User Fees for Medicare Solution

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Introduction The populations of countries in the Organization for Economic Cooperation and Development (OECD) are ageing. More to the point, the number of people over the age of 65 (who are presumed to be dependent for their support on the rest of the population) will increase more rapidly than the number of people of working age... who are presumed to be the chief source of support for the young and the elderly. [1] In preparation for the inevitable strain this demographic phenomenon will place on social programs, many countries have re-evaluated the feasibility of continuing to provide existing health care programmes.[2] Japan, faced with the most acute ageing problem of all OECD nations, has implemented user fees for the elderly, in an attempt to mitigate the economic and social problems caused by its ageing population.[3] (See Japanese Lessons, page 22). This paper addresses the questions of whether Canada can follow Japan s lead in charging health care user fees to its elderly citizens, and whether we should do so if it proves to be possible.

the Elderly: or Dissolution?

Can A Canadian Government Follow Japan's Lead?

A. The Canada Health Act, 1984

Although jurisdiction over health care is allocated to the provinces,[4] the administration of health care is a costly undertaking. The federal government, which wanted to have some control over the administration and provision of health care in the provinces, essentially bought its way into controlling a designated provincial power by offering substantial transfer payments to the provinces. These payments are conditional upon the provinces compliance with federal health care guidelines, especially as outlined in the *Canada Health Act, 1984*.[5] Therefore, a province can legislate nominally on any health care issue, but if such legislation is not in accordance with the federal stance the province is likely to lose some or all of the federal transfer payment amount. Specifically, the 1984 legislation explicitly withdrew the previously held right of the provinces to collect a full federal cash contribution if they charged user fees.[6]

How, then, could user fees for the elderly arise? Three possible scenarios exist. First, the provinces may want to charge or allow user fees while the federal government wants to prevent them from doing so. If this were the case, the implementation of user charges for the elderly by a

1 Organization for Economic Cooperation and Development, *Health and Pension Reform in Japan* (Paris: OECD, 1990) at ix.

2 Organization for Economic Cooperation and Development, *Aging Populations* (Paris: OECD, 1988) at 64. For a discussion of recent US concerns, see H. Fineman, "Mediscare" (18 September 1995) 126:12 Newsweek 38.

3 OECD Japan, see note 1 at xi. User fees are patient charges which vary with utilization of the system. These should not be confused with premiums, which are monthly amounts payable that do not vary with use of the system and are not set to reflect risk of illness. Two of Canada's ten provinces charge premiums.

province would violate at least two of the five criteria of the Canada Health Act: universality[7] and accessibility.[8] Furthermore, if some but not all provinces implemented a user fee system for the elderly there would be a problem with portability.[9] Most importantly, user fees would directly contravene the Act's prohibition of such charges.[10] The penalty for contravention is a dollar-for-dollar deduction from the federal contribution for all revenue earned by a province through user fees.[11] Economically, therefore, marginal benefit from imposing user fees begins to accrue only when the net profit from user fees exceeds the maximum entitlement to contributions from the federal government.

Until the late 1970s it seemed that net profit from user fees would never exceed the federal contribution. Under the former 50:50 cost sharing formula, the federal contribution was a considerable enticement to the provinces to follow the Act to the letter. In 1977, however, the form of federal health care financing changed[12] Recently, payments to the provinces have been declining.[13] This decrease in funding has federal politicians speculating that provinces may soon ignore the repercussions of losing the federal amounts. For example, after announcing an extended freeze on funding, former Progressive Conservative Finance Minister Michael Wilson recognized publicly that:

> ...limiting the growth of transfers...raises concerns about the ability of the federal government to continue enforcing national medicare principles under the *Canada Health Act, 1984*. Legislation will be introduced to ensure that the federal government continues to have the means to enforce those national medicare principles. The principles of the *Canada Health Act, 1984* will not be compromised.[14]

The implication in this statement is that a federal government that supported the 1984 Act could find a way to undermine the actions of provinces that wished to depart unilaterally from the Act's requirements. That is, even if one form of payment is declining, there are still other means to punish dissident provinces. Recent developments (see below), however, might lead one to believe that both the federal government and the provinces realize that greater power is indeed shifting to the provinces.

A second possibility is that the federal government would want the

4 Sections 91 and 92 of the *Constitution Act, 1867* delineate the level of government that is to hold certain powers: these are commonly referred to as the "division of powers" sections. Sections 92(7),(13), and (16) have been interpreted by the courts and academics to give power over health care to the provinces. See: *Carruthers v. Therapeutic Abortion Committees of Lions Gate Hospital* (1983), 6 Dominion Law Reports (4th) 57 at 63 (Federal Court of Appeal) [regulation and control of hospitals]; P.W. Hogg, *Constitutional Law of Canada*, 3rd ed. (Toronto: Carswell, 1992) at 546 [regulation of physicians as professionals]; *Schneider v. The Queen* (1982), 139 Dominion Law Reports (3d) 417 (Supreme Court of Canada) [medical treatment and health matters as local or private matters].

5 RSC 1985, chapter C-6. The Act reiterated the four fundamental criteria of the medicare program as established in the *Medical Care Act, 1966* (RSC 1970, chapter M-8), namely, comprehensiveness, universality, portability, and public administration. In addition, the new statute included a fifth principle — accessibility.

6 *Canada Health Act*, see note 5 at section 19(1). There is an exception, in section 19(2), for fees charged to inpatients who were considered "more or less permanently resident in a hospital or other institution."

7 *Canada Health Act*, see note 5 at section 10 [the requirement that all insured services be offered on the same terms to all provincial residents].

8 *Canada Health Act*, see note 5 at section 12 [the requirement that access to insured services cannot be impeded by means of a charge or otherwise].

9 *Canada Health Act*, see note 5 at section 11(1)(b)(i) [and particularly, with reimbursement between provinces].

provinces to implement user fees, and the provinces themselves would not. While the federal government has no constitutional mandate to legislate directly on health care, it can exert intense pressure on the provinces by modifying the terms of the Act. The federal government could amend the Act to create an exception to the prohibition of user fees; that is, any user fees *for the elderly* would no longer be prohibited. This modification would only create an enabling provision the provinces would not be obliged to charge fees. If the federal government wanted to force the provinces to collect user fees, the Act would have to be amended to impose a penalty on those provinces that did not charge such fees to users of the system. Admittedly, such a change would represent a marked departure from the purpose of the Act. But as will be discussed below, there have been major changes in Canadas social climate over the last ten years, which could create an impetus for such reform at the federal level.

Finally, it is possible that both the federal government and the provinces would want user fees to be instituted. This scenario would be the least complicated to implement: the federal government could simply amend the Act so as to allow provinces to charge user fees to the elderly. The only possible issues of contention might then concern amounts to charge and how to deal with users from outside the province of treatment.

B. The Canadian Charter of Rights and Freedoms

The preceding discussion on jurisdiction must be tempered by an understanding that the courts can strike down legislative provisions that are found to be unconstitutional. If a government decided to implement a user fee structure for the elderly, its actions would be subject to judicial review. Two complex questions need to be answered to determine the constitutionality of an age-specific user fee. First, would a medicare user fee for the elderly constitute discrimination based on age, contrary to the equality provisions in section 15(1) of the Charter?[15] And if such a law is discriminatory, could the limitation on the rights be considered reasonable and demonstrably justified in a free and democratic society?[16] If the answer to the latter question is yes, then section 1 of the Charter can operate to save offending legislation from being struck down as unconstitutional. There are two leading

10 *Canada Health Act*, see note 5 at section 19(2).

11 *Canada Health Act*, see note 5 at section 20(2).

12 A. Thomson, *Federal Support for Health Care* (Ottawa: The Health Action Lobby, 1991) at 11.

13 D. Fagan, "Health Costs Not Spiraling, But They Still Eat Up GDP" *The [Toronto] Globe and Mail* (25 August 1993) A5.

14 Thomson, see note 12 at 1.

15 Section 15(1) of the Canadian Charter of Rights and Freedoms reads as follows: "Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, *age* or mental or physical disability." (emphasis added)

16 According to section 1 of the Charter all guaranteed rights are "subject to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society." For the original statement of the Supreme Court of Canada's test for this section, see the leading case of *R. v. Oakes*, [1986] 1 Supreme Court Reports 103.

Supreme Court of Canada cases on the issue of government legislation which discriminates against the elderly. In evaluating the scope and application of sections 15 and 1 of the Charter to the issue of user fees for the elderly, it is instructive to examine the reasoning of the court in each case, to determine the factors on which the court s decisions turned.

In *McKinney v. University of Guelph*,[17] the Supreme Court of Canada was given the opportunity to consider a section 15 Charter challenge to mandatory retirement provisions. The *Ontario Human Rights Code*, the legislation under examination in that case, only prohibited discrimination on the basis of age in employment up to the age of 65. The court found this

17 *McKinney v. University of Guelph*, [1990] 3 Supreme Court Reports 229.

Japanese Lessons

In 1973, as a result of a grassroots socialist movement among municipalities, the Japanese government implemented a system of public grants to lighten the health care cost burden borne by the aged.[1] Despite its initial popularity, this free medical care for the elderly lasted only ten years. By 1983 the numerous problems with the amendment had become painfully clear to the government. When the 1973 amendment came into force, [t]he number of the elderly in physicians waiting rooms immediately doubled and health costs shot up 300% in the [following] four years. [2] Health care costs soared from 1973 to 1983, as increased wages, the ageing of the population, the development of advanced medical care technology and changing disease patterns caused a rapid increase in costs.[3] More precisely, national medical costs for the aged rose 600% between 1973 and 1982, doubling from 10 to 20% of total health care costs.[4] As a result, the Japanese government passed a new bill in 1983,[5] in which one of the main features was the introduction of user fees for services to the aged.[6] A further motivation for the implementation of the user fees may have been to control indiscriminate use of services by...elderly patients. [7]

The user fees imposed by the 1983 law were a payment of 400 yen (about $3 US) for the first outpatient visit in a given month, and a charge of 300 yen ($2.25 US) per day for the first two months of inpatient care.[8] The inpatient charge was to apply to those over the age of 70 and those aged 65 to 69 years who were covered under another insurance plan.[9]

In 1985 the Council for the Health of the Aged submitted a report stating that the elderly could afford to pay more of their medical costs than required under the 1983 law. In response to this and other proposals from the Ministry of Health and Welfare, the law was amended in 1987[10] to reflect greater charges for both out-patients [800 yen ($6 US) per month] and in-patients [400 yen ($3 US) per day throughout hospitalization].[11]

A key question is whether these user fees have worked in Japan. As with any complex social calculus, the impact of a

1 *Amendment to the Law for the Welfare of the Aged* (1973).

2 C.W. Kiefer, "Care of the Aged" in E. Norbeck and M. Lock, eds., *Health, Illness, and Medical Care in Japan* (Honolulu: University of Hawaii Press, 1987) at 92.

3 Organization for Economic Cooperation and Development, *Health and Pension Reform in Japan* (Paris: OECD, 1990) at 14.

4 Kiefer, see note 2 at 90.

5 *Law of the Health and Medical Services for the Aged* (1983).

6 OECD Japan, see note 3.

7 Kiefer, see note 2 at 93.

8 Kiefer, see note 2 at 93.

9 OECD Japan, see note 3.

10 *Amendment to the Law of the Health and Medical Services for the Aged* (1987).

11 K. Sonoda, *Health and Illness in Changing Japanese Society* (Tokyo: University of Tokyo Press, 1988) at 55.

legislated age limit to be a breach of section 15. Likewise, in *Tetreault-Gadoury v. Canada*,[18] the Supreme Court of Canada held that a provision of the *Unemployment Insurance Act* that disallowed receipt of normal unemployment benefits by persons 65 years of age or older violated section 15 of the Charter.

It seems likely, therefore, that any government legislation that imposed health care user fees on the elderly would be ruled discriminatory. Where the effect of a governmental action is to impose a burden or remove a benefit from a group enumerated in section 15(1) of the Charter, then that action will be found to be discriminatory regardless of whether it was

18 *Tetreault-Gadoury v. Canada (Canada Employment and Immigration Commission),* [1991] 2 Supreme Court Reports 22.

single factor on health care costs in a country is nearly impossible to isolate. For example, possible deterrent effects of user fees may not have been at work in Japan. It has been noted that ...these cost-sharing requirements...have done little to diminish the average citizens proclivity to visit the physician often. [12] Low health care costs may have less to do with user fees than with the realization of other efficiencies. On the other hand, Japan is one of the few industrialized countries that appears to have its health care expenditures under control.[13] In 1990 Japan spent only 6.5% of its GDP on the provision of health care; Canada expended 9.1% of its GDP on health care that year.[14] Despite Japans relatively lower medical expenditures, the Japanese live longer than Canadians... and their infant mortality rate is lower. [15]

When Japan passed health care reform legislation in 1983 and amendments in 1987, it did so at a time when an extremely conservative ideology prevailed in Japan, and thus the law may not have been unpopular. Evidence to this effect comes from polls, conducted after 1987, which reflected public discontent with sales tax and defence, but did not cite any problems with the health-care system.[16] It has been observed that:

> [a]ll the evidence suggests that the public is satisfied with cost-sharing and is not averse to making some payment at point of service; in a society which has traditionally stressed the need for personal responsibility the governments approach to payment of services is not a contentious issue.[17]

Because of the very different context into which this Japanese law was thrust, Japanese lessons must be taken with a proverbial grain of salt. Currently, it would not be an easy task for a Canadian government to superimpose a Japanese system onto our markedly different society. However, similar conservative trends in Canada, coupled with similar demographic shifts, make it more and more likely that some time soon we may follow the lead of Japanese health care legislative reforms. ■

12 J.K. Iglehart, "Japan's Medical Care System" in M.M. Rosenthal and M. Frenkel, eds., *Health Care Systems and Their Patients* (Oxford: Westview Press, 1992) at 154.

13 R.G. Evans, "The Canadian Health-Care Financing and Delivery System: Its Experience and Lessons for Other Nations" (1992) 10 Yale Law and Policy Review 362 at 384.

14 D. Fagan, "Health Costs Not Spiraling, But They Still Eat Up GDP" *The [Toronto] Globe and Mail* (25 August 1993) A5.

15 M. Janigan, "A Prescription for Medicare" (31 July 1995) 108:31 Maclean's Magazine 10 at 10.

16 H. Fukui, "Japan in 1987: An Eventful Year" (1988) 28 Asian Survey 23 at 31.

17 M. Powell and M. Anesaki, *Health Care in Japan* (New York: Routledge, 1990) at 99.

motivated by a discriminatory purpose. The more complex question is whether the legislation could be saved by section 1 of the Charter. The answer to this question may be influenced by the final outcomes in *McKinney* and *Tetreault-Gadoury* for although the legislation in both cases was held to be discriminatory, in one it was upheld under section 1 while the other one was struck down.

Despite the finding in *McKinney* that the impugned section of the *Ontario Human Rights Code* contravened the Charter, the Supreme Court upheld the section as having been justified under section 1. The court reasoned that the specific provision sought to protect a certain group (that is, those aged 45-65) and that there was an acceptable rationale for the exclusion of those over 65 years of age:

> The truth is that...there are often solid grounds for imparting benefits on one age group over another in the development of broad social schemes and in allocating benefits.[19]

The court found that the legislature was attempting to strike a balance between the need to extend human rights protection to those over 65, and the possible congestion that would result in the workplace if older employees deferred retirement and younger ones were held back as a consequence. The court held that if legislation were to interfere with mandatory retirement, it would create personnel and human resource management problems in both the private and public sectors. Furthermore, the court determined that:

> [a] legislature should not be obliged to deal with all aspects of a problem at once. It should be permitted...to take account of the difficulties, whether social, economic or budgetary, that would arise if it attempted to deal globally with them.[20]

Therefore, the Code was permitted to stand unaltered, as it constituted a reasonable limit on section 15 Charter rights.

In contrast, the Supreme Court struck down the discriminatory provision of the *Unemployment Insurance Act* in *Tetreault-Gadoury.* The government contended that the main objective of the provision was to prevent abuse of the system by those who could also receive government pension money; in addition, the provision served to maintain coherence and rationality within the government s legislative scheme. While the court found

19 *McKinney*, see note 17 at 297.

20 *McKinney*, see note 17 at 237.

that these objectives were reasonable, it did not support the means used to accomplish them. The court noted that there was:

> ...no evidence...that those over age 65 abuse the Act any more than those in other age groups...The burden, of course, rests upon the government to adduce such evidence.[21]

The court also stated that avoiding double benefit payments, could have been achieved by simply deducting pension receipts from unemployment benefits. [22]

Finally, the court considered whether the objectives of the *Unemployment Insurance Act* would be furthered by the continued inclusion of the section in question, and, whether...denying benefits to individuals over 65...is compensated for by the provisions of other Acts. [23] It was noted that:

> ...there was no evidence put forth to show that the government could not afford to extend benefits to those over 65. More significantly, there is also no evidence to show that any of the other Acts attempt to fill the gap by addressing the problem of 65-year-olds who...do not receive a pension at all.[24]

The Supreme Court held that the government objectives could easily have been attained by less intrusive means, and the discriminatory section was struck down.[25]

Overall then, if health care user fees were imposed on the elderly, and such legislation was ruled discriminatory under the Charter s equality provisions, would that legislation be saved by section 1? The most valuable tools available to a government to justify legislation of this type under Charter scrutiny are empirical evidence, and reasonable consideration of alternatives. The onus is on the government to show that the mischief it sought to avoid is real, and preferably that it is quantifiable in economic terms. It would have to show that it could no longer afford to finance free medical care for the aged. Furthermore, it would have to demonstrate that it was the aged in particular who were straining the system. Such a contention would require evidence of increasing usage rates that correlate directly to ageing.[26] The government would have to establish that it had considered other alternatives, but reasonably felt that the legislation represented the smallest intrusion on the Charter rights of the elderly. If the court could

21 *Tetreault-Gadoury*, see note 18 at 45.

22 *Tetreault-Gadoury*, see note 18 at 45.

23 *Tetreault-Gadoury*, see note 18 at 46.

24 *Tetreault-Gadoury*, see note 18 at 46.

25 *Tetreault-Gadoury*, see note 18 at 47.

26 Such evidence would not be difficult to produce. See Marzouk, note 36; see also note 53 and accompanying text.

envision a less intrusive way for the government to meet its objectives, the user fees would not pass the minimum impairment test. Most likely, the court would also search for some guarantee that a person discriminated against, who could not afford the user fee, still could receive medical services without prejudice.

While an examination such as the one above may not take into account all of the considerations that might be pertinent to the Supreme Court, it is clear that it would not be impossible for a government to adduce the evidence required to uphold a discriminatory user fee law under section 1 of the Charter. As the *McKinney* decision demonstrates, legislation which has been shown to discriminate on the basis of age has been upheld by the Supreme Court in the past. This result suggests that discriminatory user fee legislation could be similarly upheld in the future.

Should A Canadian Government Follow Japan's Lead?

A. Potential Benefits

Three arguments, set out below, are traditionally raised in support of user fees. Additionally, this paper examines a fourth possible rationalization of user fees not found in other literature. The first argument is that user fees will generate net revenues. The theory is that actual revenue collected from patients will help to offset the costs of medical care. This theory is based on the premise that revenues from user fees will exceed the additional costs of administering such a system. In other words, the implementation of user fees must be a profitable endeavour for it to contribute any amount to the health care budget. Some critics have intimated that revenues from user fees would not outstrip additional administrative costs.[27]

The second argument in favour of user fees is that user fees will deter frivolous visits. This argument is based on supply and demand economic theory, which hypothesizes that, imposing prices on users of health services automatically reduces quantity demanded (and thus utilization) and thereby limits cost. [28] Empirical support for this theory comes from the RAND health insurance experiment, conducted in the United States from 1974 through the 1980s, which was one of the largest and most comprehensive studies ever undertaken in the health insurance field.[29] Although no

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27 *Preserving Universal Medicare* (Ottawa: Supply and Services Canada, 1983) at 23.

28 M.L. Barer et al., *Controlling Health Care Costs by Direct Charges to Patients: Snare or Delusion?* (Toronto: Ontario Economic Council, 1979) at 12.

29 J.P. Newhouse, *Free for All? Lessons from the RAND Health Insurance Experiment* (Cambridge: Harvard University Press, 1993) at 4.

elderly individuals or families were used as subjects, the experiment still provides some significant insights into the behaviour of a population faced with varying medical user fees. The study found that, [u]se of medical services responds unequivocally to changes in the amount paid out of pocket. [30] Furthermore, it was not necessary to implement extraordinary fees to have a significant deterrent effect since the largest drop in outpatient service usage occurred after the first level of payment, when services were simply no longer free.[31] While the RAND study may demonstrate that user fees cause reductions in system usage, it has been pointed out that the study, ...did not, and by design could not, show that this led to an overall system-wide reduction in utilization and costs. [32]

People use Canada's medical system imprudently because they do not appreciate the public expense inherent in medical services. Because we are accustomed to receiving free care, we consequently waste it as one might waste tap-water.

Some direct Canadian evidence on the deterrent effect of user fees comes from records kept in Saskatchewan during a brief period when that province implemented a user fee structure. In the late 1960s, Saskatchewan had a fee structure of $1.50 per office visit, and $2.00 per emergency, home, or hospital outpatient visit. The result of these fees appeared to be a reduction of hospital days by 2.5% for two years. After that, days of care and office visits returned to previous levels while admission rates increased by 10%.[33] Thus, Canadian indicators of the effectiveness of user fees as a deterrent to health care system use are not as clear cut as those of the RAND experiment.

A third argument suggests that user fees promote so-called cost association by linking value to medical services. This theory suggests that people use Canadas medical system imprudently because they do not appreciate the public expense inherent in medical services. Because we are accustomed to receiving free care, we attach no real value to it and consequently waste it as one might waste tap-water. User fees would make people link

30 Newhouse, see note 29 at 40.

31 Newhouse, see note 29 at 42.

32 R.G. Evans et al., "The Truth About User Fees" (October 1993) 14:8 Policy Options 4 at 7.

33 K.R. Grant, "The Inverse Care Law in Canada: Differential Access Under Universal Free Health Insurance" in B. Singh Bolaria and H.D. Dickinson, eds., *Sociology of Health Care in Canada* (Toronto: Harcourt Brace Jovaovich, 1988) at 118.

value and real cost to medical services. Dubbed the visible-link argument by prominent writers in the field,[34] the assumption is that people will be disinclined to waste a valuable commodity. This argument, however, could be flawed. Part payments, by attaching a nominal value to a costly service, might confuse the public even further. The end result could still be a vast undervaluation of medical treatment, causing the inherent side-effect of overuse to continue unabated.

Finally, user fees could provide individuals with an incentive to maintain desirable, health-conscious behaviour. The converse of a penalty for being sick is a reward for staying healthy (not a reward in actual monetary terms, but a reward in terms of user fee costs not incurred). On this basis, user fees would encourage individuals to look after their own health through diet and lifestyle improvement to save money in the short run. Dual benefits would result from this emphasis on prevention. First, presumably the medical system would be used less by a healthier population. Consequently, the overall public costs of running the system should decrease. Second, the population would actually get healthier surely the goal of health care systems generally. User fees may play a role in shifting the emphasis from treatment and reactive procedures to healthy choices that prevent later health problems. But the benefits of behaviour modification and systemic change go even deeper. Long-term benefits would accrue to individuals as future generations of Canadians are indoctrinated by their families to care for their own health. Monumental benefits would be reaped by a nation with a healthier population.

B. Potential Costs

There has been concern that deterrent measures like user fees could result in an actual decline in the overall health of the elderly, as people will be reluctant to see physicians when they ought to. The RAND study statistics tend to demonstrate that people are not willing to sacrifice needed or recommended medical procedures because a user fee exists.[35] Rather, they will rationalize their use of the system by evaluating more carefully whether their ailments require medical attention. Additionally, Canadian research implies that decreased use may not mean decreased health:

34 Barer, see note 28 at 12.

35 Newhouse, see note 29 at 42.

> Recent Canadian evidence suggests that increased hospitalization among the elderly is not curing morbidity...and that increased servicing to the elderly is associated with use of salvage activities and therapies of questionable effectiveness.[36]

By this account, concerns that user fees could result in a less healthy elderly population may be unwarranted.

The prevailing belief that elderly is synonymous with poor also requires re-evaluation. The idea that the elderly represent a poor group in society likely stems from their historically lower rates of income as a demographic group. The most recent Canadian census reports, however, indicate that the gap is closing rapidly. In addition, the situation is more complex than it first appears: it must be recognized that ability to pay can not be judged by a gross income comparison alone.

The first step, nevertheless, is to compare actual gross incomes. In 1981, the average gross income of all individuals up to 65 years of age was $15,275. The corresponding figure for a person aged 65 and over was $8927, approximately 58.4% of the income received by a younger person.[37] By 1990, however, an average male over 65 was reporting $24,500 in annual gross income 69% of that of his male counterpart aged 25-64, who earned $35,500.[38] The disparity for women was much less. An average woman over 65 reported $15,300 in gross income almost 76% of the $20,200 earned by an average woman aged 25-64.[39] These statistics demonstrate that women over 65 years of age have, on average, the lowest incomes. However, they also demonstrate that the elderly *as a class* are no longer as disadvantaged as they were 15 years ago, in comparison to the rest of the population, on the basis of their gross incomes.

A closer analysis of the statistics reveals numbers that are even more striking. If one compares the average income of seniors with that of persons 25 to 64, ...then after cross classifying by sex, by work activity (whether or not a person worked in 1990), and by education, in each case the average income of seniors was considerably *higher*. [40] From this finding one could extrapolate that ...the current trend towards higher educational levels of seniors will likely tend to reduce the future gap between the average income of seniors and that of the total population. [41]

36 M.S. Marzouk, "Aging, Age-Specific Health Care Costs and the Future Health Care Burden in Canada" (1991) 17 Canadian Public Policy 490 at 503.

37 *The Elderly in Canada* (Ottawa: Supply and Services Canada, 1984).

38 J.A. Norland, *Focus on Canada: Profile of Canada's Seniors* (Ottawa: Statistics Canada and Prentice Hall, 1994) at 46.

39 Norland, see note 38.

40 Norland, see note 38 (emphasis added).

41 Norland, see note 38 at 48.

Moreover, using gross income alone as a measure of ability to pay ignores real household spending power, which must factor in the costs of supporting dependants with no income. Thus, while younger individuals may earn more gross income, thereby appearing better off, younger households are also more likely to be supporting dependent members like children. In fact, average *per capita* income for senior families and households was higher than for Canadian families and households generally in 1990.[42]

A further problem with using gross income as a measure of wealth is that it does not account for debts payable, such as mortgages. In 1990, [m]ore senior households owned their own dwelling than did non-senior households. [43] Of these homeowners, 84% of senior-owned dwellings were completely mortgage-free as opposed to only 38% of non-senior owned dwellings.[44] Clearly, if two people have similar incomes, the one with fewer debt obligations will be better able to pay for health care and other costs.

Finally, gross income does not consider accumulated wealth. Of total income for seniors, 23% comes from investment.[45] This statistic demonstrates that many elderly hold substantial amounts of amassed capital. This fact has led one commentator to note that:

> [i]t is distributionally unjust for the heirs of an elderly person to profit by institutionalizing that person at public expense and then banking the public pension or earnings from the elderly persons capital (if there is any)...until, in due course, the cumulated pension and other earnings become part of the estate.[46]

This reasoning can be extended to health and medical care generally. The heirs of the wealthy elderly should not be allowed to benefit while the testator receives costly medical treatment at the expense of the tax-paying public.

Simply put, someone has to pay for health care, therefore wealth is a relative concept. The question becomes: will the next generation of wage earners and tax payers be better off, thus better able to pay than the next generation of elderly? This seems unlikely. According to a 1993 G7 draft report on ageing and health care,

> [i]f present policies are not changed, medical costs and pension payments will go up while the workforce shrinks and member states growth rates possibly slide.[47]

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42 Norland, see note 38 at 50.

43 Norland, see note 38 at 55.

44 Norland, see note 38 at 55.

45 Norland, see note 38 at 49.

46 Barer, see note 28 at 57.

47 T. Heneghan, "Japan: G7 Draft Report Focuses on Aging and Health Care" *Reuter News Service - Far East (LEXIS)* (6 July 1993).

The OECD projects that the dependency ratio in most countries will exceed 3:1 by the early 21st century,[48] and that the percentage of the Canadian population 65 years of age or older is expected to nearly double in the 50 years between 1990 and 2040.[49] It has been calculated that the Canadian health care-to-GDP ratio is likely to double over the next 40-45 years. [50]

Furthermore, as a result of improved medical technology and better lifestyles among the elderly, [51] Canada is experiencing ageing-within-ageing whereby there are now proportionately more of the older-old (meaning those 75 years of age and above).[52] Since it is well documented that the elderly use proportionately more health resources, and that the older elderly use more again, Canada's health care system may require even more than double its present resources solely because of changing demographics.[53] An overburdened base of taxpayers will have to look to those using the system disproportionately for some help in funding this use.

Simply put, someone has to pay for health care. The question becomes: will the next generation of wage earners and tax payers be better off, thus better able to pay than the next generation of elderly?

Canada In The 1990s

Attempts to tamper with medicare probably would be unpopular in Canada, as medicare is by a considerable margin the nation's most...popular public program. [54] However, many provinces and the federal government have imposed unpopular restraints and cutbacks on public spending and services, rationalizing these cuts to voters as necessary actions or means to control the deficit. Further, an increasingly dynamic political landscape makes it uncertain whether medicare will receive the same protection in the future.

Canada is presently governed by the federal Liberals, who have traditionally supported a number of Canadian public welfare programs, including medicare. In fact, it was a Liberal government that first implemented the program in the 1960s. In the 1990s, however, there appears to be a growing

48 OECD Japan, see note 1 at ix.

49 OECD Aging, see note 2 at 22.

50 Marzouk, see note 36 at 501.

51 Marzouk, see note 36 at 491.

52 Marzouk, see note 36 at 491.

53 Marzouk, see note 36 at 492.

54 R.G. Evans, "The Canadian Health-Care Financing and Delivery System: It's Experience and Lessons for Other Nations" (1992) 10 Yale Law and Policy Review 362 at 362.

conservative movement in Canada, as witnessed by the rapid rise in popularity of a new, right-wing party the Reform Party. In the most recent Canadian federal election, the Reform Party took 52 seats in the House of Commons, one seat less than the Bloc Quebecois (who became the official opposition). The leader of the Reform Party, Preston Manning, has stated that

> ...a Reform Party government would repeal much of the Canada Health Act and allow individual provinces to reform the medicare system under much looser guidelines.[55]

Great benefit could come from information gained by experimenting with user fees. But the Canada Health Act does not allow for such experimentation.

Mr. Manning is quick to point out, however, that he is not calling for user fees. Rather, he believes the decisions on health care issues should be made by the provinces and provincial electorates.[56]

Surprisingly, the Prime Minister has also made statements recently that bode poorly for the unaltered continuation of medicare in Canada. Jean ChrØtien has stated that medicare needs to be rethought if Canada is to control its health care to GDP ratio; indeed, that:

> ...$10 billion should be cut out of health care spending to get it down to European levels of 8 to 9% of GDP.[57]

During the same interview, Mr. ChrØtien indicated that federal involvement in medicare was originally intended to be temporary in nature and that the provinces might be ready now to reassume full responsibility for its administration.[58]

As mentioned earlier, the federal government is also losing power over the provinces as a result of decreased health care funding. There have been recent signs of discontent from some provinces. For example, Alberta began to charge patients for certain costly procedures by offering them only through private clinics. At first, federal Health Minister Diane Marleau threatened to cut Albertas payments. Now, a compromise seems imminent as Ottawa and the provinces have agreed to define together what constitutes a medically nec-

55 "Medicare reform, but not Reform's" *The [Toronto] Globe and Mail* (30 September 1993) A26.

56 See note 55.

57 M. Barlow and B. Campbell "Straight Through the Heart" (November 1995) 74:844 Canadian Forum 22 at 22.

58 Barlow, see note 57.

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essary service. The list is expected to exclude many services, and Canadians may soon face more charges for care.[59] From this result, it seems both the provinces and the federal government recognize that the predicted shift in power over medicare has begun. It may not be long before financially burdened provinces begin implementing fees for health services with impunity.

Conclusion

This paper has sought to address two main questions: can Canada copy Japans lead by instituting health care user fees for the elderly; and should Canada take such action? The debate as to whether it would be economically, politically, or socially astute to create a user fee structure is a contentious one. On the one hand, Canada spends an inordinate percentage of its GDP on health care.[60] To rely on present growth rates to subsume future escalation of health care costs may be a mistake. If the economy were to falter in the future, the health care cost to GDP ratio might become unbearably large.[61] Politicians from all parties, supported by a strong conservative movement in Canada, have begun to face the challenges posed by the expense of social programs. Recent statements and actions of key political players intimate that medicare as Canadians know it may not exist for much longer.

Yet one wonders if the proposed user fees would significantly reduce the governments burden of health care provision. It seems likely that user fees would contribute towards health care budgets, have a deterrent effect on frivolous visits, and create an economic incentive to pursue more health-conscious behaviour, which in turn could result in systemic change and a healthier society. It also appears that user fees would produce no appreciable decline in the health of the elderly population, and that it is the elderly themselves who will be in the best position to pay their own medical costs in the near future. Great benefit could come from information gained by experimenting with user fees. But the *Canada Health Act, 1984* does not allow for such experimentation,[62] thus the present debate is largely theoretical.

It has been said that medicare is the last truly Canadian thing left; that it epitomizes the Canadian spirit of protecting those who can not protect themselves. But the time seems near when the young can no longer afford to protect the old, and the old may no longer need protecting. ■

59 M. Janigan, "A Prescription for Medicare" (31 July 1995) 108:31 Maclean's Magazine 10 at 10.

60 In 1993, Canada spent $72 billion or 10.1 percent of its GDP on health care. This ratio is the second highest in the world behind only the United States: see Janigan, note 59 at 11.

61 See Heneghan, note 47, and accompanying text.

62 W. Watson, Report of the Policy Forum on Medicare in an Age of Restraint (Kingston: Queen's University, 1984) at 12.