Public Health Spending in Canada:

Paying the Workers

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Part I:
Sustainability vs Cost Containment

- Sustainability
  - An equilibrium concept
    - Institutions
    - Tastes of taxpayers/voters
    - Tastes of healthcare workers

- Cost Containment
  - A directive from taxpayers/voters (or their agents)
    - Fewer services?
    - Lower prices/wages?
    - Improved Efficiency?
Service reductions

- This approach was used in 1990s
- Less tolerance for it now

- Assume new reductions are off the table for the moment

- This leaves:
Redistribution and/or Efficiency?

- Is primary goal redistribution?
  - “Pay doctors less so taxpayers can have more”
  - Given, e.g., Occupy movement could be “moral” rationale since many MDs are (literally) in the 1%

- Or, is primary goal efficiency?
  - Reform system to deliver services in more resource-efficient manner?
    - Hours/service, not $/hour

- Imply different approaches

- Or, both (not really independent – efficiency wages)
Much talk of relative degrees of market power on behalf of sellers and buyers (and users) of health services

My suggestion: Bilateral Monopoly
- Rubenstein (1982) bargaining model

What determines outcomes?
- Discount rate (Unions lower than governments?)
- Outside option/opportunity cost (Varies with context)
**Negotiate over prices/wages**

- Ontario doing this now with broad public sector including MDs
- Government in MUCH better bargaining position than in the past
  - Local and world excess supply of workers
  - Canadian dollar is high
  - Gov debt high

- Also, some quasi-unilateral cuts to institutions
  - E.g., last Ontario budget cut funding to medical schools for PG education on per-student basis
Physicians per 1000 Population in Selected OECD Countries
Figure 4: First year Post-MD trainees by MD Location

<table>
<thead>
<tr>
<th>Year</th>
<th>CMGs</th>
<th>IMGs</th>
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<tbody>
<tr>
<td>2002-03</td>
<td>1,447</td>
<td>197</td>
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<tr>
<td>2003-04</td>
<td>1,588</td>
<td>176</td>
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<tr>
<td>2004-05</td>
<td>1,640</td>
<td>289</td>
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<tr>
<td>2005-06</td>
<td>1,790</td>
<td>289</td>
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<td>2006-07</td>
<td>1,893</td>
<td>340</td>
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<td>2007-08</td>
<td>1,975</td>
<td>405</td>
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<tr>
<td>2008-09</td>
<td>2,078</td>
<td>426</td>
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<tr>
<td>2009-10</td>
<td>2,273</td>
<td>466</td>
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<tr>
<td>2010-11</td>
<td>2,418</td>
<td>427</td>
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<tr>
<td>2011-12</td>
<td>2,475</td>
<td>437</td>
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</table>
If efficiency (examples)

- Recognition that return on investment in prevention is primarily to the province (& patient) not the provider
  - So province should act
- Improved management
  - LEAN (from yesterday), but only start
- (Better) Use of information technology
- Remuneration and incentives
Scopes of practice changes

Better use of teams/appropriate provider

- Lowest cost provider for each service
- Of course, if each service were correctly priced then what provider performed it would not matter
- Seems common that low end of scopes of practice are overpriced compared to high end of scopes of practice

In short, create healthcare system

- BUT, coordination has costs (& opponents)

Overall, long-term and not easy
Part II – Trends and patterns

- Or, why do we care how much providers (esp. physicians) are paid?
Real Per Capita Total and Public HHR Expenditures, 1975-2011

Source: CIHI (2011b) and Statistics Canada.
Inflation adjusted using the all goods CPI.
Real per Capita Provincial Public Spending on Physicians, 1975-2011

Source: CIHI

<table>
<thead>
<tr>
<th></th>
<th>NF</th>
<th>QU</th>
<th>ON</th>
<th>SK</th>
<th>AB</th>
<th>Canada</th>
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<tr>
<td>Mean</td>
<td>$189,107</td>
<td>$178,931</td>
<td>$205,977</td>
<td>$204,238</td>
<td>$167,052</td>
<td>$182,532</td>
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<tr>
<td>20th %ile</td>
<td>$58,691</td>
<td>$69,135</td>
<td>$64,552</td>
<td>$70,435</td>
<td>$62,644</td>
<td>$64,758</td>
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<td>$170,002</td>
<td>$163,985</td>
<td>$166,325</td>
<td>$147,843</td>
<td>$120,611</td>
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<td>80th %ile</td>
<td>$297,569</td>
<td>$263,366</td>
<td>$310,551</td>
<td>$304,667</td>
<td>$260,670</td>
<td>$274,281</td>
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## What are MDs' Earnings Relative to Distribution of Non-Health Workers

<table>
<thead>
<tr>
<th>20th %ile MD</th>
<th>83.80%</th>
<th>87.50%</th>
<th>78.40%</th>
<th>87.50%</th>
<th>75.50%</th>
<th>81.30%</th>
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<tbody>
<tr>
<td>Median MD</td>
<td>99.60%</td>
<td>99.10%</td>
<td>98.20%</td>
<td>99.10%</td>
<td>94.50%</td>
<td>98.00%</td>
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<tr>
<td>80th %ile MD</td>
<td>99.90%</td>
<td>99.70%</td>
<td>99.50%</td>
<td>99.80%</td>
<td>99.00%</td>
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<tr>
<td><strong>Mean</strong></td>
<td>$54,464</td>
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<td>$60,303</td>
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<tr>
<td><strong>20th %ile</strong></td>
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<td><strong>50th %ile</strong></td>
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<td><strong>80th %ile</strong></td>
<td>$68,475</td>
<td>$65,645</td>
<td>$83,364</td>
<td>$73,668</td>
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<td><strong>What are Nurses' Earnings Relative to Distribution of Non-Health Workers</strong></td>
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<tr>
<td><strong>20th %ile Nurse</strong></td>
<td>68.30%</td>
<td>52.70%</td>
<td>53.50%</td>
<td>61.10%</td>
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<tr>
<td><strong>Median MD</strong></td>
<td>86.00%</td>
<td>76.20%</td>
<td>77.00%</td>
<td>82.30%</td>
<td>73.10%</td>
<td>77.00%</td>
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<tr>
<td><strong>80th %ile Nurse</strong></td>
<td>89.10%</td>
<td>85.70%</td>
<td>87.50%</td>
<td>89.10%</td>
<td>85.40%</td>
<td>87.70%</td>
</tr>
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</table>
Likely short-term bang is from price reduction
  - May not endure, but more likely than in past
  - Ontario taking the lead

Longer term and more socially valuable cost containment from efficiency improvements
  - These are hard on several dimensions and require long-term focus and determination
  - Not clear that either Ministers, ministries or local administrators have sufficient of either