Atlantic Institute for AIMS Market Studies

We Can't Go On Like This:

What an ageing population, the consumer revolution and accelerating globalisation mean for the future of health care.

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Atlantic Institute for Market Studies

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Notes for a talk by Brian Lee Crowley, President of AIMS,
to the Annual Meeting of the Canada-Sweden Business Association
Stockholm, Sweden, 25th May 2005

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Ladies and Gentlemen,

I have been asked to speak to you today about health, wealth and power, and to place those concepts in the context of the challenges facing both Canada and Sweden, especially against a background of an ageing population.

Basically we can say that those who have wealth and power will also succeed in getting the health care that they want. But we need to unpack that statement to see how both the international economic context and the structure of our populations will affect the ways in which the wealthy and the powerful, by which I mean chiefly the Baby Boom generation, are liable to get their health care in the years to come. In doing so I will certainly refer to Sweden, but because I spend my time thinking chiefly about Canada I will use mostly Canadian examples to illustrate what I think is coming. In any case, Sweden's problem of population ageing is more acute than Canada's, and so if one of us is to learn from the other, I suspect it will be Canada that will be learning from Sweden. In fact, a good friend of mine, who is a well-known analyst of the Swedish health care system, Johan Hjertqvist, tells me every time that he comes to Canada, that the debates we are having over our health care system remind him of what was happening in Sweden 10 years ago.

In the little time I have, I'd like to touch on four major challenges:

1. Cultural change, not demographic change;

2. Technological change (including new things we can do and the challenge to intellectual property);

3. The limits of what the public sector can pay for;

4. The challenge of globalisation and the limits to what the state can do.

1. Cultural change, not demographic change

There is controversy over whether an ageing population actually means rising health care costs. I side with those who think it will have a major impact. Those who think the impact will be small are looking backward, at how patterns of health spending have been distributed across age groups in the past. But this is an instance where I am quite convinced that the future will not be like the past. There is a vast cultural shift going on, in which the Baby Boomers, who have been the most demanding generation in history, are now moving into retirement and are going to bring their informed consumer mindset to bear on the health services that they expect, just as they have brought it to bear on so many other fields of life in earlier decades.

How will this affect health care? In earlier times, people deferred to their doctors, who controlled access to medical services. People took their doctor's advice. Now the old doctor-patient relationship is dying, if not already dead.

Doctors say that one of the biggest trends of recent years is patients showing up with print-outs from the Internet about their medical conditions and appropriate treatments. Many people are seeing alternative medical practitioners as their primary caregivers. As Richard Bohmer, a physician and professor at the Harvard Business School says, "The development of new programmes and tools for patients to take more control of their own health is based on a very important new assumption about how competent patients are…The increase in medical knowledge, and its widespread availability is the engine moving decision-making capability and therefore decision rights to the patient."[1]

According to a survey of health care consumers by The Change Foundation in Ontario:

> One out of every two people appears to be a "responsibility-taker", taking control of their health and actively searching out options. They believe that most of the responsibility lies with them. About half of respondents believe that, in general they have as much medical knowledge as physicians. About half (53%) agree that they are the prime decision makers on their own health and about half (48%) regard healthcare as offering a wide range of choices. These results point to a very empowered consumer who feels very able to make health care choices.[2]

Add to this the fact that technology is changing fundamentally the way we relate to medical practitioners.

Virtually any kind of pharmaceutical product can now be purchased over the Internet from providers who are not in Canada and not subject to our government's controls. It is possible to have many kinds of diagnostic and other procedures carried out remotely, again by people who need not be in Canada or in Sweden. Your x-rays can be read just as easily by a radiologist in Boston or Bombay as by one in Toronto or Stockholm.

Increasingly surgery can be carried out in surgical booths equipped with video cameras and robotic arms, so that the surgery can actually be performed by surgeons physically separated from their patients. Also, as the phenomenon of medical tourism demonstrates, well-off patients are quite capable of seeking out high quality treatments in corners of the world where they can escape both queues and government-imposed controls on access to medical services they wish to get. In Canada, there are increasing reports of consumers travelling abroad for hip replacements, plastic surgery and laser eye treatment – and not just to the US, but to India and South Africa and France. Here in Europe you will know that the European Court has ruled that EU nationals may not be prevented by their national government from getting the treatment they want from other EU national health services.

In a world in which you can go to a surgical booth in Canada and be operated on by the best surgeon in the world, who may be at his office in London or Houston or Minneapolis, or where you can deal with a bonded medical services broker who can get you in to see some of the most reputable surgeons in the

[1] http://hbswk.hbs.edu/pubitem.jhtml?id=4502&t=special_reports

[2] http://www.changefoundation.com/tcf/tcfbul.nsf/eb2d6f6074fe4c9c052567180004b916/bd386df9384a038585256b920057e8c2/$FILE/ATTCZ8WJ/ConsumersReportSummary.pdf

world in exotic locations, health care predicated on the notion of a closed national system in which people must take what public authorities decide they should have simply will not and cannot survive.

I will also mention that, in Western countries, the Baby Boom generation is not only the richest in history, but it is also benefiting from a significant wealth transfers, as their parents die and pass on the wealth they have accumulated in the postwar years. These people are educated, determined, well-off and used to getting their way.

So these empowered consumers are now moving into an age where they will encounter more and more diseases associated with ageing. In the past, these diseases would simply have been accepted as a fact of life by both patients and physicians, with the objective being to manage them so as to minimise discomfort. But this will no longer be acceptable. People who have been used to getting their own way in so many other fields will not accept being fobbed off, especially when they can easily get on the Internet and become aware of the various treatments that are available for their ailments.

Let's look at an example. Many of the diseases of ageing are neurological – Parkinson's, Alzheimer's, etc. Already the total cost of treating Parkinson's (direct and indirect costs) in Canada, nearly 10 years ago, was estimated at $560m, and according to Harry Robertson, head of the Department of Pharmacology at Dalhousie, Alzheimer's cost would be 5-10 times that of Parkinson's, and strokes would cost more again than Alzheimer's. The Boomers will demand, and get, a major shift of research resources into dealing with these diseases, and when treatments emerge, they will demand to get those too, regardless of the cost, so the numbers I've just given you are only a very tiny starting point.

This might be a good time to think about the relationship between the cultural change I'm describing among users of the health care system, and the increasing technological feasibility of treating many diseases that not so long ago were regarded as essentially untreatable. I know that there are representatives of the Brain Repair Centre at Dalhousie University[3] here among us today, and I know that they will have a great deal to say to you about some of the remarkable technological innovations they have been responsible for in anticipation of the opportunities that an ageing population represents.

This, then, might be the right moment to move on to think about the impact of technological change on the world I am describing.

2. Technological change (including new things we can do and the challenge to intellectual property)

Let me open a small parenthesis here and mention that in most industries, technological innovation is a cost reducer, not a cost driver, but this seems to be less the case in health care than elsewhere. This is driven, in my view, by three key factors. In many cases the new technologies are not substitutes for existing techniques, but are additive – solving problems that we were unable to solve before, and yet not allowing us to dispense with already existing techniques and technologies. Second, innovation only helps to reduce costs when you can shift activities from old, less technology intensive approaches to new, more technology intensive ones. But in the government and provider-dominated health care systems you and I

[3] http://www.brainrepair.ca

are used to, these shifts of resources out of old approaches and institutions and into new ones is severely hampered.

Consider, for example, that according to David Cutler, a Harvard economist, coronary artery bypass surgery costs about $30k per patient, angioplasty with stent is about $20k, and medical management of heart disease, relying chiefly on pharmaceuticals such as beta-blockers, without intensive therapies, is expected to cost about $10k.[4] Leave aside the fact that we may in a few short years be able to cause the heart to grow new valves on its own (at unknown cost and with unknown efficacy), and we can see that resources could be made to go much further with low-intensity treatment.

On the other hand, in a publicly financed system such as ours, that has heavily invested in hospitals and surgeons, even if you are able to shift the patients to lower cost treatments, you save no money because it is politically virtually impossible to reduce hospital capacity, community medical employment or the number or even the specialties of surgeons – and you certainly can't reduce their incomes!

An ageing population, even if it doesn't increase the demand for medical care overall, changes the mix of goods and services demanded, and the public sector is not good at responding quickly to that sort of shift in demand.[5] We'll need more of some types of specialists and fewer of others, but the public sector tends not to anticipate those changes, rather it waits until they're already occurring to begin to look for manpower. We'll need different physical facilities, as well, and again the public sector tends to be slow to build. Existing facilities won't be easy or cheap to refit to meet new demands. It's unlikely that we'll have anything like the number of palliative care facilities or assisted living facilities that we'll need if we rely on the public sector to produce them.

The same, obviously, applies to drugs, and we already know that if we reduce the return to investment in pharmaceutical R&D, or the profitability of supplying the product, firms will pull out. The flip side is that if we allow drug companies to make a profit, they will supply the drugs we want. And having mentioned drugs, I had better open a small parenthesis here, for as soon as we talk about drugs, we immediately meet one of the great challenges at the confluence of science, politics and economics.[6]

In the battle against disease, human ingenuity has proven itself a formidable combatant. Often using drugs as our chief weapon, we have made in the last century progress against illnesses that were simply assumed to be an unalterable fact of human existence. Now, however, human ingenuity in its destructive form threatens the flow of pharmaceutical innovation just at the moment when it is poised to lay its greatest triumphs at mankind's feet. But now that the importance of drugs has been understood by patients, and their budget implications seized by health planners, there is a huge battle underway over which is more important: cheaper drugs today or more new drugs tomorrow.

[4] http://hbswk.hbs.edu/pubitem.jhtml?id=4504&t=special_reports
[5] I am indebted for much of this argument about shifting resources within publicly funded health care systems to Guelph University Professor Brian Ferguson, who is Fellow in Health Care Economics at my Institute.
[6] This section of my talk draws extensively on my Institute's recent work on public policy and the pharmaceutical industry, available at http://www.aims.ca/pharmaceuticals.asp?cmPageID=331

In 1920, 15 people out of every 100,000 in North America were condemned to die from flu and pneumonia. Another 15 each would be lost to syphilis and diphtheria, while tuberculosis would carry off a staggering 118. Today for each of these diseases the death rate is less than one out of every 100,000 annually.

These victories of the human mind over our human frailties are repeated over and over again. In the United States, death rates from atherosclerosis have declined 74%, from ischemic heart disease, 64%, from emphysema, 57%. Deaths from HIV/AIDS declined from a high of 15 per 100,000 population to about 3 or 4 after the introduction of the first effective drugs in 1995.

That's not all. We are opening the door on a whole new world of drug innovations because of the recently completed mapping of the human genome. The number of known "receptors" (the parts of the human organism that drugs can potentially target and use to defeat disease) has risen from around 450 to over 4000. And because we mapped the *human* genome, we don't have to fool around with the haphazard identification of receptors in rats and hamsters and other lab animals. We can zero in on what works for people, and even ultimately make "designer drugs" tailored for each individual.

But this huge increase in the scope for scientific research and disease-defeating and life-prolonging drugs will be hugely expensive to explore. For every drug that is successfully brought to market, dozens of experimental agents fail. With the huge increase in receptors to research, the potential for great discoveries is increased, but so too is the number of failures we will have to pay for as we grope our way to new wonder drugs. That is one of the chief reasons why the pharmaceutical industry estimates that it costs around $800-million for each major new drug; the failures must be paid for by the successes. And by the way, as a point of comparison, the R&D costs for the latest high-tech razor from Gillette was US$800m.

It's also why drug patents are so important to innovation — even huge drug companies may find that a handful of products generate the lion's share of their revenue, supporting a vast research effort that reaches beyond the successful drugs and the diseases they treat.

But once a drug has been discovered, the actual cost of producing an individual pill or dose of the medicine may be literally pennies. This difference between relatively low costs of production and the much higher prices actually charged by drug companies makes it easy to portray them as unscrupulous profiteers, exploiting human misery to make a buck. And politicians in search of passing popularity will often play this card, attacking the "greedy" drug companies for electoral advantage. Yet no politician ever cured a child of leukemia, or prolonged the life of a beloved grandparent.

Around the world, politicians are forcing drug companies to lower their prices much closer to their cost for just stamping out each pill. They deny the companies' products access to hospital dispensaries, or they create buying cartels, or they reduce patent protection or any one of a host of other manoeuvers, as we have frequently done in Canada. The result has been that drug prices have been lowered for medical marvels already discovered, but at the cost of needlessly prolonging the suffering caused by diseases that we have not yet conquered.

It's not the end of new drug discoveries but, compared to what we could be doing, they will come more slowly and with less regularity than at any time in the postwar era. Yes, drug companies need to be watched to make sure they don't abuse their power, and yes, we need to find ways to make sure that the most vulnerable among us aren't deprived of access to the drugs they need, but doing so by slowing everyone's access to the next generations of drugs is the wrong tradeoff to make. Unfortunately, it appears to be good politics, because politics is an innately conservative force – as we've already seen, it tends to favour what is, because the status quo is backed by many, many votes, whereas innovations that could deliver services quicker and cheaper remain merely potential, not actual. The future has few votes.

That is why markets, that move resources to back efficiency-creating innovations, are dynamic forces for change, while politics privileges the past and powerful interest groups. Add to that that publicly funded monopoly health care systems see all innovation as a cost to be funded out of current cash-flow, while markets see efficiency-enhancing innovation as a cost-saving to be financed out of future earnings. Add all of these factors together and you begin to get a sense of why technology in health care has been a cost driver rather than a cost reducer, and why innovation is so slow to be introduced in health care. As one of the researchers for our recent Royal Commission on health care so brilliantly if disturbingly put it – new technologies are only a health care cost driver if you use them….

3. The limits of what the public sector can pay for

Under this rubric I'd like to make a few observations:

First, Bill Robson, in an excellent paper for the C.D. Howe Institute, has made a convincing case about the future course of health care costs.[7] He compared current spending levels, projected into the future, with projections taking into account a number of reasonable assumptions about rising costs, driven by demographics, technological change and assumptions about growth in the economy. The most conservative (and implausible) projection showed the Medicare system with an unfunded liability of $500 billion over the next 3-4 decades, or about the current national debt. If his worst set of assumptions came to be realised, the unfunded liability would be $1.2 trillion. Similar projections by the office of the superintendent of financial institutions in Ottawa came to a similar conclusion of a Medicare unfunded liability of over $1 trillion. This is the amount by which taxes would have to rise (over and above the revenues generated by the increases generated by normal economic growth at current tax rates) in order to finance the current unreformed system. My own judgment is that this level of tax increase or rise in the public debt, or combination of the two, is just not in the cards, even though the Government of Canada is clearly running budget surpluses in part to clear borrowing room for the foreseeable rise in pension and medical liabilities due to our ageing population.

But one big problem with the ageing of the population is the way the tax burden is distributed under pay-as-you-go programmes such as Medicare.[8] Pay-as-you-go ("PAYGO") financing means these are funded

[7] http://www.cdhowe.org/pdf/rob-18.pdf

[8] I am indebted for much of this argument about generational inequities in pay-as-you-go financing systems within an ageing population, and the need to encourage individual savings as a result to Guelph University Professor Brian Ferguson, Fellow in Health Care Economics at my Institute.

through intergenerational transfers. That kind of program works fine when the population continues to grow at a constant rate, and/or when per capita output grows, but it doesn't work well when population growth slows.

The issue is simply the amount that each working age individual has to pay in transfers to the older age groups. Even if costs don't grow all that rapidly, the population of taxpayers will not be growing - when the baby boom group retires it may well fall - so the *burden* of payments on individuals can increase faster than the payments as a whole. The drop in the labour supply when the baby boom group retires will drive up the wages of labour which will make the burden on the working age groups less heavy than it might have been otherwise, but the burden will still be growing.

When the dependency burden was primarily youth dependency it would, in principle, have been safe for the government to fund the increased use of educational facilities, pediatric services etc by borrowing because the population benefitting would eventually enter the labour force and pay the taxes which would pay off the debt that had been incurred to build schools and universities for their benefit (we didn't do it sensibly, but that's another matter). You can't do that with an increasing aged dependency burden - the dependent group is not going to be in a position to pay it back, hence the intergenerational equity problem.

One much discussed way of dealing with this is so-called “pre-funding”, or what people who speak like human beings would call savings. Apologists for the current system often advocate public sector saving – in other words taxing people more today than the value of the public services they consume, and setting aside the excess in a fund to be drawn down later to pay health care costs when the public is less able to bear the burden because of population ageing, among other factors. But if, like me, you’ve looked at the way governments run most PAYGO retirement schemes, such as US social security, you’ll share my scepticism about the capacity of governments to run surpluses and invest the funds in the market rather than spend them. Simply paying down the debt isn't necessarily a help here - it increases your capacity to borrow to support the aged population, but that debt still has to be repaid by future working age populations. Debt, after all, is merely deferred taxes, and happily governments have now made it far more difficult for themselves to inflate their way out of the burden of such debt.

Let me add to this that an increasing draw on the scarce resources of the public sector in health care increases the pressure at all times to direct those scarce dollars to where they will produce the greatest public benefit. In that context, consider that some very significant share of public health care spending produces absolutely no measurable benefit whatsoever.

My colleague David Zitner, who is Director of Medical Informatics at Dalhousie University and is also a health care policy fellow at my institute, argues that something like thirty percent of all medical procedures performed today in Canada produce either no benefit, or are actively harmful. According to a study published by Drs. Baker and Norton in the Canadian Medical Association Journal[9], for every 200 people admitted to a Canadian hospital as many as three die from preventable health system error – a

[9] http://www.cmaj.ca/cgi/content/full/170/11/1678

higher rate, by the way, than in the United States. Many more are maimed and hurt because of preventable error.

David Cutler of Harvard says "If you ask 'For what share of all the things that are done in the medical system is there good, hard evidence that in that patient it is an effective therapy?' nobody knows the answer, but it is probably 20%."[10] In other words, the range of useless or even harmful procedures is somewhere between thirty percent and eighty percent of all those performed. And with all those pushy boomer consumers, with their access to the internet and their determination to have access to all the latest diagnostic equipment and techniques regardless of what the system wishes them to have, I personally doubt that this is going to change any time soon as long as consumers of health care services have no direct financial stake in the decisions they make about consuming health care services.

Our best bet is probably encouraging individual saving for future health care consumption. We haven't done enough of it to this point, since individual saving is discouraged by the mere presence of public sector tax-transfer mechanisms - we tend to believe the government when it says that the public system will always be there for us. We probably should be encouraging people to save for their own future health needs – i.e. encouraging medical savings accounts and various other forms of insurance vehicle (another area for future innovation due to demographic change) - and making it clear that these will have to provide a very large portion of future health care needs for a very large part of the population.

We already know what happens when you rely on the public sector - look at Canadian provincial drug plans, for example. Faced with rising costs they reduce coverage and shift costs to the elderly population, who are generally not in a position to absorb those additional costs because they did their past saving on the assumption that the government meant it when it promised them drug coverage. In the UK, the NHS is also explicitly looking at rationing access to care by age, but at least it's being open about it. The irony is that the NHS had only just shaken the reputation that its approach to dealing with the health care problems of the elderly was to put everybody over the age of 60 on an ice-floe and push.

Encouraging saving also helps with some of the funding incidence problems. Private savings, while in part invested in government bonds, are also invested in the markets, meaning in new capital equipment. That means that the returns on those savings are paid out of capital income to a greater degree than tax-transfer systems achieve. And the increase in physical capital investment increases the productivity and therefore the income of labour, easing the burden of any transfers that have to be funded out of tax revenue.

The best bet for increasing private saving is to give MSAs tax breaks – that way there is some loss of government tax revenue, but it's less than the cost of fully funding health care out of tax revenues. Ultimately, of course, we pay for our health care, but it is not at all clear who pays and who benefits. MSAs make it much clearer that individuals are responsible for funding their own future, that they can't assume that their friends and neighbours are going to do it for them, through the tax system.

[10] http://hbswk.hbs.edu/pubitem.jhtml?id=4504&t=special_reports

In addition, the state will have to get out of paying for low-value added services. This means a couple of things. Here in Sweden, you are now used to user fees, which require patients to pay out of pocket for relatively low value services such as doctor visits. In Canada, however, we still insist that the state pay, so we subsidise equally the physician visits of billionaires and paupers. Here we have much to learn from Sweden.

Over and above that, we will have to get much more serious about distinguishing those services that provide real value to patients, and under what circumstances, and restrict public payment to those services. This will require us eventually to decide in advance what proportion of public expenditure we are prepared to devote to health care, and to rank all services in order of importance, excluding the lower value services once the money has been expended on higher value ones. This becomes easy to understand when you realise that it costs the same to insure all Nova Scotians against upper respiratory infections (colds and flu) as it does to insure them all against coronary bypass surgery. Yet there are no effective treatments against upper respiratory infections (untreated, lasts a week, properly treated only lasts 7 days), whereas coronary bypass surgery is the sort of thing that individuals cannot afford to pay for by themselves. If there is to be risk sharing, it makes sense to share the risk of things individuals can never hope to pay for alone.

4. The challenge of globalisation and the limits to what the state can do

Now we come to the final part of the themes I promised to develop with you, and that has to do with the changing context within which our respective governments and societies must react to the challenges I have described.

Between 1970 and the year 2000, Sweden fell from fourth to seventeenth position in the OECD league table of the world's richest countries, expressed in terms of GDP per capita. Similarly Canada, which used to be one of the most attractive places for foreign direct investment, has been falling steadily down the league tables. In spite of creditable productivity performance, in spite of relatively good records in terms of putting our populations to work (another area, by the way, where Canada could learn something from Sweden), we are clearly losing ground relatively, if not absolutely, in the economic world that is emerging.

I don't have time to explain why all of this is happening, but let me say by way of a quick pen portrait that in the postwar period we traded largely inside our own countries, or with countries with cost structures very similar to our own. Well-developed costly welfare states were relatively affordable as a way to prop up the purchasing power of low-income consumers, with the money flowing back to high productivity workers and companies in the form of the purchase of goods and services.

All of that is falling apart. The tremendous freeing of trade that has occurred in the past 25 years or so has meant that high productivity companies and workers in low-cost countries can now compete for and capture those consumer dollars. This means two things. First of all, expensive welfare states are now a competitive disadvantage, especially where the spending does not produce a high return on investment, as I have shown that a great deal of health spending does not. Second, this is not a race to the bottom, but on the contrary, a winning arrangement for everyone in the world, provided we know how to play our

respective roles. After all, the division of labour, as Adam Smith showed, is at the very root of everybody's prosperity. To succeed, we have to concentrate on what we do better than anyone else, or at least in those things where we have comparative advantage, which is not quite the same thing. Because of the liberalisation of international trade, China and India have dragged more people out of absolute poverty than have ever been seen before in the history of the human race.

And it's not just China and India that are getting it, or even just the Asian Tigers. Look right on your own doorstep at, say, Slovakia. According to the BBC[11]:

> Foreign investment in Slovakia is expected to total about £1.5bn (2.2bn euros) this year, twice the amount attracted in 2004. According to the World Bank, Slovakia had the fastest transforming business environment in the world last year, and already comparisons are being drawn with Ireland's economic transformation in the 1990s.

The reasons for the boom seem pretty straightforward:
Low labour costs, low taxes and political stability make this one of the most attractive economies in Europe. Last year, the government replaced its income, corporate and sales tax with a nineteen percent flat tax rate which is now eyed enviously by some Western countries like Austria and Germany and possibly Sweden.

The BBC quotes one observer as saying that investors:

> ".....see that Slovakia is well placed geographically. But I think it's the government's reform of the labour code as well that makes this an attractive place to be. It's much more flexible than western Europe, hiring and firing is easier, and it's easier to work longer hours."

In less than two years, Slovakia is expected to produce more cars per head than any other country in the world.

We cannot turn back the clock. All we can do is to ask ourselves how our societies can change in order to respond to these challenges while preserving what is best about us. I think, at least in the health care field, my talk has laid out some of what has to be done. In summing this up, let me say at the outset, that I believe our countries, Canada and Sweden, have it in them to be world leaders in health care innovation, and that this is, indeed an area where we have in the past shown how much we can do. But this is also an industry that has been hamstrung by highly politicised public policies. These policies have concentrated on public funding of existing techniques and professionals. Because it has been financed by PAYGO and dominated in its decision-making by highly organised and powerful provider groups, health care public policy has been a major roadblock to both technological and managerial reforms. This has indisputably lessened the amount of innovation that we have been able to create, both for ourselves and for export.

[11] http://news.bbc.co.uk/2/hi/europe/4506109.stm

Take just one example; pharmaceutical products.

In a paper just published by Roger Martin, the Dean of the Rotman Business School at the University of Toronto, and James Milway, Executive Director of the Institute for Competitiveness and Prosperity[12], the authors examined the biopharmaceutical sector in Toronto, which because of the presence of many high quality factors of production in that sector, should be a North American leader in R&D and innovation in pharmaceuticals. Instead it lags well behind its peers, such as Boston.

Why? Martin and Milway are unambiguous: "On a per capita basis, Ontarians spend about three-quarters of their U.S. counterparts on drugs. While many applaud this, it represents a public policy choice. We have lower prices, but the lack of a sophisticated buying process means a less well developed cluster and reduced innovation and upgrading from our impressive factors conditions. The single dominant buyer in the process in Ontario differs from the process in the United States — one with multiple buyers who are both demanding and sophisticated as a result of the pressure placed upon them by the end consumer, who is more educated and has multiple choices of health care providers and a system that is less restrictive at the state level."

The outcome is that Canada produces pharmaceutical inventions at half the rate of the US industry, per capita investment in R&D is one of the lowest in the developed world, R&D investment grew 13.5 percent annually versus 32.5 percent in the US, and average wages in Ontario's biopharma cluster are 38 percent lower than in the largest US states. Pretty clearly government policies in Canada squeeze pharmaceutical company profitability. R&D and production activities will, in a globalised pharmaceutical industry, be transferred to the jurisdictions where the greatest post-tax profits can be generated, and that in turn generates investment in R&D effort that, in its turn, generates new discoveries, production, R&D and so forth. The US has created a virtuous circle in this regard, Canada a vicious one.

Yet the argument for bringing virtually all of the health care industry under the control essentially of public authorities is being undermined, in large part by the some of the demographic and cultural factors I've mentioned. Public and medical authorities are losing the ability to determine what health care consumers will accept. The paths by which increasingly wealthy and demanding health care consumers will be able to evade government controls on their consumption of health care services are growing. Our understanding about the value of many health care services is increasing, and we can more and more see that many of them produce little in the way of measurable public benefit. Put this in the context of a population structure that calls into question the equity of a PAYGO system, as well as in the context of a globalising world where public authorities must ensure that their tax burden actually produces significant public benefit, and we have set the stage for a major re-think about health care public policy.

I hasten to underline that I do not believe that absolute taxation burden is a measure of competitiveness. It is perfectly permissible to have a heavy taxation burden if you get high-quality high-value public services in return. But if my analysis of the situation has any merit, we are in fact paying for a high proportion of health care services of doubtful value and paying for them in a way that is generationally highly inequitable. The traditional strategy of restricting access to these services will not work, and in any case

[12] http://www.competeprosper.ca/clusters/biopharmaCluster.pdf

will constitute a major competitive impediment to our specialising in an area where historically we have shown that we are among the best in the world: medical innovation.

Only by taking advantage of the shift to the discriminating health care consumer, by shifting part of the cost of medical decisions to them, through sophisticated tax-assisted insurance products such as medical savings accounts, can we turn what has been a growing competitive disadvantage into an advantage, harnessing this incredible sophisticated buying power and investment capital to our capacity for medical innovation. And we can contribute more than we are able to today to dealing with the many diseases that we cannot yet control, let alone cure. In that context, I believe that reform is not merely an economic imperative, but a moral one as well.

Thank you and best wishes in your deliberations today.

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