

IV

Health Care and Economic Security

4.1 Introduction

Previous chapters have laid out the sources of retirement income security for Canadians and have introduced related public policy issues. The remaining chapters examine in detail public policy issues facing these retirement income security schemes. They also look in detail at the impact that population aging will have with respect to the continued viability of these various systems.

As shown in this chapter, population aging will have its major impact on two government-sponsored economic security systems, retirement income security and health care. Analysis has shown that the impact on other support systems (education, for example) is expected to be smaller. Both retirement income security and health care provide economic security to Canadians: retirement income by providing a source of funds for retirement, and health care by removing a source of expense risk. As was reported in Chapter 2, it has been estimated that the income of elderly Canadians would have to be as much as one-third higher if they had to pay for the various services covered under public health insurance (National Council of Welfare 1984, p. 62).

On the other hand, if any segment of government spending rises faster than the growth in tax revenues, it will create competition among all programs for scarce government resources. Thus, if health care costs were to rise faster than government revenues, for example, they could threaten other security systems such as Old Age Security (OAS) and the Guaranteed Income Supplement (GIS).

This chapter reviews the evolution of the health care system in Canada and historic health care costs as a percentage of the Gross Domestic Product (GDP). It also shows how an aging population, of and by itself, will create cost-escalation pressures on the health care

system. This chapter does not look at any issues that could be called “micromanagement” of the Canadian health care system. Many writers have stated that the problem with the Canadian health care system stems from inefficiencies, inappropriate services, and poor management, not lack of funding.

For example, the National Forum on Health states that “without exception, all reviews have concluded that the health care system needs better management, not more money” (1997, vol. 2, sec. 2, p. 5). For readers interested in these issues, many references are available, including the National Council of Welfare (1990), Evans (1993), Blomqvist (1994), Rachlis and Kirshner (1994), Angus, Cloutier, and Algert (1995), Barer (1995), Deber and Williams (1995), Barer, Lomas, and Sanmartin (1996), and the National Forum on Health (1997). Issues concerning the efficiency and efficacy of the present health care system are not explored in this chapter.

4.2 The History of Health Care Delivery in Canada

In Canada the responsibility for health care falls primarily under provincial jurisdiction. Hence, it took time, and political ingenuity, for a national health care system to evolve, and there are still significant provincial variations in both benefits and financing.

The first federal intervention was the National Health Grants Programme of 1948, which was intended to overcome perceived shortages of health resources after the Depression and World War II. A universal coverage hospital insurance plan already existed in Saskatchewan (1946), followed by one in British Columbia (1949). These provincial schemes appeared to result in both

greater equity of access to services and better control of costs than the systems in other provinces, which were made up of industry prepayment plans combined with government subsidies to assist persons unable to pay.

In 1958 the federal government introduced the Hospital Insurance and Diagnostic Services Act whereby it would pay approximately 50% of the cost of provincial health care plans that qualified under defined criteria. By 1961 all provinces and territories had joined the national program, which focused on prepayment of hospital in-patient care and diagnostic services. This was followed by the Medical Care Act (1968), which added universal coverage of physician services. All provinces and territories joined the medical care arrangements by 1972.

Because of a concern that there was no incentive for the provinces to control costs, new funding arrangements were legislated in 1977 (Established Programmes Financing Act, or EPF). Instead of the federal government paying approximately 50% of the cost, payments from the federal government became composed of an increased transfer of tax revenues and special cash grants. As a result of this act, federal contributions, in general, would rise with GDP. This placed the responsibility for controlling health care costs, beyond the rise in GDP, solely on the provinces. Along with the EPF arrangement, the federal government granted conditional support for nursing home care, residential care for adults, health aspects of home care, and ambulatory health care services. The motivation for this federal intervention was not just the goal of establishing a national health care system:

The money was provided, not because the federal government was interested in creating national standards for extended health care programmes but to meet provincial criticisms that federal funding encouraged provinces to adopt high cost solutions to health and aging problems, specifically by utilizing hospitals rather than nursing homes. (M. Brown 1987, p. 31)

In the early 1980s the federal government became concerned that certain of the original basic standards, such as universal access, were being eroded. In particular, it objected to user fees being charged by hospitals and extra billing by some doctors, allowed by some provinces. Its answer was the Canada Health Act (1984), which imposed financial penalties on provinces that did not allow reasonable access to health services without financial or other barriers. The conditions for federal assistance, as established in the Canada Health Act, are the following:

1. *Public administration:* The program must be administered on a nonprofit basis by a public authority, appointed by and accountable to the provincial government.
2. *Comprehensiveness:* The program must cover all necessary hospital and medical services.
3. *Universality:* All eligible residents must be covered for insured health services.
4. *Portability:* Coverage must be portable from one province to another. Insured health services must be available to Canadians temporarily out of their own province.
5. *Accessibility:* Insured services must be provided on uniform terms and conditions for all residents. Reasonable access to insured services must not be precluded or impeded, either directly or indirectly, by charges or other mechanisms. Financial impediments, such as deductibles, for essential medical services are viewed as a breach of the criteria at the federal level, and the funding reduction can be equal to the value of the deductible.

By the late 1980s all provinces had passed legislation complying with the Canada Health Act.

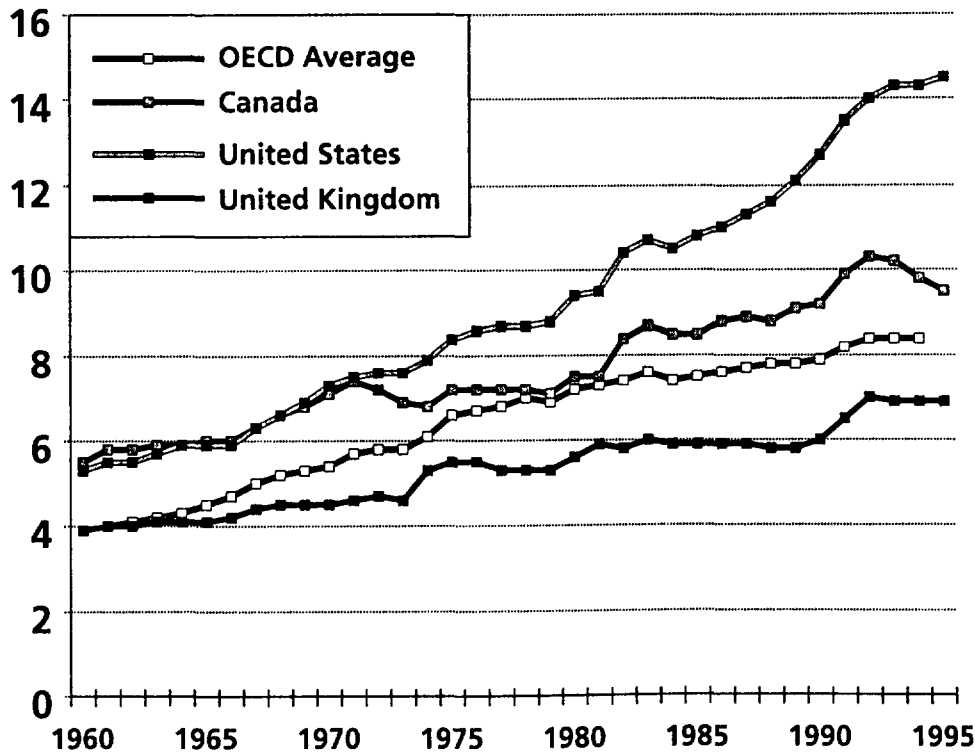
In the 1990s the federal government, in an effort to lower the federal deficit, made several cuts to its transfer payments that support provincial health care. Provinces responded by scaling down their health care programs, by closing some hospitals (and beds in others) and by shifting some costs to employer health care plans and to individuals. This was done in a manner that did not compromise federal funding under the Canada Health Act.

The immediate impact of these cutbacks can be seen in Figure 4.1. While total health expenditures exceeded 10% of GDP in 1992 and 1993, these expenditures have actually fallen since then and represented 9.5% of GDP in 1995 (National Forum on Health 1997, p. 12).

Each province and territory has its own method of paying its part of the costs. Two provinces—Alberta and British Columbia—require premium payments by participants as part of their funding. In Alberta, residents aged 65 and over (and their dependants) do not pay premiums. These two provinces subsidize low-income residents. Ontario, Quebec, and Manitoba use a payroll tax, payable by employers, to partly fund their health care schemes. All other provinces finance their plans solely through general tax revenues.

Variance in benefits exist. Prescription drug plans are found in all provinces and territories except Prince Edward Island. Dental care plans for the elderly exist in Alberta and the Yukon. Hearing aids are covered

FIGURE 4.1
HEALTH EXPENDITURES AS A PERCENTAGE
OF GDP, CANADA, U.S., U.K., AND OECD
1960-95



Source: National Forum on Health, Synthesis Report 1997, p. 12.

benefits in British Columbia, Saskatchewan, and Alberta. In the area of long-term care, several provinces have insured nursing home care. For a discussion of other provincial variations, see Hall (1996, pp. 251-53).

The introduction of government funding caused health care expenditures to rise:

Not surprisingly, the introduction of comprehensive public insurance in Canada between 1956 and 1971 increased expenditures on hospital and medical services significantly. Measured in terms of 1971 dollars per capita, expenditures increased from \$1,141 in 1956 to \$4,403 in 1971, representing an average growth rate of 9.42 percent. While over half of this growth was financed rather painlessly through growth in real GNP, it nevertheless also represented a trend toward increasing tax burdens for Canadians. (M. Brown 1987, p. 32)

However, since 1971, with government as the primary payor, health spending in Canada has not risen as rapidly as in the United States and has moved more in line

with other Organization for Economic Cooperation and Development (OECD) countries, as illustrated in Figure 4.1.

4.3 Shifting Demographics and Its Impact on Health Care

That the Canadian population is aging, and at an increasingly rapid pace, was documented in Chapter 2. As was explained there, Canada now has a relatively young population, especially among developed nations, not even ranking among the oldest 20 nations of the world. However, over the next 30 years, as the postwar baby boom ages, Canada will see a rapid increase in the number of people aged 65 and over. In fact, it will experience the fastest rate of increase among the developed nations (see Table 2.3). The impact of these shifting demographics on the Canadian health care system is reviewed in the next two sections, beginning with the

impact on the historical supply of health care, and then the impact on future demand for health care.

4.3.1 Impact on the Supply of Health Care Resources

As outlined in Section 4.2, the present Canadian health care system was designed between 1958 and 1972. One of the critical building blocks of that evolution was the report of Justice Hall in 1964 (Canada 1965). One must remember that Hall's analysis was done at the end of what was a long and continuous period of high fertility. Many of Hall's conclusions were based on the assumption that high birth rates would continue into the future. As a result, Hall foresaw a shortage of health care resources in Canada. Based on then-existing population forecasts and an assumption that there was some "unmet need" in health care that public health insurance would reveal, he set a goal of a population-to-physician ratio of 857:1 and concluded that Canada needed more medical schools and more doctors for the future (Evans 1984).

Soon after the government put Hall's plans into motion, Canada experienced the end of the baby boom and the beginning of the baby bust. The result of the push for more health resources was an average annual growth rate in physician supply between 1968 and 1975 that exceeded population growth by 3.4% per annum (Lomas and Barer 1986, p. 251) and a resultant ratio of population to physicians of 452:1 in 1990 (see BDO Dunwoody 1994). As Lomas and Barer state,

the physician supply was increased in anticipation of an increased demand that never occurred. . . . Thus, by the beginning of the 1970s it was clear that an already physician-dominated health care system had become over-burdened with them, with significant effects on total health care expenditures. An appropriate policy response to this situation was not, however, as obvious. (1986, p. 251)

Fulton (1993, p. 23) claims that Hall's projections would have provided health care to a population of 37 million Canadians in 1993, whereas by 1993 our population was only 27 million, a 37% difference.

According to the National Council of Welfare (1990, p. 34), there could be a surplus of 5,982 doctors in Canada by the year 2000, given rates of growth in the population and the profession. They estimate that with the control that doctors have over many of the health care costs, this could mean well over \$1 billion a year in terms of excess billings, tests, and procedures.

If these estimates are true, or even only close to reality, then the recent "cutbacks" in some provincial plans may

only be returning the system to the levels originally deemed appropriate. However, as the National Council of Welfare notes:

One of the unfortunate realities in the world of health is the wide gap between the opinions of the experts who study our health care system and the views of ordinary Canadians.

The experts say we have more doctors than we need. The general public believes we have too few. The experts think we have enough hospital beds. The public wants more. The experts have their doubts about some of the latest medical technology. The public seems completely uncritical and wants all it can get immediately.

More fundamentally, the experts believe that curative medicine is reaching its limits and that more substantial gains in health will come through preventing illness. The public still seems preoccupied with disease and clings to its faith in miracle cures. (1990, foreword)

But what of the future? Having misread the need for health care services once, is Canada in danger of missing the mark again because of the demands that an aging population might place on our health care system?

4.3.2 Impact on the Future Demand for Health Care

Could the rapid rate of increase in the Canadian elderly population mean a rapid rate of increase in the total cost of health care? If so, what impact might that have on other government-funded programs that will also be affected by this aging process?

The programs most affected by population aging are social security and health. As Denton and Spencer state, "The results . . . suggest that health care, and more especially social security, will absorb increasingly large shares of GDP. Reduced shares for education can be expected, but that would provide only a partial offset" (1995, p. 180).

But as Barer et al. point out, it is necessary to determine whether this demographic pressure should be categorized as an "avalanche" or a "glacier." Thus, one needs to determine whether Canada is approaching a crisis or an inexorable but manageable pressure on costs.

Given the statistics on the aging of the population as outlined in Chapter 2 (for example, a 141% increase in the number of elderly in Canada by 2025), it is not surprising that health care costs are expected to rise, especially since the old/old proportion of the population is growing faster than the young/old, and it is the old/old who make the largest demand on the health care system (Barer, Evans, and Hertzman 1995, p. 201).

Table 2.4 (taken from Denton, Feaver, and Spencer 1996, pp. 28–30) showed that the percentage of the pop-

ulation aged 65 and over will double in the next 40 years, and that the percentage of the population aged 85 and over will more than triple (see also Fellegi 1988; Murphy and Wolfson 1991). Denton and Spencer used these demographics, and quinquennial sex-specific cost data, in an economic model to determine what impact population aging will have on government expenditures in three areas: health care, education, and social security. Health care here includes hospital, medical, preventive, and other health care costs, but only those paid for by the government. Similarly, education costs are only those paid by the government. Social security costs include the Canada/Quebec Pension Plans (C/QPP) and OAS (including the GIS and the Spouse's Allowance [SA]). Denton and Spencer (1995, p. 178) present the impact of population aging on these government expenditures when per capita expenditures for each age-sex group are held constant (1986 = 100.0) shown in Table 4.1.

TABLE 4.1
IMPLIED EXPENDITURES (1986 = 100.0)
HEALTH, EDUCATION AND SOCIAL SECURITY
1991–2041

Year	Health	Education	Social Security	Total
1991	110.1	99.6	116.9	105.7
2001	131.3	105.4	146.6	117.2
2011	150.4	107.9	180.3	127.1
2021	175.7	107.9	246.6	138.6
2031	201.1	110.0	314.0	149.4
2041	214.6	111.4	337.1	155.1
Growth Rate per Annum*	1.4%	0.2%	2.2%	0.8%

Source: Denton, and Spencer 1995, p. 178.

*Author's calculations.

Very similar projections were done by the OECD in the late 1980s. The OECD projected the rate of increase in public social expenditures between 1980 and 2040 (1980 was set equal to 100 in all countries) assuming constant real per capita expenditures by age within each program (see Table 4.2).

Denton and Spencer go on to model "expected" rates of economic growth (given a growing population) and then project the proportion of the future Gross National Product each of the three sectors can be expected to consume, assuming that productivity improvements will be equal across all sectors (see Table 4.3). Comparing Tables 4.1 and 4.3, one can see that, assuming growth in the economy, the impact of population aging among the three

TABLE 4.2
GROWTH OF PUBLIC SOCIAL EXPENDITURES
IN THE OECD (1980 = 100)
1980–2040

Country	Health	Social Security	Total*
Australia	240	288	207
Britain	121	130	110
Canada	218	304	187
France	119	172	128
Germany	90	126	97
Italy	108	134	107
Japan	146	229	140
Sweden	117	123	109
United States	178	215	165

Source: Walker 1990, p. 384.

* Includes all social expenditures (e.g., education, unemployment).

TABLE 4.3
PROJECTED GOVERNMENT COSTS RELATIVE
TO THE PRODUCTIVE CAPACITY
OF THE ECONOMY

Year	Health	Education	Social Security	Total
1991	6.2%	5.5%	4.6%	16.3%
2001	6.8	5.4	5.0	17.2
2011	7.4	5.1	5.6	18.1
2021	8.2	4.9	6.8	19.9
2031	8.9	4.8	8.0	21.7
2041	9.2	4.7	8.3	22.2
Ratio 2041/1991*	1.48	0.85†	1.80	1.36
Growth Rate per Annum*	0.8%	—	1.2%	0.6%

Source: Denton and Spencer 1995, pp. 180.

* Author's calculations.

† This may be optimistic. Since 1966 the ratio of young people to working-age people has dropped from 84% to 45%, but spending on education increased from 5.9% of GDP to 6.6% (Canadian Institute of Actuaries 1995, pp. 9–12). See also McDaniel (1997, p. 10).

sectors (health, education, and social security) does not change. What does change is the apparent affordability of the systems if some growth in the economy is assumed. For example, in Table 4.1, health care costs more than double (from 110.1 to 214.6). However, if the economy grows, then the share of a growing economy that is consumed by health care only grows 48% in the same period.

The analysis by Barer, Evans, and Hertzman (1995) is a useful addition to this discussion. First, their analysis points out that people aged 65 and over made up 11.7% of the population in 1991/92, and 4.75% of the

population were 75 and over. However, those 65 and over accounted for nearly 60% of hospital inpatient days, and 40% of all days were provided to those 75 and over (ibid., p. 201), as shown in Figures 4.2 and 4.3. They go on to say, however, that these statistics have more to do with increased utilization rates and increased levels of service provided than with the aging of the population.

In a paper completed for the OECD, Barer notes that this is not just a Canadian problem:

When one examines utilization and cost trends in individual countries, they show a common and unambiguous pattern. Care of the elderly absorbs a growing share of the health budget, but this is almost entirely a result of increases in the per capita rates of use (age-adjusted) by elderly people. Increases in their numbers, or their ages, have much smaller effects. Any claim that demographic forces have played a major role in the past escalation of health costs, in aggregate, is simply false. (1995, p. 22)

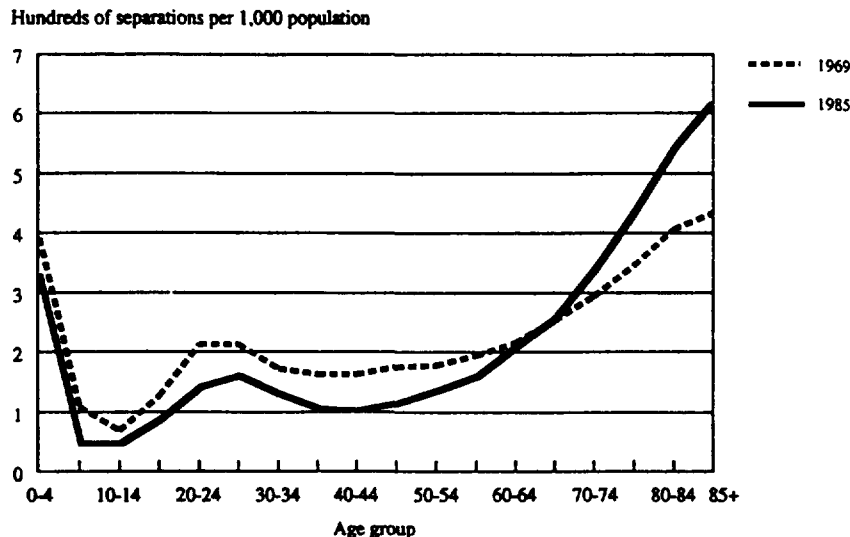
Barer, Evans, and Hertzman (1995) conclude that if servicing levels for the elderly had remained at 1961 rates, the 60% "use" statistic quoted above (use of inpatient days for those 65 and over) would only have been 40%. Finally, they argue that the health care system providers and players want us to believe that the cause is the aging

of the population, since that would mean that it is beyond their control. This is done to divert attention from the real question: Why are elderly people getting so much more health care? (ibid., p. 218).

Their arguments can be viewed as both good news and bad news. The good news is that the rising costs of health care in Canada to date have not been driven primarily by an aging population. Rather, increased costs have occurred because of increased servicing of the elderly. Thus, if increased servicing is controlled, the rate of increase of health care utilization by the elderly could be softened. The projections of Denton and Spencer (1995) assume constant cost for each age and sex group; that is, they take a health care cost vector and apply it as a constant to an aging Canadian demographic profile to project health costs. If service levels can be decreased, projected health care costs can also be decreased (see also Lomas and Barer 1986). If the utilization rates continue to increase as over the past decade, however, the cost projections of Denton and Spencer will prove optimistic (see also Fellegi 1988, p. 4.14, and Henripin 1994, p. 92).

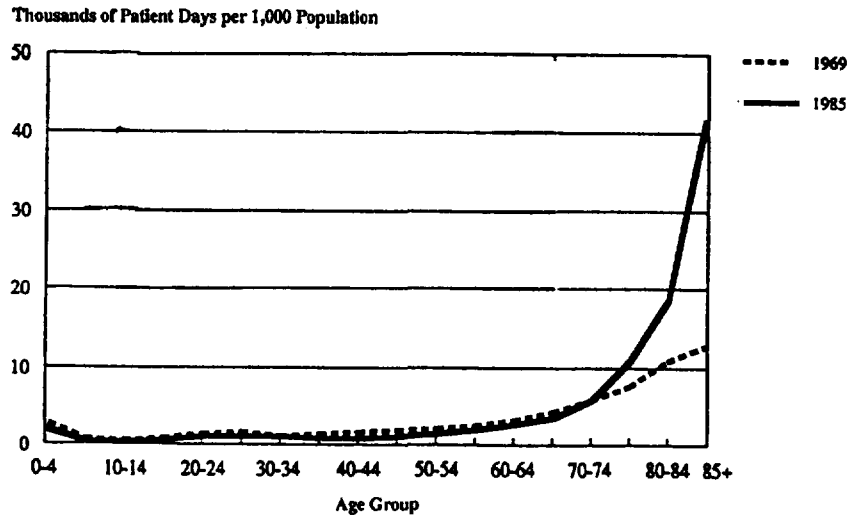
The Canadian Institute of Actuaries (1996a, pp. 6-7) showed that if health care costs rise 1% per annum faster than earnings (as they did during the 1980s), the portion of GDP spent on health care will rise by more than five

FIGURE 4.2
TOTAL HOSPITAL SEPARATIONS
1969 AND 1985



Source: Barrer, Evans, and Hertzman 1995, p. 204.

FIGURE 4.3
TOTAL DAYS OF SEPARATIONS
1969 AND 1985



Source: Barrer, Evans, and Hertzman 1995, p. 204.

percentage points to 15% by 2020, representing a 50% increase in the share of GDP taken by health care. To maintain the current level of health care costs as a percentage of GDP (around 9.5%) during the next 25 years, the rate of growth of health care costs in Canada must be kept 0.5–0.75% below the rate of growth in earnings.

Barer, Evans, and Hertzman (1995, p. 196) also answer the question as to whether the aging of the population and its impending impact on health care costs should be viewed as an avalanche or a glacier. Consistent with the findings of the Canadian Institute of Actuaries, they determine that the impact of population aging on total health care costs (in real terms, net of inflation), will be slow—about 1% per annum:

Projections suggest that future effects, while not inconsequential, will appear gradually, and will be within the capacity of historical rates of economic growth. Yet these consistent research findings, like a light house lost in the fog, have remained obscured by the persistent claims that the aging of the population will bankrupt our health care systems. (*ibid.*, p. 195)

These comments are consistent with the analysis by Denton and Spencer (1995), which showed that the increase in health care costs over the next 50 years, purely because of population aging (that is, service levels held constant), will average 1.4% per annum.

However, health care is not alone in creating upward pressure on government budgets. According to Denton

and Spencer’s projections, while the growth rate for health care is projected to be 1.4% per annum, the growth rate for social security is 2.2% per annum, or 57% higher. While social security is a much smaller government program than health care today (4.6% of GDP versus 6.2%), it will grow more rapidly and almost equal health care in terms of projected government expenditures by 2041 (9.2% for health care versus 8.3% for social security).

If government revenues are finite, then how will these growing demands for public funding be met? What will public policy priorities be?

4.4 The Future Competition between Health Care and Retirement Income Security for Scarce Government Resources

It would be easy to assume that health care and retirement income security are two completely independent programs. That might, however, be a mistake in predicting the direction of future public policy.

A broader perspective of what it means to be healthy, beyond being free of disease, was first identified by the World Health Organization (WHO) with its 1940 definition of health as “A state of complete physical, mental, and social well-being.” In its Ottawa Charter, the

WHO (1986) stated that health is a resource for everyday life, not the objective of living. It identified the prerequisites for health as peace, shelter, education, food, income, stable ecosystem, sustainable resources, social justice, and equity. These broader determinants of health (that is, beyond traditional medical care) were restated in the National Forum on Health (1997, p. 9), which went on to say that previous actions on these broader determinants of health (versus traditional health care) led to most of the improvement in the health status of Canadians over the last century.

In *Achieving Health for All: A Framework for Health Promotion* (Canada 1986), Jake Epp, Minister of National Health and Welfare, stated that the number one challenge for improved population health was the reduction of inequities in the health of low- versus high-income groups: "There is disturbing evidence which shows that despite Canada's superior health services system, people's health remains directly related to their economic status" (ibid., p. 4).

It is clear from the literature that there is a strong correlation between income and life expectancy. Studies that provide evidence of this are many and include Kitagawa and Hauser (1973), Rosen and Taubman (1979), Caldwell and Diamond (1979), Hadley and Osei (1982), Duleep (1986), Rogers (1992), Sorlie et al. (1992), Wilkinson (1992), Feinstein (1993), and Menchik (1993). Research using Canadian data includes Wilkins, Adams, and Branker (1990), Wolfson et al. (1990), and Adam (1995).

Recent research has found evidence of a widening gap in the life expectancy of high- and low-income persons (Duleep 1989; Pappas et al. 1993). The effect of income appears to be stronger than many other variables that can have an impact on life expectancy such as race and education level. Rogers (1992) and Menchik (1993) found that the effect of race on life expectancy was virtually eliminated when family income was accounted for. In addition, Menchik (1993) found no separate effect of education on life expectancy once income was taken into account.

Mustard and Frank in their chapter "The Determinants of Health" point out that "The most dramatic historical improvements in the health of the average individual have been associated with increased prosperity. The enhanced prosperity of regions leads to better living and working conditions" (1994, p. 8). The National Forum on Health states:

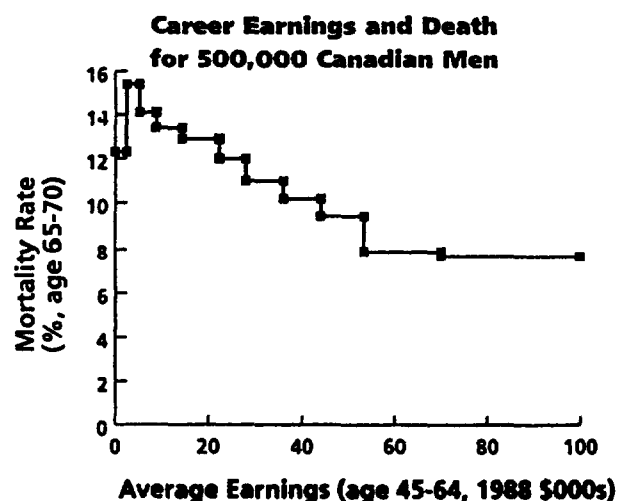
We have known for some time that the better off people are in terms of income, social status, social networks, sense of

control over their lives, self-esteem and education, the healthier they are likely to be. The wealthiest Canadians can expect to live four years longer than the poorest Canadians. . . . Higher incomes are related to better health not only because wealthier people can buy adequate food, clothing, shelter and other necessities, but also because wealthier people have more choices and control over decisions in their lives. This sense of being in control is intrinsic to good health. (1997, p. 15)

Two recent studies by Wolfson et al. (1990) and Adams (1995) provide additional evidence of the correlation between income and life expectancy using Canadian data. Figure 4.4 shows results obtained by Wolfson et al. using a longitudinal study of Canadian male mortality by preretirement income. As the authors note, "It is difficult to imagine a clearer and more unequivocal result. These data cover over half a million individuals, and for each individual data from almost a quarter century of their lives have been drawn. . . . It should be emphasized that these are not cross-sectional results" (ibid., p. 6).

The authors determine that an hypothesis that poor health causes low economic status cannot be used to explain the results. They show that these mortality differentials remain for the subset of workers whose (real) earnings were generally increasing year after year prior to retirement (clearly not a group for whom illness harmed employment). Wolfson et al.'s work correlates postretirement mortality with preretirement income. This does not

FIGURE 4.4
MORTALITY RATES
AGES 65-70 BY CAREER EARNINGS



Source: Wolfson et al. 1990, p. 5.

indicate, however, whether postretirement income correlates with postretirement life expectancy.

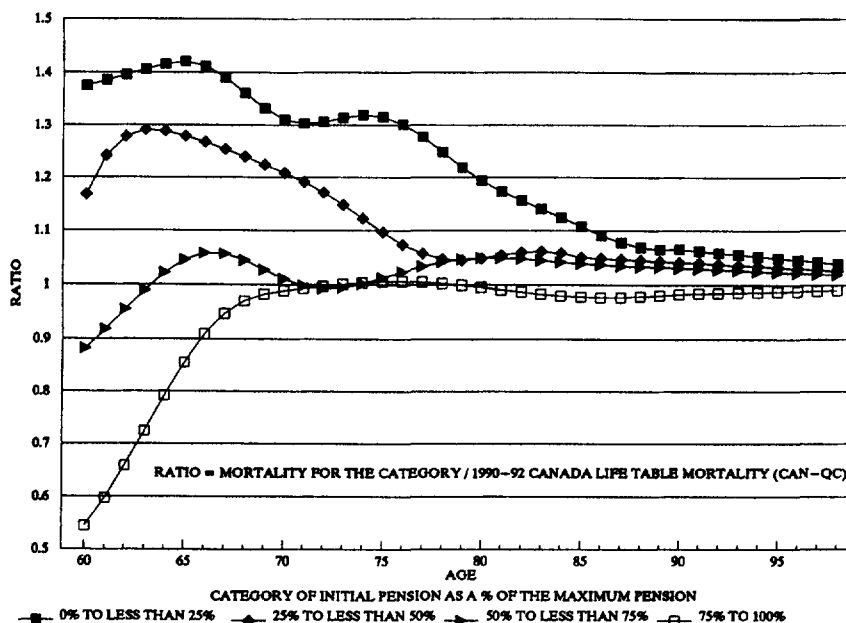
Studies have been done to determine the correlation between postretirement income and mortality (for example, Adam 1995). One recent study analyzed postretirement mortality rates as a function of the size of the CPP retirement benefit received. The CPP database is an excellent resource for this analysis. For every Canadian who has ever earned more than the Year's Basic Exemption (YBE), the CPP files contain a complete career earnings record for every year in which earnings exceeded the YBE. Also, because one's retirement income ceases upon death, and because there is a CPP death benefit, the exact date of death of all CPP participants is available. Using the CPP records, one is thus able to compare age at death with the level of the retirement income being paid to determine if there is evidence of increased longevity with larger social security income.

The findings of one such study are shown in Figures 4.5 and 4.6. Mortality is presented, by gender, for retirement income beneficiaries stratified into four groups: those receiving 0–25% of a full benefit, those receiving 25–50% of a full benefit, those receiving 50–75% of a full benefit, and those receiving 75–100% of a full benefit.

Clearly, those with higher incomes have lower mortality and, thus, enhanced life expectancies. There is more than a 50% differential in mortality rates (for example, 0.027 versus 0.018) at the younger male ages, decreasing fairly regularly to nothing at the oldest ages (also found by Wolfson et al. 1990). However, a 50% differential in mortality rates does not mean a 50% differential in life expectancy. Life expectancy depends on survival. For example, if the mortality rates at a certain age are 0.018 and 0.027, respectively, there is a 50% differential. However, the survival rates at that age are 0.982 and 0.973, respectively, or less than a 1% differential. Based on the CPP analysis, for men, there is a maximum 15% differential in life expectancy at age 60 for the highest incomes (75–100% of full benefits) versus the lowest incomes (0–25% of full benefits).

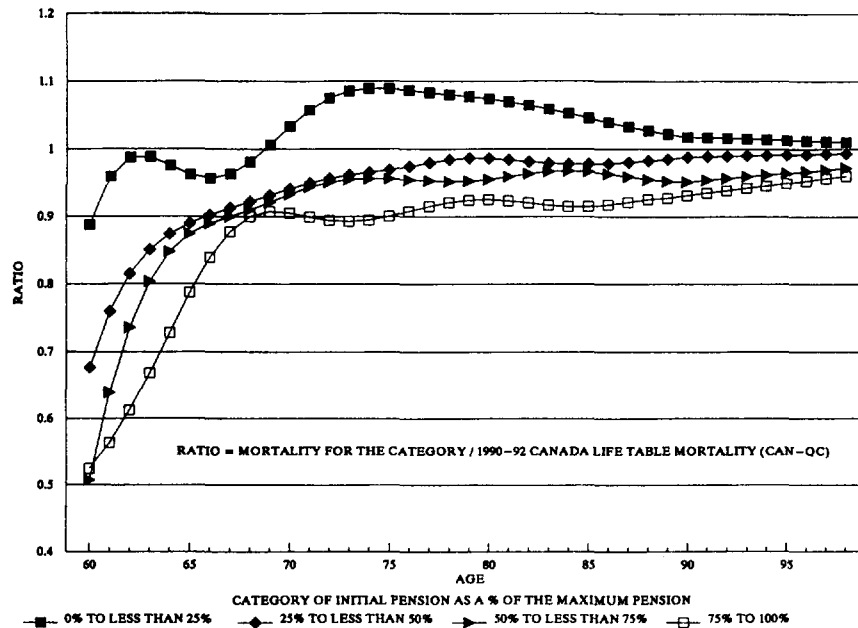
The differentials are much smaller for women. However, for the period of study (1988–94), CPP retirement income for women would be less indicative of family income, and women's true standard of living, than CPP retirement income for men since much of the indicated income for women was from survivors' benefits. Only when women achieve full lifetime earnings records will statistics like those in Figure 4.6 be indicative of the true standard of living of women. Having said that, other

FIGURE 4.5
CPP GRADUATED MALE MORTALITY
BY LEVEL OF RETIREMENT PENSION



Source: Private Memo from CPP Actuary.

FIGURE 4.6
CPP GRADUATED FEMALE MORTALITY
BY LEVEL OF RETIREMENT PENSION



Source: Private Memo from CPP Actuary.

studies have found smaller mortality differences by income levels for women than for men (Arber and Ginn 1993). However, there is clearly a strong correlation between actual postretirement income and mortality.

Mustard and Frank (1994, p. 8) also recognize the correlation between income disparity and the health status of a country (see also Frank 1995; Hertzman 1996; Canadian Public Health Association 1997): "In general there are correlations between a nation's GNP per capita income and health status measures such as life expectancy. But there are rather strong correlations between the degree to which national income is equitably distributed and health status" (Mustard and Frank 1994, p. 13). In that regard, Canada's retirement income security system represents an important sharing and redistribution of national income.

Mustard and Frank go on to identify the potential competition between paying for traditional health care and other programs that may affect population health:

It appears there could be a threshold for useful spending on the formal health care system. Beyond that threshold, overall population health may actually suffer not only because the care itself has marginal or dubious benefit, but also because less money is available to support health enhancing activities in the general social and economic policy spheres. (1994, p. 9)

Of course, one of these competing social policies is the provision of retirement income security. Thus, it may well be argued, in the competition for scarce real resources, that not only is the provision of retirement income security a positive public policy goal in and of itself, but it is also good for public health (that is, two benefits for the price of one).

What effect might this have on future public policy? There are several potential impacts that might be expected. It is conceivable that the federal government could use the connection between income/income redistribution and health to defend further erosion of its direct funding of traditional medical care. The federal government's argument would be that because it sponsors and pays for our retirement income security programs (for example, OAS/GIS), it is making its contribution toward good health in the process and should not be expected to contribute further by also paying for traditional health care. On the other hand, given the correlation between income/income redistribution and health, any future cut-backs of the federal retirement income security systems should be expected to have detrimental effects on population health.

This demonstrates a classic Canadian conflict between the federal and provincial governments. Health care is a

provincial matter, and the federal government has effectively capped its future expenditures and handed the total risk (that is, growth in costs) to the provinces. At the same time, however, the federal government believes it has the power to limit the ability of the provinces to control their health care costs by passing such legislation as the Canada Health Act (1984) and Bill C-91, which extends patent protection for pharmaceuticals and increases drug costs to the provinces.

Basic retirement income security benefits (that is, OAS/GIS) are almost totally a federal cost center (there are some provincial supplements, but they are small in the total picture). While the CPP is self-sufficient (it runs entirely from CPP contributions), it is the federal Ministry of Finance that is the driving force behind proposed CPP reform. Thus, the federal government unilaterally faces the political heat of sharper rates of increase in social security costs.

Thus, as the population ages, there is potential for competition between government-sponsored retirement income security and health care for scarce government resources. Politically, this will play itself out as a classical battle between the federal and provincial governments as to who pays what share of the total economic security bill in Canada.

4.5 Conclusion

This chapter has indicated the potential for competition between retirement income security and health care for scarce government resources. One should not assume that more health care means better health. In a paper comparing international health outcomes and the level of health care spending, Babazono and Hillman (1994) found that total health care spending is not related to any health outcome tested. Instead, they determined that nonhealth care resources may be as important to health outcomes and health care spending. Moreover, if available resources are limited, other investments may suffer if too much is spent on health care. An appropriate balance between health care spending and nonhealth care spending is crucial. Nevertheless, Canadians continue to behave as though medical care is the only determining factor of health status (National Forum on Health 1997,

vol. 2, sec. 3, p. 9). The Federal-Provincial-Territorial Advisory Committee stated that

There is mounting evidence that the contribution of medicine and health care is quite limited, and that spending more on health care will not result in further improvements in population health. On the other hand, there are strong and growing indications that other factors such as living and working conditions are crucially important for a healthy population. (1994, p. 3)

One of those "other factors" is the provision of retirement income security. As argued above, as the population ages, the ability of the government to maintain today's level of funding for both health care and retirement income security will be under significant pressure. Traditional health care and retirement income security eat from the same finite economic pie. Canadians have already seen the intention of the federal government to decrease retirement income benefits in its reform of the C/QPP (discussed in detail in Chapters 5 and 6). As Evans and Stoddart have stated,

The expansion of health care draws resources away from other uses that may also have health effects. In public budgets, for example, rising health care costs for the elderly draw funds that are then unavailable for increased pensions or other forms of social support; rising deficits may even lead to pension reductions. . . . A society that spends so much on health care that it cannot or will not spend adequately on other health-enhancing activities may actually be reducing the health of its population. (1994, p. 55)

Given the strong positive correlation between income levels and longevity, it can be argued that retirement income security is an important public health resource. In fact, it has been argued that increased spending on traditional health care may not result in enhanced public health. Thus, in any potential competition between retirement income security and traditional health care for scarce government resources, the provision of retirement income security might be given preference over traditional health care, since retirement income security might do as much to enhance population health as traditional health care while also providing retirement income security. It is anticipated that this will become an important public policy issue.