers to how the welfare state creates inequalities among citizens. For

example, welfare states which rely on means-tested programs stigmatize recipients and create greater inequalities than do welfare states which provide universal benefits.

Under the welfare regime typology, Canada is classified as a liberal welfare state (Esping-Andersen, 1998: 141). The liberal welfare regime, which also characterizes Great Britain and the United States, ensures the primacy of the market by providing income-tested programs with minimal benefits. Recipients are stigmatized and there is a great degree of inequality. Citizens are therefore encouraged to rely on the market for both employment and the provision of services. At the opposite end of the welfare state typology is the social democratic regime, characteristic of countries such as Sweden, Norway, and Denmark. Social democratic regimes provide a wide number of decommodifying, universal programs that promote the principles of equality (Esping-Andersen, 1998: 142). A cause and consequence of these decommodifying and egalitarian state policies, is a much greater balance in power between the capitalist and working classes than would be found in liberal welfare states.

The degree of decommodification and social stratification a country's welfare state brings about depends on the balance of power that exists between the capitalist and working classes. Social democratic countries are characterized by a high rate of unionization and strong labour movements. In Finland, for example, 81% of workers were unionized in 1994, and 95% of workers were covered by collective agreements. In contrast, workers in Canada and the United States had unionization rates of 38% and 16% respectively (Navarro, 1998: 654). Another measure of working class power is the presence of a labour party in government. The social democratic countries have a long tradition of strong labour parties. The New Democratic Party in Canada has traditionally

been supported by the working class. Again, the United States stands out as a country with no labour party in (or out of) government. It is no surprise then that Canada's welfare policies are less decommodifying and less egalitarian than welfare states in social democratic countries, but more so than the welfare state in the United States. Indeed, the size of the social wage depends on the level of militancy of the labour movement (Navarro, 1976: 452).

In terms of health care policy, in many respects Canada more closely resembles a social democratic regime than it does another member of the liberal regime, the United States (Olsen, 1998: 196). In comparison to the United States, Canada's universal health care system is much more decommodifying than health care delivery in the United States. Except for the poor and the elderly, Americans are expected to purchase health insurance or receive insurance from their employer. The American health care system also exacerbates inequality. While the wealthy can purchase the best health care treatments, the under-or uninsured are unable to afford even the most basic treatment.

The fact that Canadians are able to access physician and hospital services free of charge at the time of service, regardless of employment status, however, ignores the more fundamental division between the liberal and social democratic welfare regimes. By actively promoting equality, the social democratic welfare states have confronted the social conditions which give rise to disease: inequality, and poor living and working conditions. The Canadian health care system, however, ignores these conditions and focuses solely on eliminating payment at the point of entry to the health care system. The non-radical nature of Medicare in altering class relations is evident in the following quote by Mackenzie King,

> Social insurance, which in reality is health insurance in one form or another, is a means employed in most industrial countries to bring about a wider measure of social justice, without, on the one hand disturbing the institution of private property and its advantage to the community, or on the other, imperiling the thrift and industry of individuals (Swartz, 1998: 537).

Thus, while social democratic welfare states are proactive in that they attempt to prevent the conditions which give rise to ill health, Canada is reactive and attempts to cure disease after it has occurred.

A curative approach to medicine serves to deflect attention away from the social conditions that cause disease, and places the responsibility for health on the individual (Swartz, 1977: 335; Coburn, 1999: 840). Furthermore, since Medicare gave access to all citizens and defined health in terms of access to care, it encouraged the belief that everyone had equal access to health, despite continuing inequalities in health status (Walters, 1982: 168). In recent years the curative approach to health care has been joined by the lifestyle approach to disease prevention (Tesh, 1988). As will be discussed in the next section, this approach has been used by neo-liberal ideology to justify cuts to health care spending.

THE IDEOLOGY OF PRIVATIZATION

Coburn (1999) notes that whereas capital and the state were fairly autonomous during earlier stages of capitalism, this balance changes with the introduction of global capitalism. Competition on a global scale forces corporations to reduce the costs of production, which is primarily achieved by exploiting labour. Capital becomes mobile as it seeks to use the cheapest labour available. Labour, however, remains locally based

(Coburn, 1999: 839). The mobility of capital has important implications for the relationship between the state, capital, and labour. Actual mobility, or even the threat of mobility, gives capital more power over labour. Labour unions settle for wage decreases in exchange for continuing employment. States also give in to capital, accepting their claims that prosperity is dependent on concessions to business (Coburn, 1999: 839). In addition, capital becomes highly unified and strongly opposes the welfare state. As such, government spending on the welfare state comes increasingly under attack from the right (e.g., the Business Council on National Issues, the C.D. Howe Institute, The Canadian Taxpayers Federation, and the Fraser Institute). As well, foreign (mainly U.S.) holders of national debt threaten higher interest rates if market oriented policies are not put in place (Coburn, 1999: 844).

Navarro (1998) argues that globalization is being used as an excuse by governments to implement unpopular neo-liberal policies. Neo-liberalism is characterized by the belief that public deficits and state regulation of labour markets are intrinsically negative, welfare state spending and redistribution of resources hinders economic growth, and the flow of goods and finances should not be regulated by the state (Navarro, 1998: 609). Rather than a response to economic conditions, welfare reforms are political decisions. But because globalization, a kind of economic determinism, is being blamed, political decisions are not seen for what they really are; i.e., state policies favourable to capital accumulation of profit. In fact, Navarro argues that neo-liberalism is capital's response to the increased demands of the working class (p. 656).

Navarro (1999) argues that states are not powerless. Instead, what is needed is a strong labour movement and a strong state willing to intervene in the areas of production

and distribution. He points to social-democratic countries which have been highly integrated in the global economy for many decades. In fact, welfare state expansion in these countries coincided with the expansion of their export economy (Navarro, 1999: 19). Navarro thus refutes the claims that the social-democratic countries have experienced a high rate of unemployment as a result of integration into world markets. Rather, he argues that high unemployment in countries such as Sweden was a result of too little public employment. In countries such as Norway where there is a much more developed public sector, the unemployment rate of 4.9% in 1995 was the lowest in the world (Navarro, 1999: 27).

Nevertheless, the Canadian government has made it clear to its citizens that Canada must be seen as a good investment for foreign capital. Despite Finance Minister Paul Martin's recognition that "universal health care and quality education are Canadians' highest priorities," the October 2000 mini-budget provided only $21.1 billion over five years for CHST payments and an additional $1 billion for the purchase of diagnostic equipment. The bulk of the surplus was committed to cutting taxes. In fact, the Canadian government will provide $100 billion worth of tax cuts by 2004-05 (Government of Canada, 2000).

As with other social programs, health care spending has been portrayed as spiraling out of control, even though Evans (2000) notes that Canadian health care spending has never done anything mathematically interesting. In fact, in 1970 just prior to the implementation of Medicare in Canada, both American and Canadian health spending accounted for 7% of GDP. Public health insurance kept Canadian spending down while American spending increased faster than the OECD average (Evans, 2000:

37). In 1997 Canada's national health expenditure was 9.0% of GDP, compared to 13.6% of GDP spent by the U. S. (CIHI, 1999: 18). Even with more money being spent on health care in the U.S., aggregate measures of health status suggest that Canadians are healthier. For example, in 1997 the average life expectancy at birth for males and females is 78 years in Canada and 76 years in the U.S. The infant mortality rate in Canada is 5.5 per 1,000 live births, compared to 7.2 in the U.S. (World Health Organization, n.d.). Indeed, Evans points out that Canadians are not receiving less health care than Americans, they just pay less for it (Evans, 2000: 24).

Health care prices are lower in Canada for a number of reasons. First, Canada achieves an economy of scale with a publicly administered health care system, rather than thousands of insurance companies and HMOs providing coverage to U.S. citizens. It has been estimated that administrative costs are between 10-15% higher in the U.S. than in Canada (Evans, 2000: 40). Second, a portion of private health care revenue must be allocated for profit and advertising costs. Third, physician incomes in the U.S. are higher than in Canada. In fact, fee levels (controlled for the exchange rate) have been found to be 50% higher than in Canada (Evans, 2000: 41).

Furthermore, Canada's health care spending is not markedly different from that in France or Germany, 9.6% and 10.4% of GDP respectively (CIHI, 1999: 18). Nevertheless, health care is expensive. Health expenditures consume one-third of provincial budgets (Burke & Stevenson, 1998: 604). It is therefore not surprising that with reduced federal support for health care, the provinces are eager to shift health care costs to the private sector. These changes to the health care system have also been accompanied by an ideology which supports privatization and individualism.

Waitzkin (2000) argues that social institutions such as education, the family, and the health care system transmit ideas and beliefs that support the established order. He points out that biological explanations of disease justify the purchase and use of expensive technology, which attaches positive evaluations to industrial technology, while at the same time de-values less invasive but equally effective interventions. For example, fetal monitoring is seen as more effective in preventing perinatal complications than is prenatal care for poor women. Furthermore, scientific ideology tends to depoliticize and remove health issues from critical scrutiny (Waitzkin, 2000: 28). The strength of a political economy approach to health care is that it recognizes that health is connected to the political and economic systems of society. Waitzkin writes, "without these connections [health to political and economic systems] the health system falsely takes on the appearance of an autonomous, free-floating entity, whose defects purportedly can be corrected by limited reforms in the medical sphere" (p. 4). It is important to recognize that not only is health status affected by one's place in the social structure; the organization of health care also transmits values about how disease should be treated.

Armstrong et al. (1997) point out that the current move towards privatization is about much more than simply reducing government spending. Equally important is changing the expectations, rights, and responsibilities of workers and citizens. Instead of making excessive claims on the state, citizens are being told to take responsibility for their own health (Armstrong et al., 1997; Navarro, 1985). The federal government emphasized the importance of the individual in determining their health in *New Perspective on the Health of Canadians* (Lalonde, 1974). This document advanced the Health Field Concept and took into account four factors which play a role in creating a

healthy population: human biology, the environment, lifestyle, and health care organization (Lalonde, 1974: 31-32). While it was seen as an important breakthrough in recognizing the role of environmental and lifestyle factors in causing disease at a time when human biology was seen as the most important determinant of health, upon closer examination the Lalonde report simply shifted the focus from biology to lifestyle factors. Thus, with this approach, the individual's lifestyle is to be viewed as "having contributed to, or caused his (sic) own illness or death" (Lalonde, 1974: 32). Not only are lifestyle factors given primacy over the other three factors; lifestyle choices are not viewed in a social, political, or economic context. Indeed, "individual blame must be accepted for the deleterious effect on health of their lifestyles" (Lalonde, 1974: 26).

The focus on lifestyle as the cause of morbidity and mortality has also been criticized in that it can provide justification to policy makers that health care really does not matter when it comes to determining the health of a population. Thus, governments that are worried about the costs of health care are given a supposedly cheaper alternative to investing in health care personnel, infrastructure, and technology (Swartz, 1998; Burke & Stevenson, 1998; Tesh, 1988). If Canadians can be convinced to quit smoking, exercise, and eat healthy by government programs such as Participaction and Body Break, less money will need to be spent on health care needs. Burke and Stevenson (1998) point out that the federal government's commitment to lifestyle factors occurred at the same time as it started to reduce its contribution to health care. Indeed, between 1975 and 1990, the federal government's contribution to health care declined from 30.8% to 27.7% (Burke & Stevenson, 1998: 610). If the responsibility for poor health lies with

the individual and his/her lifestyle choices, it is easy to place the responsibility for paying for health care needs on the individual as well.

Both the biological and lifestyle approaches to disease place the responsibility for disease and cure on the individual, rather than at the collective level. An individualistic approach deflects attention away from class structure and relations of production (Waitzkin, 2000: 48). However, the lifestyle model places even more responsibility for health on the individual than does the biological model of disease. Under the biological model, disease was seen as somewhat random and out of the control of the individual. Hence, health care was necessary because you never knew if you would acquire a disease. In contrast, the lifestyle model does not view poor health as random. Rather, individuals should know that smoking, a poor diet, and lack of exercise lead to disease. Therefore, since the individual knew the risks, it is the individual who should pay for the consequences.

Navarro (1976) points out that this individual solution to health strengthens the tenet of capitalism that one should be free to do whatever one wants—to be rich or poor, to be healthy or to be sick (440). It is all within the control of the individual. Navarro notes that much of the disease that occurred in the 1800's when Friedrich Engels was writing about the poor living and working conditions of the working class was supposedly due to the poor moral fiber of the workers. Today, poor health is seen to be the result of the public's ignorance and lack of concern for their own health. In both cases the solution to poor health is individual prevention and individual therapy (Navarro, 1976: 447).

Researchers such as Evans and Stoddart (1998) point out that by reducing the amount of money spent on health care, more money could be spent on other health-enhancing services such as housing and pensions, creating further savings in health care in the future. Burke and Stevenson (1998) contend, however, that given the welfare state in general is experiencing retrenchment, it is suspect to assume that any savings in health care will be re-directed to other forms of social spending. Evans and Stoddart are ignoring the politics of the welfare state. Money taken out of health care serves capitalist interests by reducing social spending so taxes can be reduced. A re-allocation of social spending would not meet this objective. Furthermore, spending on programs such as social assistance or employment insurance would be much more objectionable to capital since this would reduce workers' dependence on the labour market. While Evans and Stoddart's proposal would do much to prevent disease, it does not take into account the realities of a liberal welfare state.

Crawford (1985) argues that under the rhetoric of health care spending and lifestyle factors lies a political agenda to shift the costs of care to patients and consumers, while at the same time loosening environmental and occupational dangers. The next section will explore a number of hypotheses of how this shift from public to private payment is distributed throughout the population.

CHAPTER 4

HYPOTHESES

The goal of this study is to assess whether individuals have been paying for more out-of-pocket health care costs and to determine how out-of-pocket health spending is distributed throughout the population. At present there is very little data to answer which groups have been affected the most by shifting health care costs to individuals (Uplekar, 2000: 900; CIHI, 1999: B-4). The following hypotheses will be explored.

1. Since the 1990's out-of-pocket health care expenditures have increased.

As discussed earlier, aggregate data points to an increased role of private expenditures in the financing of health care. Fuller (1998) reports that in 1975, 76.4% of the total health care bill was publicly funded, while 23.6% was paid by private insurance or out-of-pocket payments. By 1997 the split was 68% public and 32% private, below the OECD average of 75.7% public and 24.3% private (Deber, 2000: 27). In 1975, Canada ranked 14th out of 22 OECD countries in terms of the proportion of health care spending that is publicly financed. In 1993, Canada dropped to 18th, and in 1997 dropped to 19th, ahead of only Australia, Portugal, and the United States (Deber, 2000: 26). It is expected that while some of these costs have been paid for by insurance companies, out-of-pocket health care spending has also increased.

2. Since the 1970s there is greater disparity in out-of-pocket health expenditures between provinces.

By changing how health care is financed, from 50-50 cost sharing to block funding, the federal government has less control over how the provinces spend transfer payments. In addition, the amount of money provinces receive from the federal government has also been reduced. Mhatre and Deber (1998) predict that as federal transfers to the provinces decline there will be greater decentralization and disparity in health care. Walters (1982) also notes that the federal government is much more able to transcend the narrow interests of the capitalist class to promote the long-term interests of capital. Provincial governments, on the other hand, are much more likely to support the regionally specific interests of the capitalist class (Walters, 1982: 166). Without federal control of health care money, provinces are more able to spend transfer money according to their own provincial priorities. Alberta, for example, has focused on cutting taxes. As one of the richest provinces, Alberta is a low health care spender (Deber, 2000: 31). Deber (2000) notes that the wealthiest provinces have complained the loudest about health care spending.

Furthermore, some provinces have populations with greater health care needs. Saskatchewan and Manitoba, for example, have the highest rates of senior citizens and Aboriginal people in their population. The elderly have been found to use a disproportionate amount of health services and the Aboriginal population has been found to have poor health status compared to other Canadians (Shanahan & Gousseau, 1997: 20). The Atlantic provinces of Nova Scotia and Newfoundland have populations with high unemployment rates, high rates of poverty in children from lone-parent families, and

a low GDP per capita. Higher rates of poverty and unemployment have been found to lower health status and life expectancy (Shanahan & Gousseau, 1997: 12).

Thus, some provinces have greater challenges in meeting the health care needs of populations with lower health status and greater health care needs, such as the elderly, the poor, and Aboriginals. On the other hand, the reduced federal control over transfer payments allows provinces greater control over the form and extent of provincial health care funding. It is therefore expected that provinces will have made different political choices in regards to health care financing; increasing disparity between provinces in terms of the amount citizens in different provinces will pay out-of-pocket for health care goods and services.

3. Low-income households spend less on health care than will higher income households, yet this represents a greater proportion of their household income.

Cochrane (1972) argues that the welfare state has eliminated class inequalities in industrialized societies—creating "classless societies," where the concept of class is irrelevant. The blurring of class has resulted in a narrowing of inequalities in consumption. Navarro (1976), however, argues that a clear understanding of the distribution of resources and power, and the role of the welfare state in advanced capitalist countries makes social class a much needed category of analysis. Indeed, research points out that the welfare state has not reduced inequalities in terms of both health status and the consumption of health care.

Health is not randomly distributed throughout society. One's place in the social structure plays a large part in their health status. One of the most consistent epidemiological findings is an inverse relationship between social class and mortality (Nancarrow Clark, 2000: 122). Social inequality is strongly associated with a variety of health measures, including age-adjusted death rates and low birth weight. People at the top of the socio-economic hierarchy are healthier than those in the middle, who in turn are healthier than people at the bottom of the hierarchy (Chernomas, 1999: 10). Thus, households that can least afford health care may need it the most.

The 1982 Family Expenditure Survey (FAMEX) found that while the poor spent less money than higher income groups on out-of-pocket health expenses, their health care expenses as a percentage of family income were greater than for higher income groups—2.5% for the lowest income group versus 2.1% for the highest income group (Badgley, 1991: 664). Badgley (1991) concludes,

> [Medicare] appears to have had a displacement effect whereby middle and upper income groups have been afforded the opportunity to purchase more optional health benefits and continue to outstrip the financial capacity of the poor, whose health needs remain more extensive and severe. (p. 664)

The poor are also much less likely to have private insurance through their employer. Like pay, fringe benefits such as medical and dental insurance, are not equally distributed. People employed in lower-tier service jobs, especially those employed part-time, part-year, or on a temporary basis receive very few benefits. In 1989, 83% of employees in the manufacturing sector had medical benefits, compared to 43% of employees in the service sector, and this number drops to 11% for employees in the service sector with non-standard work arrangements (Krahn & Lowe, 1993: 114). Hence, as the state encourages private payment for health care, those employed in the

secondary labour market have less access to private insurance than do those employed in the primary labour market, increasing their out-of-pocket health expenses.

Because members of the lower class have greater health care needs and are less likely to have private insurance through their employer, it is expected that as the state retreats from the funding of health care, low-income households' out-of-pocket health care costs will consume a greater proportion of their household income. Yet because of their lower income, they will actually spend less on health care than do higher income earners.

4. Older people spend more on health care than do younger people.

As people age they require more health care services than do younger people. The Manitoba Centre on Aging (1996) found that in 1991-1992 Manitoba seniors had on average 4.4 health problems. Furthermore, as seniors aged the number of health problems increased. For example, seniors 65-74 years of age had 3.9 health problems, compared to seniors 85 plus who had on average 5.3 health problems (p. 85).

The higher number of health problems in the elderly translates into greater use of health care. In 1994, people over the age of 65 accounted for just under 12% of the population, but 48% of public spending for health care (Deber, 2000: 35). In Manitoba, seniors accounted for 13.3% of the population in 1994-1995 but used 27.6% of medical services and accounted for 31.6% of hospitalizations (Manitoba Centre on Aging, 1996). Hospital stays also increased with age. In Manitoba, people under the age of 45 stayed in

hospital on average 4.2 days, compared to 12.6 days for people 65-74 and 20.1 days for people over the age of 75 (Manitoba Centre on Aging, 1996: 114).

As people age they clearly have greater health care needs and consume more health care than do younger people. However, senior citizens may have the least amount of resources to pay for health care. Statistics Canada reports that in 1998, 44.4% of unattached senior citizens had a low income, compared to 37.5% of people under 65 years of age.

With older peoples' greater need for and use of health care, it is expected that they will be paying more for health care as provinces increase deductibles for pharmaceuticals and remove procedures from provincial health care plans (cataract patients must pay for a foldable lens in Manitoba and Alberta, for example).

5. As the number of members in a household increases, out-of-pocket health care spending also increases, yet per person spending decreases.

Analyzing the 1964 FAMEX, Williams (1968) found that as the number of household members increased, household spending on health care also increased, but per person spending decreased. This variable not only takes into account the number of dependent children, but also captures the number of adults in a household, some of whom may be classified as dependents due to illness or disability.[2]

While larger families will spend more on health care because of more children and possibly disabled, sick, or elderly family members living in the household, per person spending is expected to be more in households with fewer members. Single person

[2] It is not possible to determine the number of dependent adults in a household due to the way in which the variables are coded.

households, for example, may not have someone to care for them during times of poor health, and may be required to pay for a health care worker to help them at home. The importance of a spouse for support is evident in the following answers to a question posed by the Manitoba Centre on Aging in 1991-1992. The question asked respondents whom they were most likely to turn to for support in a time of need. Almost 39% of respondents named their spouse or common law partner as their main source of support. Fifty-four percent of those aged 65-74 relied on their spouse, compared to only 19% of people over the age of 85. This drop in support from spouses as people age is accompanied by an increase in relying on others such as a paid caregiver for support. Only 0.4% of seniors aged 65-74 relied on this type of support, compared to 2.5% of seniors aged 85 and over (Manitoba Centre on Aging, 1996: 102).

Thus widowhood and the declining health status of an elderly spouse could require a person to rely on other types of support, some of which may require out-of-pocket payment.

CHAPTER 5

MATERIALS AND METHODS

THE DATA SET

In order to assess whether the evidence supports the hypothesis that health care expenditures have been increasingly shifted to the individual from the state, Family Expenditure Surveys (FAMEX) spanning the period of 1969 through 1996 are examined. The FAMEX provides detailed data on the income and expenditures of households in Canada, as well as various socio-demographic variables. The primary use of the FAMEX is to update the weights used in the Consumer Price Index, which is used to adjust pensions, wage settlements, and support payments for inflation. As well, the FAMEX is used by researchers to determine the Low-Income Cut-off level.

Through Statistics Canada's Data Liberation Initiative, FAMEX for the years 1969, 1978, 1982, 1986, 1992, and 1996 are available for use by the academic community. Thus, household income spent on health care can be examined over the period when Medicare was becoming universal through to the 1990s when health care reform was underway throughout the country.

SAMPLING

Sampling in the FAMEX is conducted using a multistage stratified clustered sample selected from the Labour Force Survey sampling frame. The six FAMEX surveys used in this study provide national coverage of household expenditures. Other FAMEX surveys are not used in this study as they were restricted to selected census metropolitan areas and census agglomerations. Table 5.1 presents the sample size and the response rate for each FAMEX survey used in this study.

Table 5.1 *Sample size and response rate for FAMEX surveys, 1969-1996*

Year	Final Sample Size	Response Rate
1969	15,140	69.2%
1978	9,356	72.3%
1982	10,938	81.3%
1986	10,356	76.6%
1992	9,492	73.8%
1996	10,417	77.3%

All of the FAMEX surveys exclude persons living on reserves, and patients and inmates living full time in collective households such as nursing homes, hospitals, and penal institutions. The survey is an interviewer-assisted survey.

INDEPENDENT AND DEPENDENT VARIABLES

Independent variables used in the study are province of residence, household income, age of respondent, number of household members, relative price, and year of survey. While gender is an important variable when studying health and health care, it is not included in this analysis. This is because the unit of analysis is the household, and it would be impossible to tell how much was spent on health care goods and services by male and female members of the household. The dependent variable is the amount of household income spent on health care services and products. The variable health care spending is composed of a number of different services and products. The following health care categories are contained in each of the FAMEX surveys (see Appendix for definitions).

- Health care
- Direct costs to household
- Health care supplies
- Medicinal and pharmaceutical products
- Eye care goods and services
- Dental care
- Hospital and other health care services
- Other health care goods
- Health insurance premiums
- Physician's care

However, while all health care items are included in each FAMEX survey, each item is not consistently separated from other health care items. Thus, in one survey year it is possible to see the amount spent solely on pharmaceutical products, but in other years pharmaceutical products are included with other health spending such as over the counter medicines and health care supplies.

MEASUREMENT

Province of residence is recorded for each household. Because different codes and categories were used during different years of the survey, regions first had to be recoded. For the years 1969, 1978, and 1982 the provinces were grouped according to region. Regional categories are: Atlantic Provinces, Quebec, Ontario, the Prairies, and British Columbia. The grouping of provinces according to region is problematic only in that Alberta was grouped with Manitoba and Saskatchewan. The 1986 survey coded provinces according to region but created a separate code for Alberta. The 1992 and 1996 surveys coded all provinces separately. For the purposes of this study four regional dummy variables were created (Atlantic, Quebec, Prairies, and British Columbia) with Ontario being the reference variable.

The independent variable, income, is measured on a ratio scale. This variable includes the before tax incomes of all members of the household over the age of 14. Income sources include wages and salaries, self-employment earnings, investment income, government transfer payments, and income from other sources such as pensions, alimony, and child support payments. Using the Consumer Price Index, the household

income variable was controlled for inflation. Thus, all income figures are in 1992 dollars. The household income variable, however, caused problems with normality and heteroskedasticity. To correct this problem the log of the values of household before tax income was computed.

The age variable is also measured on a ratio scale. However, each survey had different age codes for people under the age of 24 and over the age of 70. For example, the 1978 survey coded everyone over age 15 as their actual age, whereas the 1996 survey did not code the actual age of the respondent until age 24. There was a similar problem at the opposite end of the age scale. While the 1969 survey coded a person's actual age up to age 80, the 1996 survey only did this up to the age of 70. Thus, the age variable was recoded so that all respondents 24 years of age and under were coded as age 24, and all respondents 70 years of age and over were coded as 70 years of age. All other values are the actual age of the respondent. There will be some error by using the age of the respondent in households where spouses' ages are vastly different. However, the benefits of using a continuous age variable, rather than a dummy variable for presence of senior citizens in the household, will outweigh the error that will enter into the measurement by using age of respondent.

Number of household members was also coded inconsistently between different years of the survey. All survey years, except the 1996 FAMEX, recorded the actual number of household members. The 1996 survey, however, coded the actual number of household members up to five and then coded any more members as six or more. Thus, this analysis was forced do adopt the more restrictive codes of the 1996 survey.

In order to determine whether out-of-pocket health spending has increased between 1969 and 1996, dummy variables were created for each year of the survey. A dummy variable was created for the years 1969, 1978, 1982, 1992, and 1996, and 1986 was used as the reference year. This is because it was the first FAMEX survey conducted after the federal government re-committed itself to health care by passing the Canada Health Act, and is therefore expected to have the lowest amount of out-of-pocket health care spending.

Because it could be argued that increases in out-of-pocket health spending could be due to the increasing costs of health care goods and services, a relative price variable was used as a control variable. The relative price variable was calculated for each year of the survey by dividing that year's Health Price Index value by that year's Consumer Price Index value.

The dependent variable, health care expenditure, was recorded according to the respondents' recollection or collection of receipts for health care expenditures (data quality concerns will be addressed later). The actual dollar value of all expenditures was recorded, including Provincial Sales Tax (PST) and the Goods and Services Tax (GST). All health expenditures on health care products and services that are not covered by a pre-paid plan are included. In order to control for the inflation of health prices, all health expenditures were controlled for inflation using the Health Price Index. Thus, all health expenditures are in 1992 dollars. As with the independent variable, household income, amount spent on health care caused problems in regards to meeting the assumptions of normality and heteroskedasticity, which are required if multiple regression is to be used.

Again, the log of the values of amount spent on health care was computed to correct this problem.

METHOD OF DATA ANALYSIS

Statistics Canada requires all users of their data to use the appropriate weight variable when conducting data analysis. This is to correct for any sampling error that may occur during the course of data collection. Without weighting this data set the Atlantic provinces are over-represented in the sample, while Ontario is under-represented. Before the six FAMEX surveys were combined into one data set, each FAMEX survey had variables recoded, new variables created, and then the appropriate weight variable was applied. Once this was completed for each data set, the six FAMEX surveys were then combined into one data set.

Outliers were then analyzed and removed from the analysis. This was accomplished by running the regression analysis and then analyzing the studentized deleted residuals for extreme values. Extreme values identified by the Explore function in SPSS were analyzed in greater detail and then deleted. In total 2,450 cases were deleted, reducing the original sample size of 65,699 to 63,249. Outliers were taken almost evenly from all years of the survey. Older respondents and lower income households were more likely to be removed from the analysis. These cases tended to have extreme values for the amount spent on health care, combined with a very low income (in some cases a negative income). While it is important to recognize that removing very low income households from the analysis may introduce bias into the

results, these outliers were removed as they are extreme values and unrepresentative of the Canadian population. In addition, because the FAMEX survey is cross-sectional, it provides data on only one year of a household's finances. Thus, the year of the survey may not represent the "normal" income of the household. In some cases, data quality was also an issue as respondents reported spending 300-500% of their income on health care goods and services.

Descriptive statistics were then conducted to analyze the amount spent on health care and the percentage of income spent on health care. The mean values were compared between different groups (province or residence, income quintile, age of respondent, and number of household members) for each year of the survey. As well, variables were combined to see the effects of a number of socio-demographic variables on out-of-pocket health care spending. For example, the effects of income quintile and province of residence were examined, as well as the effects of age and province of residence.

Multiple regression analysis was then performed. Using the above variables, the multiple regression model to explain how out-of-pocket health spending is distributed throughout the Canadian population and through time is as follows:

Y (log of amount spent on health care) = a (intercept/constant) + 1969 dummy variable + 1978 dummy variable + 1982 dummy variable + 1992 dummy variable + 1996 dummy variable + log of household before tax income + age of respondent + number of household members + Atlantic region dummy variable + British Columbia dummy variable + Prairie dummy variable + Quebec dummy variable + relative price

Because Canadians have always had some out-of-pocket health expenses, it is important that a trend analysis be conducted. Without a baseline measure, out-of-pocket health expenditures could be attributed solely to health care reform of the 1990s, when in

fact out-of-pocket spending has always played a role in health care financing. By analyzing the regression coefficients, it is possible to determine whether households have experienced greater out-of-pocket health expenses and whether some households spend more on health care than do other households.

CHAPTER 6

RESULTS

This chapter presents the results of the analysis that was conducted on the FAMEX surveys. First, descriptive statistics comparing the mean amount spent on health care out-of-pocket and the percentage of income spent on health care for different groups are presented. Second, the results of the regression analysis are presented. A discussion of the results and how they relate to health care policy and privatization is presented in the subsequent chapter.

DESCRIPTIVE STATISTICS FINDINGS

Descriptive statistics were first run in order to see if there were any differences between years in terms of the amount spent on health care out-of-pocket and the percentage of income spent on health care. In addition, the amount and percentage of income spent on health care were compared between different groups to see if the effects of health care policy were distributed equally between different groups within the Canadian population. All dollar amounts are in 1992 dollars.

Health Spending by Year

As can be seen in Table 6.1, the introduction of Medicare reduced the average amount spent by Canadians on health care products from $1,175 in 1969 to $911 in

1978.[3] Between 1978 and 1986 the mean amount spent on health decreased each year. In 1992, however, health spending increased from $869 in 1986 to $903. Health spending again increased in 1996 to $975, the highest amount Canadians spent out-of-pocket on health care since the introduction of Medicare.

Table 6.1 *Mean amount and percentage of income spent on out-of-pocket health care costs, by year.*

Year	Mean Amount	Mean % of Income
1969	$1,175	4.42%
1978	911	2.30
1982	904	2.31
1986	869	2.27
1992	903	2.45
1996	975	2.60

From Table 6.1 we can also see that out-of-pocket health spending, as a percentage of income, also decreased with the introduction of Medicare. In 1969 the average percent of income spent on health care was 4.42%, compared with 2.30% after the introduction of Medicare. The percentage of income spent on health care stayed at this level during the 1980s and then started to increase in the 1990s. On average, Canadians spent 2.45% of their income on health care in 1992 and 2.60% in 1996, the largest amount since 1969.

[3] Because of the very large sample size, all differences between means are statistically significant.

Health Spending by Region

As can be seen in Table 6.2, before the introduction of Medicare, citizens spent between $767 and $1,500 on health care expenses, with people in the Atlantic provinces spending the least and Ontario residents spending the most. After the introduction of Medicare, out-of-pocket health spending in all provinces decreased. Again, residents of the Atlantic provinces spent the least, a trend that would continue until the 1990s, and Ontario residents spent the most. Beginning in 1982, however, residents of British Columbia spent the most on health care. In fact, in 1996 citizens of British Columbia and the Atlantic provinces spent more out-of-pocket on health care than they did in 1969 (although this is partly due to the low amount spent in the Atlantic provinces in 1969). Throughout the 1990s Ontario citizens spent the least out-of-pocket on health care. Other low spending provinces included Quebec and the Atlantic provinces, while the Prairie provinces and British Columbia were high spenders. In fact, health spending by Ontario and Quebec residents declined dramatically throughout the time period, from a national high of $1,500 and $1,300 respectively in 1969, to a national low of $820 and $870 respectively.

Table 6.2 Average amount of *out-of-pocket health care spending by region and year.*

Region	1969	1978	1982	1986	1992	1996
Atlantic	$767.12	$686.07	$736.26	$707.93	$824.40	$859.06
Quebec	1,327.48	792.90	858.81	863.68	858.39	878.62
Ontario	1,536.02	1,309.16	1,080.71	944.85	766.57	820.66
Prairies	1,126.45	863.07	884.05	864.92	973.32	1,061.87
B.C.	1,130.90	958.66	952.83	977.25	1,198.67	1,158.59

As discussed earlier, the 1969, 1978, and 1982 FAMEX surveys grouped all prairie provinces together. Beginning in 1986 it was possible to separate Alberta from Manitoba and Saskatchewan. Table 6.3 demonstrates that for each year Albertans spent considerably more on health care than did Manitoba and Saskatchewan residents.

Table 6.3 *Out-of-pocket health care spending in Manitoba, Saskatchewan, and Alberta, 1986-1996.*

Province	1986	1992	1996
Manitoba & Saskatchewan	$ 735.74	$ 827.45	$ 906.82
Alberta	1,029.01	1,189.55	1,341.74

While residents in all three prairie provinces spent more on health care in each successive year, the difference between what residents in Alberta spent and what residents in Manitoba and Saskatchewan spent out-of-pocket also increased. Indeed, the difference between what Alberta residents and residents of the other two prairie provinces spent on health care increased from $293 in 1986 to $362 in 1992, and $435 in 1996. In fact, Albertans spend more out-of-pocket on health care than do residents of any other region.

And unlike residents of Manitoba and Saskatchewan, compared to statistics based on the three prairie provinces, Alberta residents spent more out-of-pocket on health care in 1996 than they did in 1969.

The above data demonstrate that there exists substantial variation in out-of-pocket health spending between the provinces, a trend that has continued since 1969. In each year of the FAMEX survey citizens in different provinces spent different amounts on out-of-pocket health care expenses.

Health Care Spending by Income Quintile

The descriptive statistics just discussed are averages for all Canadians. The next set of results describe out-of-pocket health spending for different income quintiles in each year of the FAMEX survey. Table 6.4 shows the average amount each income quintile spent on out-of-pocket health care products in each year of the survey. In each year, the lowest income quintile spent the least amount of money on health care goods and services. As the income quintile increases, the amount spent on health care also increases. For example, in 1969 the lowest income quintile spent $679 on health care, compared to the $1,773 spent by the highest income earners.

Table 6.4 *Amount spent out-of-pocket on health care, by income quintile and year.*

Quintile	1969	1978	1982	1986	1992	1996
1[4]	$678.52	$376.81	$382.13	$372.61	$430.85	$464.80
2	957.43	707.73	687.27	671.36	719.57	802.43
3	1,188.32	920.60	880.76	864.00	925.27	976.45
4	1,387.00	1,111.35	1,064.83	1,082.00	1,086.56	1,177.17
5	1,772.63	1,461.32	1,447.58	1,391.39	1,393.90	1,500.40

Table 6.4 also shows that, for all income quintiles, the introduction of Medicare decreased the amount spent out-of-pocket on health care. Out-of-pocket health care spending decreased for each income quintile in each year through 1978 to 1986 when out-of-pocket health care spending reached its lowest point. Beginning in 1992, all income quintiles experienced an increase in the amount spent on health care. However, the increased amount spent out-of-pocket was not distributed equally throughout all income groups (see Table 6.5). Between 1986 and 1992 the amount spent on health care increased by $58 for the lowest income quintile and only $2.50 for the highest income quintile. In fact, except for the middle-income group, as income quintile increases, the additional amount of money spent on health care between 1986 and 1992 decreases.

Out-of-pocket health spending continued to increase for all income quintiles between 1992 and 1996 (see Table 6.5). This time, however, the upper income groups experienced greater increases in health spending. The total difference between health care spending in 1986 and 1996 ranges from a low of $92 in the lowest income quintile to

[4] The first income quintile refers to the lowest 20% of before tax incomes, while the fifth quintile refers to the highest 20% of before tax incomes.

$131 in the second income quintile. Although all income groups experienced substantial increases in their health spending between 1986 and 1996, Table 6.5 shows that as income quintile increases, the increased amount spent on health care between 1986 and 1996 represents a smaller proportion of 1996 health care spending.

Table 6.5 *Increase in Health Spending by Income Quintile, 1986 to 1996.*

Income Quintile	Difference Between 1986 and 1992	Difference Between 1992 and 1996	Total Increase Between 1986 and 1996	Total Increase as % of 1996 Health Spending
1	$58.35	$ 33.84	$ 92.19	19.83%
2	48.21	82.86	131.07	16.33
3	61.27	51.18	112.45	11.52
4	4.56	90.60	95.16	8.08
5	2.50	106.51	109.01	7.27

Data reporting the amount spent on health care demonstrate that lower income Canadians have always paid less out-of-pocket for health care than have upper income Canadians. However, when the amount spent on health care is reported as a percentage of income, we can see that lower income Canadians have always spent more on health care than have upper income earners. In fact, for every year, as income quintile increases, the percent of income spent on health care decreases. Table 6.6 shows that all income groups spent a smaller percentage of their income on health care after the introduction of Medicare. However, after 1978 the two lowest income quintiles experienced increases in the proportion of income that was spent on health care, while the upper income groups spent less of their income on health care. Health spending as a percentage of income also increased for lower income earners during the 1990s but stayed relatively stable for upper income earners.

Table 6.6 *Percent of income spent on health care, by income quintile and year.*

Quintile	1969	1978	1982	1986	1992	1996
1	7.36	2.92	3.08	3.00	3.50	3.79
2	4.64	2.57	2.68	2.66	2.84	3.13
3	3.81	2.25	2.24	2.19	2.36	2.42
4	3.31	2.02	1.95	1.93	1.94	2.02
5	2.69	1.71	1.68	1.53	1.52	1.53

Thus, lower income earners spend less money on health care than do upper income earners, but what they do spend represents a greater proportion of their income. Furthermore, out-of-pocket health care spending as a percentage of income has increased for lower income earners, but has stayed pretty even for upper income earners.

Health Spending by Income and Region

The above data demonstrate that there exists variation in both the amount spent on health care and the percentage spent on health care between income groups, with low-income earners spending less on health care than do higher income earners. However, the amount spent on health care by the lowest income quintile represents a higher percentage of their income than the higher amount spent by the highest income quintile. Earlier results also showed that there exists variation in health spending between provinces. Does there exist provincial variation in terms of inequality in the percentage of income spent on health care by lower and upper income earners?

Table 6.7 *Difference between lowest and highest income quintiles in percent of income spent on health care, 1969, 1978, and 1996, by region.*

Region	1969	1978	1996
Atlantic	2.95	1.48	1.79
Quebec	6.06	0.84	1.31
Ontario	5.67	1.36	1.97
Prairies	5.89	1.31	3.07
B.C.	4.18	1.35	2.55

As can be seen in Table 6.7 there was a large difference in the percentage of income that the lowest and highest income quintiles spent on health care in 1969. For example, in Quebec the lowest income quintile spent 6% more of their income on health care than did the highest income quintile. After the introduction of Medicare, this inequality decreased substantially in all provinces. By 1996, however, inequality between lower and upper income earners increased in all provinces, with the greatest levels of inequality in Western Canada.

Health Spending by Age

Health spending by age group is much like a bell-shaped curve. Out-of-pocket health spending increases between the age groups of under 30 to those aged 30-39, reaches a peak in the 40-49 age group, and then spending decreases successively for the age groups 50-60, 60-64, 65-69, and those over the age of 70 (see Table 6.8). The high amount spent on health care by people aged 40-49 could be the result of larger household

sizes for people in this age group, combined with expenditures in categories such as dentists, orthodontists, and eye care goods and services. This bell-shaped pattern occurs until 1996 when people between the ages of 60-64 spend the most on health care. For all survey years people aged 70 and over spend less on health care than do people aged 65-69, who in turn spend less than people aged 60-64. This could be due to the fact that provincial programs help people 65 and older with health care costs, such assisting in the purchase of prescription drugs. Furthermore, means-tested health programs would take effect for the older elderly who have lower incomes than the younger elderly.

Table 6.8 *Health spending by age group and year.*

Age Group	1969	1978	1982	1986	1992	1996
Under 30	$951.41	$737.80	$711.98	$635.49	$620.85	$637.13
30-39	1,239.65	972.83	941.44	875.97	865.33	855.00
40-49	1,377.44	1,221.31	1,190.25	1,142.05	1,113.07	1,111.03
50-59	1,274.76	1,112.06	1,127.66	1,066.98	1,029.40	1,109.49
60-64	1,130.53	904.67	873.83	915.22	1,011.04	1,134.07
65-69	1,044.05	630.65	730.24	721.30	831.02	1,084.68
70+	953.89	468.51	530.41	603.80	742.05	940.37

As can be seen in Table 6.8, people aged 65-69 and people over the age of 70 benefited the most from the introduction of Medicare, reducing their 1969 out-of-pocket health spending from $1,044 and $954 to $630 and $469 respectively. However, since 1978 health spending for people in these two age groups increased each year. In fact,

between 1992 and 1996 health spending by people aged 65-69 increased by $254 to $1,085, higher than what people in this age group spent in 1969.

Prior to the introduction of Medicare, people under the age of 30 spent less on health care than did those aged 70 and older. After Medicare was introduced, those 70 years of age and over spent less on health care than people under the age of 30. In 1992 and 1996, however, spending by the two age groups returned to the 1969 pattern with those under 30 spending less on health care than those aged 70 and over. This also occurred for people aged 65-69, except that this age group began to spend more than people under the age of 30 in 1982.

Health Spending by Seniors Across Regions

The above data demonstrates that seniors benefited the most from the introduction of Medicare and have seen the biggest increases in out-of-pocket health spending during the 1990s. But are some provinces requiring senior citizens to pay more for health care than are other provinces? Table 6.9 shows that there is regional variation between how much seniors pay out-of-pocket for health care expenses.

Table 6.9 *Out-of-pocket health care spending by seniors (65+), by region and year.*

Region	1969	1978	1982	1986	1992	1996
Atlantic	$ 742.57	$507.27	$611.60	$606.01	$756.95	$874.72
Quebec	1,360.94	545.24	640.38	653.22	738.62	752.69
Ontario	1,276.55	602.87	631.73	678.53	641.99	893.73
Prairies	888.35	520.18	631.27	563.09	831.83	1,225.44
MB & SK	-	-	-	577.85	860.41	1,181.51
Alberta	-	-	-	531.43	752.70	1,318.11
B.C.	735.68	634.85	648.32	941.79	969.46	1,082.06

Seniors in the Atlantic provinces, Quebec, and Ontario pay considerably less for health care than do seniors in the prairie provinces and British Columbia. In 1996 Quebec seniors paid the least amount out-of-pocket ($752) compared to Alberta where seniors spent on average $1,318 on health care. Furthermore, spending by seniors in the Western provinces increased faster during the 1990s than in the other provinces. This is best illustrated by the dramatic increase in out-of-pocket health spending experienced by Alberta's seniors. Between 1986 and 1996, Alberta jumped from the lowest out-of-pocket health spender to the highest with an increase in health spending of $787 in a ten-year period. In other words, seniors in Alberta spent almost 2.5 times more on health expenses in 1996 than they did in 1986.

Ontario seniors also experienced significant increases between 1992 and 1996, but they still paid less in 1996 compared to 1969, unlike the Western provinces whose seniors spent more out-of-pocket on health care in 1996 than they did before the introduction of Medicare.

Clearly there exists significant variation between regions in out-of-pocket health spending by seniors. The disparity between provincial out-of-pocket health spending has increased throughout the 1990s and is now similar to the level of variation that existed in 1969. However, the roles for the eastern and western provinces reversed, with Quebec, the Atlantic provinces, and Ontario low out-of-pocket spenders and the western provinces high out-of-pocket spenders.

Health Spending by Household Size

In regards to the number of household members, Table 6.10 shows the general trend of decreasing out-of-pocket health care expenses between 1969 and 1978, with slight fluctuations during the 1970s and 1980s, and increases during the 1990s. Compared to 1969, all household sizes, except one-member households, spent less on health care in 1996. One-person households spent on average $57 more on health care in 1996 than in 1969.

Table 6.10 *Out-of-pocket health care spending by household size and year.*

Members	1969	1978	1982	1986	1992	1996
1	$551.16	$440.50	$488.81	$487.71	$541.43	$608.49
2	1,065.86	822.49	848.50	828.85	907.08	1,007.91
3	1,244.27	950.94	968.91	981.00	955.71	994.44
4	1,349.10	1,121.47	1,101.75	1,061.81	1,092.82	1,160.10
5	1,402.78	1,220.27	1,221.61	1,197.18	1,204.22	1,334.85
6+	1,407.27	1,259.77	1,343.66	1,302.50	1,277.60	1,348.60

While larger households spent more on health care, per person spending actually decreased as the number of household members increased (see Table 6.11). The greatest difference in per person spending occurs between households with two members and households with three members. The difference in per person household spending between two-member and three-member households increased from a low of $87 in 1986 to $135 in 1992 and $172 in 1996. Furthermore, between 1992 and 1996, out-of-pocket health spending increased the most for households with only one or two members.

Table 6.11 *Per person health care spending by size of household and year.*

Members	1969	1978	1982	1986	1992	1996
1	$551.16	$440.50	$488.81	$487.71	$541.43	$608.49
2	532.93	411.25	424.25	414.43	453.54	503.96
3	414.76	316.98	322.97	327.00	318.57	331.48
4	337.28	280.37	275.44	265.45	273.21	290.03
5	280.56	244.05	244.32	239.4	240.84	266.97
6+	234.54	209.96	223.94	217.08	212.93	224.77

While smaller sized households spend less on health care, per person health spending decreases as household size increases. As well, health spending for one or two member households has been increasing faster than has health spending in households with three or more members.

MULTIPLE REGRESSION RESULTS

In addition to the above descriptive statistics, a multiple regression model was analyzed. To review, the multiple regression model consists of the dependent variable, amount spent on health care, and the independent variables, year of survey, income, age of respondent, number of household members, region, and price. Both the amount spent on health care and income variables were transformed using the log function to correct for heteroskedasticity and normality.

The multiple R for the regression model is 0.51 (see Table 6.12). Thus, the absolute value of the correlation between amount spent on health care and the independent variables is 0.51. The R^2 of the model is 0.25520. This means that 26% of the variability in the dependent variable, amount spent on health care, is explained by the independent variables. The adjusted R^2 is 0.25506. Because there is only a 0.00014 difference between the R^2 and the adjusted R^2, there is little random fluctuation in the data. With such a large sample size this is to be expected. The F statistic indicates that the model is statistically significant.

Table 6.12 *Multiple regression analysis of independent variables.*

Variable	B	Beta	Significance
1969	.536285	.223157	.0000
1982	-.003185	-.001168	.7929
1992	.063897	.021890	.0035
1996	.069884	.024779	.0014
log income	.622676	.429291	.0000
age of respondent	.009705	.143218	.0000
# household members	.083441	.121349	.0000
Atlantic region	-.210149	-.085446	.0000
B.C.	.105110	.032915	.0000
Prairie region	.023334	.009877	.0254
Quebec	-.065467	-.025177	.0000
price	-.578136	-.027445	.0037
constant	-.277194	-	.1480

Looking at the partial coefficients to see the effect of each independent variable on the dependent variable while controlling for the other independent variables, we can see that the value of the intercept (constant) is -.277 (see Table 6.12). This means that even without accounting for the independent variables, Canadians spent log -.28 dollars on health care. The multiple regression equation is as follows:

log amount spent on health care = -.2772 (constant) + .5363 (in 1969) + -.0032 (in 1982) + .0639 (in 1992) + .0699 (in 1996) + .6227 * log of income + .0097 * age of respondent + .0834 * number of household members + -.2101 (if in Atlantic region) + .1051 (if in B.C.) + .0233 (if in Prairies) + -.0655 (if in Quebec) + -.5781 * price

By interpreting the above formula we can see that for one unit change in log income there is a .6227 increase in the log amount spent on health care. As well, for one unit change in the age of the respondent, the log of health spending increases by .0097. For one unit change in the number of household members there was a .0834 increase in the log

amount spent on health care. And for every unit change in price, there was a .5781 decrease in the log amount spent on health care.

Interpretation of the dummy variables' coefficients cannot be done in the same manner as the continuous variables. The coefficients of the dummy variables can only be discussed in relation to the reference category. Our reference category for the year of survey variable is 1986. Compared to 1986, health spending was .5363 higher in 1969, .0032 lower in 1982, .0639 higher in 1992, and .0699 higher in 1996. The dummy variable 1978 was thrown out of the equation for not meeting tolerance limits.

The reference category for the region variable is Ontario. Compared to Ontario residents, residents in the Atlantic region spent .2101 less on health care, B. C. residents spent .1051 more on health care, residents of the Prairies spent .0233 more on health care, and Quebec residents spent .0655 less on health care.

In order to determine the relative importance of each variable, it is necessary to use the standardized coefficient values (beta weights). Caution still needs to be used when interpreting the relative importance of the values of the beta coefficients since the value of one beta coefficient depends on the other independent variables in the multiple regression model. In regards to the dummy variables, compared to respondents in the 1986 survey, respondents in the survey years 1969, 1992, and 1996 spent more on health care, while respondents in the 1982 survey spent less on health care. The 1969, 1992, and 1996 dummy variables are all statistically significant at the 0.01 level. However, the 1982 dummy variable is not statistically significant. This is likely due to the similar amount spent out-of-pocket on health care in the two years (1982 and 1986).

Residents of the Atlantic provinces and Quebec spent less on health care than did residents of Ontario, while residents of the prairie provinces and B.C. spent more on health care than did Ontario residents. All of the region dummy variables are statistically significant at the 0.03 level.

In regards to the continuous variables, log of income is the most important variable in determining the amount a household spent out-of-pocket on health care. This is followed by the respondent's age, the number of household members, and price. All of the independent variables measured on a ratio scale are statistically significant at the 0.01 level.

CHAPTER 7

DISCUSSION

This chapter presents the findings to the hypotheses postulated in Chapter 4. The findings are then discussed in relation to the literature on privatization and political economy. Data quality and limitations are also discussed.

More out-of-pocket health spending in the 1990s.

Data on out-of-pocket health care spending presents some interesting findings. First, the introduction of Medicare did reduce out-of-pocket health spending by about $250 between 1969 and 1978. However, Canadians were still spending an average of $900 a year out-of-pocket on health expenses. Health spending decreased until 1986 when out-of-pocket health spending reached its lowest point. The 1986 survey was also the first FAMEX survey conducted after the federal government introduced the Canada Health Act. Since 1986 health care spending continued to increase. The pattern in out-of-pocket health spending raises interesting points around the level of decommodification that Medicare brought about, as well as the increased importance placed on the individual to assume responsibility for their health care needs.

As discussed earlier, Esping-Andersen's concept of decommodification refers to the extent to which citizens receive goods and services as a right of citizenship, instead of having to either purchase health insurance, for example, in the marketplace or rely on their employers to provide health insurance as a fringe benefit (Esping-Andersen, 1998:

135-137). Health care in Sweden is highly decommodified in that citizens spend very little out-of-pocket on health care goods and services, the majority of which is provided by the state as a right of citizenship. The majority of American citizens, on the other hand, rely extensively on the marketplace for their health care needs. They must buy health insurance, buy health care goods and services out-of-pocket, and/or rely on their employers for health insurance. In 1990, Swedish citizens spent 4.4% of household expenditure on private health care, daycare, pensions, and education, compared to 29.2% spent by Americans. When private spending and taxes are taken into account, Swedish citizens spend 41.2% of household expenditures on the above services, compared to 39.6% spent by Americans (Esping-Andersen, 2000: 8). Thus, the difference spent by citizens in the two countries is not that great. The main difference is that in Sweden the state provides the majority of services which ensures greater protection to all citizens, rather than to just those who can afford it.

Under Medicare, Canadian citizens receive free access to physicians and hospitals as a right of citizenship. All other goods and services, other health practitioners and prescription drugs, for example, are either purchased by the individual or covered by private or public insurance. The data from the FAMEX survey points out that out-of-pocket health spending is extensive and is increasing. It is important to note, however, that Canadians still pay less out-of-pocket than do American citizens. Esping-Andersen (2000) points out that on average households in the U.S. spend 5-6% of their income on health insurance alone (p. 8). The current study found that in 1996 Canadians spent 2.6% of household income out-of-pocket on *all* health care expenses.

Navarro (1976) points out that one of the tendencies of capital is the ever increasing drive for profits. This search for profits eventually invades all aspects of social life, including social services such as health and education (p. 450). Thus, goods and services provided by the state eventually become the domain of the private sphere. Waitzkin (2000) points out that in a capitalist economy, protecting and reinforcing the role of the private sphere is actually a function of the state (p. 46). As can be seen from the data presented in the previous chapter, Medicare certainly ensures a continuing role for the private sector in the delivery of health care to Canadians. In fact, initiatives such as private hospitals in all provinces and overnight private hospitals in Alberta, combined with the effects of passive privatization are encouraging an even greater role for private insurance in the delivery of health care.

The province of Alberta explicitly states its commitment to expanding the role of the private sector in the delivery of health care in the 12 provincial principles underlying the Alberta health care system. Principle seven is to ensure a strong role for the private sector in the health care system, principle eight states that consumers have the right to purchase health care goods and services, and principle nine is to expand the opportunities for the private sector to deliver health care goods and services (Plain, 2000: 43). Clearly, some governments are anxious to shift health care from a collective responsibility to the responsibility of the private sector and individuals.

Navarro (1976) argues that the form medicine takes is determined by the capitalist system and the capitalist class (p. 440). Under the mantra of neo-liberalism, governments have cut social spending, including health spending, saying that they have no choice if Canada is to remain competitive in a global marketplace. At the same time, however,

medicine is relying more and more on high-tech interventions to treat disease and disability. With less money going to health care, and with health care costs increasing, many Canadians are worried that their health care system will not be able to meet their health care needs. The public's fear, in turn, is used to support further privatization (Armstrong et al, 2000: 2) and to justify shifting the responsibility of health to the individual.

Waitzkin (2000) argues that problems in health and health care should not be viewed as independent from problems in the broader social structure (p. 7). Thus, he argues that the way we view disease and treatment reflects the broader values in society. Documents such as the *New Perspective on Health* which place blame for ill health on the individual for their lifestyle choices, and the medical model's over-reliance on high-tech interventions reinforce the view that poor health and its cure are the responsibility of the individual. He argues that the technological complexity of health care serves to depoliticize health, while other simpler methods of health care such as stress reduction, clean air and water, and safe working environments may require a direct political appraisal of the roots of health and disease (Waitzkin, 2000: 29). Despite evidence which demonstrates that increased life expectancy and better health were the result of better working and living conditions and not medical interventions, the reliance on scientific medical interventions continues (McKinlay & McKinlay, 1994: 10).

While high-tech medical interventions do little to prevent disease, they increase health care costs dramatically. The premier of Ontario, Mike Harris, said in a speech that the escalation of medical expenses raises the question as to the extent to which individuals will be required to cover their own medical expenses (Armstrong et al., 2000:

11). Clearly, based on the data presented here and the goals of some elected officials, access to health care is being based more on ability to pay, rather than as a right of citizenship. Health care has become so individualized that the cause of poor health is the fault of the individual, the cure for poor health comes about from individualized treatment, which increasingly have to be paid for by the individual.

The private sector has always been involved in the delivery of health care in Canada. After the introduction of Medicare, citizens were responsible for fewer health care costs and this amount continued to decrease until the mid-1980s. Since the 1990s, however, citizens have had to assume greater responsibility for their health care needs. One of the founding principles of Medicare, universality, was concerned with ensuring that citizens in different provinces had access to similar levels of care. The next section discusses provincial differences in out-of-pocket health care spending.

Western provinces spend the most out-of-pocket on health care.

After the introduction of Medicare, out-of-pocket health spending decreased in all provinces, and brought provincial out-of-pocket health spending more in line across the country. Ontario was an exception. Ontario had the highest out-of-pocket health spending from 1969 to 1982, and did not come in line with other provinces until after the Canada Health Act was passed in 1984. Since that time, Ontario, Quebec, and the Atlantic provinces have all been relatively low out-of-pocket health care spenders, while the prairie provinces and British Columbia have been high out-of-pocket health care spenders.

Most striking about this finding is that there is not a clear divide between have and have-not provinces. That is, high out-of-pocket health spenders are found in both have provinces such as British Columbia and Alberta, as well as have-not provinces such as Manitoba and Saskatchewan. Furthermore, some have provinces such as Ontario and Quebec are low out-of-pocket health spenders, while the Atlantic provinces, a have-not region, are also low spenders. There is also no clear pattern in regards to provinces' per capita publicly financed health care spending. For example, in 1996, Alberta was the second lowest health spender on a per capita basis, spending less than have-not provinces such as Manitoba and Saskatchewan (Nova Scotia was the lowest per capita health spender). B.C., another have province, had the highest per capita health spending in 1996 (CIHI, 2000). Thus, it cannot be argued that a lack of federal transfer money is solely to blame for increasing out-of-pocket health care expenses. As Navarro (1998) points out, states want to blame economic conditions for reduced social spending, but the blame must lie with the politicians and their political decisions. States are not powerless, even in a globalized economy. According to governments, global competition and the movement of capital are to be blamed for the "necessity" to cut social spending and reduce taxes. In reality, globalization is only an excuse for politicians to enact policies favourable to business (Navarro, 1998: 656). Furthermore, all governments are exposed to the same forces of globalization, but as this study found, different governments enact different policies, even within the same country.

Navarro (1998) argues that because policy decisions are political they respond to the class power relations in each state (p. 670). Just as Esping-Andersen argued that national differences in public policy are due to different levels of working class struggle,

it could be that differences in provincial public policy are the result of working class struggle at the provincial level. Indeed, Quebec has been at the forefront of decommodifying social programs such as providing prescription drugs to its citizens, and five dollar a day daycare programs for all citizens. Quebec also has the highest unionization rate in Canada, with 36% of employees unionized (Macredie & Pilon, 2001: 5). In comparison, Alberta has experienced dramatic increases in out-of-pocket health care spending between 1986 and 1996 and is at the forefront of privatizing health care. Alberta has the lowest unionization rate in Canada, with only 21% of employees unionized (Macredie & Pilon, 2001: 5).

Armstrong et al. (2000) point out that what is required to fix problems with the health care system is political will, something which has been lacking from the federal government. Many other health care analysts also believe that the federal government is to blame for the problems facing health care (Evans et al., 2000; Fuller, 1998; Plain, 2000). Critics of the federal government's health care policy come from across the political spectrum. Regardless of the ruling provincial party, there is one thing all provinces agree on: the need for more money from the federal government for health care.

Indeed, not only has the federal government reduced health care funding, reduced their control over health care money, and failed to penalize provinces in violation of the Canada Health Act, they have also given approval to health care policies which violate the principles of the CHA. Private, overnight hospitals would not have been approved by the Alberta government if the federal government had not given its approval to allow doctors to practice in both the private and public health care systems (Plain, 2000: 21).

If Ottawa had not approved this change to the CHA, Alberta would have had each dollar collected by these overnight private hospitals taken off of their CHST payment. Armstrong et al. (2000) write,

> Until the 1990s, Health Canada took the lead role in setting and enforcing national standards, and ensuring that the provinces were upholding the criteria of the Canada Health Act...Health Canada is now in danger of being reduced to a regulatory agency with an increasingly narrow range of responsibilities in the area of public health. (p. 27-28)

This reduced role of the federal government has had the effect of increasing disparities between provinces in terms of the amount citizens are expected to pay out-of-pocket for health care. Province of residence clearly affects how much a person spends out-of-pocket on health care, a violation of the universality principle of the CHA.

The most surprising finding is that citizens of Ontario spend the least out-of-pocket on health care compared to citizens in other provinces. This is despite the fact that in Ontario, privatization is "being pursued more aggressively than in any other province, except perhaps Alberta" (Armstrong et al., 2000: 10). There are two possible explanations for this finding. First, it could be that the FAMEX survey was not able to capture facets of privatization that are more prevalent in Ontario. For example, by 1998 64 Ontario hospitals were either closed or merged and the number of acute-care beds had been cut by 33% (Armstrong, et al., 2000: 12). Thus, the main change to health care in Ontario could have been the off-loading of caring work from public institutions to private households, which would not be accounted for in the FAMEX since care-work by family members is not paid for out-of-pocket. Second, Ontario could have made changes to the system without increasing costs to patients; real efficiencies could have been created in the system.

Lower-income Canadians spend less out-of-pocket on health care, but this represents a larger proportion of their income.

The most important variable used in this study in determining the amount spent on health care was income. As a household's income increases, out-of-pocket health care spending also increases. However, the amount low-income people spend on health care represents a higher proportion of their household income, compared to the amount spent by higher income households. The introduction of Medicare had the biggest impact on households in the lowest income quintile, however, increased out-of-pocket health spending has also had the greatest impact on lower income households. Out-of-pocket health spending as a percentage of income in the highest income quintile did not change during the 1980s and 1990s, and actually decreased since the 1970s.

Increases in privatization affected the lower income quintiles first, and then the upper income quintiles increased their health care spending. Increases in out-of-pocket spending were similar between all income quintiles, but again represented a larger proportion of income for lower income households. Increases in out-of-pocket health spending between 1986 and 1996 represented a 20% increase in out-of-pocket spending for the lowest income quintile, but only 7% for the highest income quintile. Furthermore, provinces with high out-of-pocket spending have greater disparities in health spending between lower and higher income households, in terms of the percentage of income spent on health care.

Given the greater health care needs of lower income households, their lower out-of-pocket health care spending raises questions concerning unmet need for health services and products. Unfortunately, the FAMEX survey is not linked to data on health

care needs and utilization, but inferences can be drawn from other research which did have access to this type of data. Millar (1999) found that even controlling for the number of chronic conditions, people with prescription drug insurance took more drugs than did people without prescription drug insurance. Furthermore, 38% of lower income people had prescription drug insurance, compared to 74% of people in the highest income group. Another group with low levels of prescription drug coverage are the self-employed, including farmers (Millar, 1999: 17-18). Millar concludes that people without health insurance may try to limit their prescription drug use, despite need, in order to save money (p. 19). Furthermore, some people may hoard outdated prescriptions, use another person's prescription drugs, or take more drugs than prescribed in hopes of reducing the duration of illness (Millar, 1999: 19).

Millar (1999) found a clear link between prescription drug use and labour market activity. Full-time, employed professionals had high rates of prescription drug coverage, compared to part-time, low-skilled, and unemployed workers. Esping-Andersen (2000) argues that linking health insurance to labour market activity is another form of individualizing health care costs. Instead of treating health care as a collective right, only workers have a reasonable expectation to be covered by health insurance. Changes to the labour market in recent decades have served to create greater inequalities between workers depending on their type of employment. The increase in service oriented jobs and part-time employment has left many workers without benefits, including extended health benefits. Thus, people who make the least amount of money are also the least likely to be covered by extended health insurance, increasing their out-of-pocket health care costs. This is a trend that is expected to continue (Esping-Andersen, 2000; Krahn &

Lowe, 1994; Millar, 1999). In addition, Esping-Andersen points out that even employer-sponsored health care has been declining in the United States as business is wanting workers to take an even greater responsibility for their health care needs (p. 5). Thus, even in the United States, there is a further push to individualize health care.

The amount of health care spent out-of-pocket seems especially perverse given the fact that expenses covered by private insurance are not counted in the FAMEX survey. Thus, people in the highest income quintile spent $1,500 in 1996 out-of-pocket on health care. This does not count health care goods and services that were purchased for them but that were covered by private insurance. Households in the lowest income quintile spent one-third of that amount, and many of these households do not have extended health insurance coverage. Despite the greater health needs of the poor, upper-income Canadians are much more able to spend a greater amount out-of-pocket on health care needs, as well as receive extended health insurance through employment. Furthermore, the lower amount of health care purchased out-of-pocket by lower income households consumes a greater proportion of household income.

Increased out-of-pocket health care spending has been defended by governments wanting to privatize health care as protecting the rights of "consumers". Indeed, principle eight of the 12 principles underlying health care delivery in Alberta states, "consumers have the right to voluntarily purchase health services outside assessed need." As discussed earlier, patients cannot be compared to consumers for a number of reasons, especially because patients do not have the expertise that allows them to make informed decisions about their health care. Plain (2000) points out that this principle does not make any sense. Why would someone want to buy health care that is not needed?

Waitzkin (2000) and Navarro (1976) point out that "freedom" and equality are two of the main contradictions of capitalism, one that is very evident when it comes to health and health care. Navarro points out that individual solutions to health care reinforce the bourgeois ideology underlying capitalism wherein one should be free to do whatever one wants. Yet, Waitzkin points out that freedom of choice is heavily class-linked. Freedom is greatest for those who have the most resources. Thus, for people in higher income groups, health care is something that can be easily purchased on the market, while poorer households depend on health care delivered by the state. The data presented in the previous chapter clearly supports these observations.

Not only are people paying more out-of-pocket for health care, in addition to what they pay for health care through their taxes, but individualizing health care expenses creates a situation in which some people are not able to access health care services. Plain (2000) points out that in Alberta where doctors can practice in the private and public spheres, preference is given to people who buy add-on treatments that the doctor receives payment for directly from the patient. In fact, Alberta Health has already received sworn complaints attesting to the fact that patients willing to buy more uninsured services receive quicker treatment in private cataract clinics (Plain, 2000: 49). As with quicker access to MRI scans, jumping to the front of the queue is a clear violation of the comprehensiveness and accessibility principles outlined in the CHA.

Despite inequalities in both health status and access to health care, lower income Canadians are still far better off in Canada than they would be in the U.S. In 1996 low income Canadians spent 4% out-of-pocket on health care, compared to low income Americans who spent 10-15% of household income on insurance premiums alone

(Esping-Andersen, 2000: 8-9). Furthermore, in the U.S., medical bills are the leading cause of personal bankruptcy (Armstrong et al., 2000: 19). Thus, the individualized approach to health care funding clearly creates inequalities between social classes. Even a publicly funded health care system has not completely eliminated social inequalities, and inequality has been increasing in recent years as private payment has become more prevalent in the financing of health care. Thus, it cannot be argued that welfare state provisions in advanced capitalist countries have made social class an outdated object of inquiry. This study clearly points out that social class is the most important demographic variable when determining out-of-pocket health care spending, even more so than age.

As people age they spend more on health care.

Looking at the data presented in the previous chapter, it is clear that the introduction of Medicare had the biggest impact upon Canadians aged 65 and over. Since then, however, out-of-pocket health care spending has increased the most for people over the age of 60. Furthermore, people over the age of 70 had their out-of-pocket health care spending double between 1978 and 1996. The introduction of the welfare state served to redistribute resources from the young to the old. After Medicare was introduced, people under the age of 30 had higher out-of-pocket spending than did those over the age of 65. Since 1982 this trend has reversed so that seniors aged 65 to 69 now pay more for health care than do people under the age of 30.[5] It appears then that the welfare state serves to re-distribute resources from the young to the old. As private

[5] People 70 years of age and over spent less on health care than people under the age of 30 until 1992.

spending assumed a greater role in health care financing, seniors have again had to take responsibility for paying for more of their health care needs.

Looking at seniors' out-of-pocket health care spending by province, it is apparent that seniors pay more out-of-pocket for health care in provinces where out-of-pocket spending for all groups is high. Again, provinces in the east have people who are low out-of-pocket health spenders, while the western provinces have people who are high out-of-pocket spenders. Alberta, however, had the most dramatic change since 1986. Between 1986 and 1996, seniors spent 2.48 times more on out-of-pocket health care spending. Alberta went from having seniors spend the least out-of-pocket to having the highest out-of-pocket health care spending. Thus, provinces with the highest out-of-pocket health care spending place the greatest burden on the people with the greatest need for health care and the least resources. The greatest impact of privatizing health care costs has been on the poor and the elderly.

High out-of-pocket health care spending is likely the result of two factors, labour market activity and health care status. As discussed earlier, in general the elderly have greater health care needs than do younger people (Manitoba Centre on Aging, 1996: 85). Furthermore, the elderly use more health care services than do the young (Deber, 2000: 35; Manitoba Centre on Aging, 1996). Thus, it is expected that as people age they will have a greater need for health insurance which would reduce their out-of-pocket health care spending. However, Millar (1999) found that after age 64, private prescription drug insurance fell from 65% to 51%. He argues that people under the age of 24 and over the age of 65 have low rates of private health insurance coverage due to their lower levels of labour market activity (Millar, 1999: 15). As well, according to the 1996-1997 National

Population Health Survey, only 45% of retired individuals had private health insurance (Millar, 1999: 16). Thus, health insurance based on employment status leaves a number of social groups without health insurance—the unemployed, the retired, stay-at-home parents, students, and the increasing number of people working in the secondary labour market. For these people out-of-pocket health care costs can be quite high.

Data from the United States points out that even means-tested programs do not meet the health needs of the elderly. Gross et al. (1999) found that almost 60% of the elderly with incomes below the poverty line did not receive Medicaid assistance in 1997. For these people, out-of-pocket health care spending represented almost half of their income (p. 2). Even recipients who did receive Medicaid spent 8% of their income on health care, double what Canadians in the lowest income quintile spend out-of-pocket. Thus, "freedom" to purchase health care goods and services on the market clearly means that some people are able to buy more health care than others. Unfortunately, the people who most need to purchase health care have the least resources to do so. Evidence from this study and data from the U.S. show that cuts to public spending are paid for by individuals with the greatest health needs and the least amount of resources to pay for health care on the market.

Households with fewer members spend less on health care, but per person spending is more than in larger households.

There is a clear relationship between household out-of-pocket health care spending and the number of household members. While larger households spend more out-of-pocket, this does not mean that each member of the household spends more on

health care than do members in smaller sized households. In fact, as household size increases, per person out-of-pocket health care spending decreases. A household with one member spends on average $608 on health care, compared to $225 per person in a household with six or more members.

One explanation for this could be economies of scale. That is, larger households buy health care in bulk, lowering the cost of supplies. Another explanation could be that seniors tend to live in one or two member households. Thus, smaller sized households tend to include seniors who have greater health care needs. Finally, living by oneself (or with an elderly spouse) would require home care services to be bought if there were not any family or friends who could come and help out in times of disability or disease. There is a quite steep drop in the amount spent out-of-pocket between two and three member households. Two member households spend $504 per person, compared to $331 per person spent by three member households. This is the largest difference in per person out-of-pocket health care spending for all household sizes. It appears as though the presence of a third person greatly reduces out-of-pocket health care spending. In fact, health spending by two person households is higher than it is for three person households.

A key component of health care reform in many provinces has been to shift care from expensive institutions to the community. Many types of surgery are now done on a day surgery basis and patients are being discharged after surgery more quickly. A report by the Saskatchewan Public Health Association concluded that cutbacks effectively "transferred costs to non-profit agencies, community groups, families and individuals" (cited in Howard & Willson, 1999: 14). Furthermore, the report found that the reduction in institutional care and increasing importance placed on the family to care for sick

relatives indirectly encouraged families to hire private nurses and homecare services, if they can afford it. For families that cannot afford to hire private caregivers, the responsibility for care work is overwhelmingly the responsibility of women (Howard & Willson, 1999: 21). This form of privatization is invisible.

DATA QUALITY AND LIMITATIONS

The first concern with data quality is in regards to respondents' recall of their expenses through the year. While individuals are encouraged to check their records, some respondents may have kept better records than others. People with pre-paid medical plans may keep better records in order to gain reimbursement from the insurance company. All families, however, are entitled to claim medical expenses on their income tax. Again, certain families such as the wealthy may keep better records due to better knowledge of the income tax rules. As well, the poor may not owe any income tax, and therefore do not bother to keep health records since they do not need any deductions to lower their taxes. It is assumed that big expenses and health care expenses that are made on a regular basis would be most easily remembered. Smaller, non-regular health care costs would be most easily forgotten.

Another concern about the data involves the ability to fully capture the range of health care expenses. For example, health expenses paid by a non-household member would not be captured by the survey. The FAMEX surveys also cannot capture other facets of health care privatization such as transferring care work to family members.

Since caring work for family members is generally unpaid work, this aspect of health care privatization would not be included in health care expenditures.

The grouping of provinces according to region also presents problems. While Ontario, Quebec, and British Columbia are considered "have" provinces and the Atlantic provinces are all considered "have not" provinces, the grouping of wealthy Alberta with Saskatchewan and Manitoba is unfortunate considering Alberta has been at the forefront of privatizing health care. The only way around this problem was to analyze the data according to region for all surveys and then provide a more specific analysis for the last three surveys which do not group Alberta with Saskatchewan and Manitoba. Results will have to be interpreted with caution.

As discussed earlier, the collapsing of the various health care categories in different survey years presents problems in regards to comparing health spending on various health care goods and services between years. For example, in the 1978 survey, health spending was collapsed into only four categories, as compared to the 15 categories in the 1996 survey. It is therefore not possible to compare specific types of health care spending between years.

Populations that were excluded from the survey also raise concerns. People who live in nursing homes were excluded from the survey. Nursing homes are not covered by Medicare and as such nursing home residents may have high out-of-pocket health expenses. Furthermore, the fact that they are living in a nursing home means that they likely have significant health care needs.

Another concern with the data is that it is impossible to separate the effects of higher health spending due to need versus spending due to changing tastes. For example,

glasses have become a fashion statement to some people who own many pairs at one time or change their frames frequently. Dentistry is another area where certain treatments have become much more popular in recent years. Orthodontics, for example, would not have been as popular in the 1960s and 1970s as it is today. While changing tastes have likely contributed somewhat to health care spending, this concern is likely more valid for higher income households and not for middle and lower income households.

A final concern about the data is that it is impossible to know whether a household is covered by an employer-sponsored health care plan. Many jobs, especially in the primary labour market, provide supplementary private health insurance for pharmaceuticals, dentists, optometrists, and other health care providers. Thus, out-of-pocket health care spending is actually underestimating the amount of non-insured health care used by these households. Again, this concern will be more applicable to higher income households. Data from the 1996/1997 National Population Health Survey found that prescription drug insurance coverage increased with income. Seventy-four percent of households in the highest income group had prescription drug insurance, compared to 38% of the lowest income group (Millar, 1999: 17).

Like all secondary survey data which was not collected with this study's purposes in mind, there are a number of limitations to the data in regards to its quality and comprehensiveness. However, it is questionable whether other data collection methods would be any more successful in resolving these problems, while at the same time providing national and historical data. Nevertheless, the limitations of the data must be recognized in order to give the most valid interpretation of the study's findings.

CHAPTER 8

IMPLICATIONS AND CONCLUSION

IMPLICATIONS

Besides providing data on the extent and distribution of out-of-pocket health care spending, this thesis has a number of implications. These implications concern health policy, the welfare state, and methodological issues.

There is currently widespread debate over the role of the federal government in health care. Some, such as the Canadian Alliance, argue for powers currently held by the federal government to be transferred to the provinces. Supporters of Medicare and other social programs, however, argue that this would create greater disparity between provinces, and lower the standards for health care set by the federal government. This study provides evidence that disparities in out-of-pocket health care spending between provinces was at its lowest in 1986, two years after the federal government re-committed itself to Medicare with the Canada Health Act. After the 1980s, however, as the federal government started to withdraw from both the funding and control over health care, disparities between provinces started to increase. Thus, in order for disparities in out-of-pocket health care spending to be reduced, the federal government must once again take the lead in ensuring health care is adequately funded and to uphold the principles outlined in the CHA.

The second implication concerns support for Medicare. If the middle and upper classes in Canada are expected to pay for health care through taxes and out-of-pocket

spending, support for state-provided health care which provides for only the most basic of health care needs would be expected to decrease. Social democratic welfare states recognize this problem. To solve this problem, countries such as Sweden effectively eliminated the need for the provision of goods on the market by providing social programs which meet the needs of the middle and upper classes (Esping-Andersen, 1998: 142). All citizens, therefore, feel as though they benefit from the system and have much less reason to resent paying for programs which meet all, rather than some, of their needs. All Canadians have experienced increases in out-of-pocket health care spending. Higher income Canadians have not experienced large increases in the percentage of income they spend on health care, but lower and middle income households have been spending a higher proportion of their income on health. If the same trend in out-of-pocket health spending continues, then it is expected that higher income households will also start to spend a greater proportion of their income on health care. Thus, higher income earners will start to question a system in which they pay for health care out-of-pocket and through taxes, without experiencing access to quicker and better health services. Armstrong et al. (2000) point out that cuts to health spending erode the quality of the Medicare system and increase private spending, which serve to reduce support for Medicare. Thus, public health spending must be increased and then maintained, and private spending must be reduced if Medicare is to be supported by the public (Rachlis et al., 2001).

Another implication concerns the welfare state in Canada. A number of writers (Burke & Stevenson, 1998; Navarro, 1998) point out that Medicare is just one aspect of the welfare state and as such is not exempt from the same forces which question public

provision of services. This thesis found that the welfare state does much to reduce inequality in terms of the amount spent out-of-pocket on health care. The introduction of Medicare lowered out-of-pocket health care spending by the people who need health care the most—the poor and the elderly. However, as private financing of health care became more important, these groups were again forced to spend more out-of-pocket on health care. It is also important to note that Medicare did not completely eliminate inequalities in health care spending. Indeed, as Badgley (1991) points out, higher income Canadians have always been able to buy more services that poor Canadians have been unable to afford, even though the poor's health care needs are greater. Navarro (1976) would argue that this is because working class mobilization did not bring about further changes to Medicare, for instance public financing for prescription drugs, dental care, and home care. It appears then that lack of class conflict resulted in the failure of the government to include health services that were not included in the Medical Care Act and the Hospital Insurance and Diagnostic Act, services which were supposed to be included after the introduction of these programs. Furthermore, in the absence of strong working-class opposition, governments have reduced funding to health care, putting in jeopardy health services that were covered by the HIDS Act. As Navarro points out, what the working class won must be continually fought for if these gains are to be protected.

A final implication of this study is in regards to the use of quantitative, secondary data analysis. As outlined earlier, there are a number of problems associated with using a database that was not designed specifically for the purposes of this study. One such problem surrounds the complexity of this topic. This thesis demonstrates that health spending is determined by a variety of factors, including health status, health care

utilization, and labour market activity, in addition to the variables examined in this study. A more complete understanding of health spending would be gained if FAMEX surveys were somehow linked to other Statistics Canada surveys, such as the National Population Health Survey (NPHS) and the Survey of Labour and Income Dynamics (SLID). With this data available to supplement data collected by the FAMEX, it would be possible to explore issues such as unmet health needs and access to health care, as well as provide a more accurate picture of private health spending by including health care paid for by private insurance companies and work sponsored private insurance.

CONCLUSION

Canada's Medicare program has never covered all health care costs. However, provincial governments have been de-listing services from provincial insurance plans at the same time as the use and cost of never insured services have increased. Aggregate data demonstrate that private health care spending has been increasing at the same time that the public share has been decreasing. Private expenditures can be broken down into third party payment by insurance companies and out-of-pocket payment by individuals. However, as other researchers have noted, there is little evidence to describe the extent and distribution of transferring health care costs to individuals from the state (CIHR, 1999; Uplekar, 2000).

Data support the hypothesis that out-of-pocket health care spending has been increasing since the 1980s. This thesis demonstrates that one's place in the social structure influences how much they spend on health care. Indeed, income, age, province

of residence, and household size are all significant factors in determining a household's out-of-pocket health care spending. Furthermore, this increase in private spending has exacerbated inequalities in terms of household out-of-pocket health spending. People who need health care the most are least able to afford increases in health spending. And what they do spend on health care represents a greater burden on their household income than does the much larger amount spent by upper income earners.

As McKinlay (1985) and Burke and Stevenson (1998) suggest, the analysis of health care policy and out-of-pocket health spending needs to be placed in a political economy perspective. This approach recognizes the vulnerabilities of Medicare in terms of economic and political forces which seek to alter the role of the welfare state in advanced capitalist countries. Indeed, Coburn (1999) points out that the development of Medicare was successful precisely because the interests of capital and labour combined at a certain stage of capitalism which needed to legitimate the role of the state. Similarly, the globalization of capital has placed new demands on the state. Business interests are now equated with national interests. Business and provincial governments point out that Medicare is too expensive and inefficient; that Canadians would receive better care if private provision and payment were allowed a greater role in health care delivery. Clearly, this is in the best interests of business and governments wishing to lower taxes. The goal of this study was to see who pays for their savings.

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APPENDIX

DEFINITIONS OF HEALTH EXPENDITURE CATEGORIES

Health Care:
All direct costs to households and insurance premiums

Direct Costs to Household:
All direct costs to households excluding insurance premiums

Health Care Supplies:
Includes expenditures on supplies such as bandages and syringes

Medicinal and Pharmaceutical Products:
Includes expenditures on prescribed medicines and non-prescribed pharmaceuticals such as cough syrup

Eye Care Goods and Services:
Includes expenditures on prescription contact lenses, prescription eyeglasses, and other eye care goods

Dental Care:
Includes expenditures on orthodontic and periodontic procedures, prescription and fitting of dentures, and other dental services such as fillings and cleanings

Hospital and Other Health Care Services:
Includes expenditures on hospital care, other health care services such as ambulances, health care practitioners such as chiropractors and therapists, and health programs such as weight control and smoking cessation programs

Other Health Care Goods:
Includes expenditures on health care goods not covered by the other categories

Health Insurance Premiums:
Includes expenditures on public hospital and medical plans and private plans (includes supplementary coverage, dental and drug insurance, and accident and disability insurance)

Physician's Care:
Payments made to doctors.