Indeed, Fox's letter is a cogent reminder that the introduction of the electronic medical record (EMR), which holds great promise for standardizing data collection, archiving important information and facilitating the sharing of patient records among physicians and institutions, may nevertheless enforce the tendency to divorce the data from the patient. This concern is particularly prominent if the focus of an EMR is on collecting information that can be coded and categorized. In contrast, if electronic systems adopt the approach of explicitly reminding practitioners to record daily narratives, the EMR could increase the use of narrative medicine principles. Perhaps we should encourage technologically inclined house staff to "blog" rather than to "chart" information for their patients!

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Reference

1. Bayoumi AM, Kopplin PA. The storied case report. *CMAJ* 2004;171(6):569-70.

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More arithmetic of health care

Contrary to the claims of Janice MacKinnon,[1] the most recent data from the Organisation for Economic Co-operation and Development (OECD), for 2002, show that Canada ranked sixth, not third, in terms of health care spending as a percentage of gross domestic product (GDP) (data available through OECD Web site at www.oecd.org/home/).

Furthermore, Canada is the only OECD country where health spending as a percentage of GDP actually declined over the past decade (from 10% in 1992 to 9.6% in 2002). By contrast, health spending as a percentage of GDP in the United States (with its multitude of user pay schemes) increased from 13% in 1992 to 14.6% in 2002.

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Reference

1. MacKinnon JC. The arithmetic of health care [editorial]. *CMAJ* 2004;171(6):603-4.

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Janice MacKinnon's health care arithmetic is incorrect.[1] She uses a figure of 8% as the annual rate of growth of health care costs in Ontario, but this value is based on current dollars and therefore does not take into account inflation or growth of the population.

The correct calculation should be based on per capita spending of constant dollars. The Canadian Institute for Health Information gives the following figures for annual rate of growth in these terms: 2.6% from 1974 to 1991, –0.03% from 1991 to 1996, and 4.4% from 1995 to 2003.[2] It is highly probable that the negative rate of growth for 1991 to 1996 corresponds to the decrease in health care transfers that occurred during the early 1990s; the subsequent increase in rate of growth is due to the replacement of part of those funds.

Furthermore, MacKinnon's reference to the increasing percentage of provincial budgets devoted to health care[1] is almost irrelevant, since the percentage depends on revenues as well as on expenditures. The provincial governments have decreased their revenues by cutting income taxes but have then implied that the increased percentage spent on health care is due to an increase in expenditures.

Finally, all the figures quoted so far have been for total health care expenditures, but what we should be debating are expenditures for the public health care system (and the services provided). The cost of our medicare system is the amount spent by the provincial governments, equivalent to 63.8% of total health care costs.[2]

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1. MacKinnon JC. The arithmetic of health care [editorial]. *CMAJ* 2004;171(6):603-4.
2. *National health expenditure trends 1975–2003*. Ottawa: Canadian Institute for Health Information; 2003. p. 5.

DOI:10.1503/cmaj.1041621

Janice MacKinnon's commentary[1] is a classic: her arguments are resilient, used time and again regardless of their flaws.

It is all about the denominator, which in this case is revenue. Health care expenditures are indeed rising faster than revenues — that is apt to happen when revenues are foregone because of tax cuts.

According to the economist Armine Yalnizyan[2] the rise in health care expenditures of all provinces and of the federal government since 1996 has been $108 billion, an arresting figure. However, this increase pales in comparison with the revenue foregone by the same jurisdictions over the same time frame, which amounts to $250 billion.

In other words, governments in Canada have given priority to tax cuts over social programs. Ontario's Premier Dalton McGuinty, whom MacKinnon quotes, won an election by giving priority to social programs over tax cuts. It is those priorities that need to be debated, not the question of dismantling the single-payer health care model in favour of more expensive and less safe alternatives.

Other facts, no doubt well known to MacKinnon, do not make an appearance in her commentary, such as the fact that health care expenditures as a percentage of GDP are at the same level as 10 years ago.[3] This is not the picture of out-of-control growth she is trying to portray.

Yes, change is needed, and the sooner the better. That view is unanimous across Canada. But privatization, taxing the sick and other related "remedies" are not the answer.

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References
1. MacKinnon JC. The arithmetic of health care [editorial]. *CMAJ* 2004;171(6):603-4.
2. Yalnizyan A. Can we afford to sustain medicare? A strong role for federal government [position paper]. Ottawa: Canadian Federation of Nurses Unions; 2004 Aug.
3. *Health care in Canada, 2004*. Ottawa: Canadian Institute for Health Information; 2004.

DOI:10.1503/cmaj.1041640

[The author responds:]

The Conference Board of Canada study[1] that I referred to in my commentary[2] compared 24 OECD countries, rather than all 30, and Canada was third in overall spending on health care in that comparison. My arithmetic on Ontario's health care spending — an average annual increase of 8% per year for the last 5 years — is based on information published by the province's finance department.[3] If constant dollars are used for health care spending, then government revenue has to be stated in comparable dollars. The result would be the same: in the last 5 years Ontario's health care costs have increased by 42% while revenue has grown by only 31%, a gap that is not sustainable.

Measuring health care costs relative to GDP omits key costs, such as the debts of hospitals and health boards, and the cost of replacing outdated equipment and facilities — about $10 billion in Ontario alone. Also, government revenue does not increase at the same pace as the economy grows and is projected to decline relative to GDP in the next 20 years.[4]

Even left-wing provincial governments have reduced corporate and income taxes to compete in attracting investment and highly educated people. Raising taxes is no panacea and could undermine the economic growth that generates revenue for health care.

What does rhetoric like "privatization" and "taxing the sick" mean? Our health care system is already a mix of public and private: Are doctors public servants or private practitioners? People already pay directly for some health care services. Why not debate what should be paid for, why and how?

Just as governments could not consistently spend more than they collected in revenue in the 1990s, health care costs cannot increase indefinitely at a faster rate than government revenue. Also, such increases are crowding out spending on education, the environment and poverty reduction, key factors in promoting a healthy population.

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1. *Understanding health care cost drivers and escalators*. Ottawa: Conference Board of Canada; 2004.
2. MacKinnon JC. The arithmetic of health care [editorial]. *CMAJ* 2004;171(6):603-4.
3. *Annual report and consolidated financial statements, 2002-03*. Toronto: Ontario Ministry of Finance; 2003.
4. MacKinnon J. The arithmetic of health care. *Policy Matters* 2004;5(3):1-28. Available: www.irpp.org/fasttrak/index.htm (accessed 2005 Feb 2).

DOI:10.1503/cmaj.1050015

Corrections

In a recent Public Health article,[1] the correct dosage for erythromycin should have been given as 500 mg (not 50 mg) four times daily for 14–21 days (depending on severity and response to treatment).

Reference
1. Weir E. Lymphogranuloma venereum in the differential diagnosis of proctitis. *CMAJ* 2005; 172(2):185.

DOI:10.1503/cmaj.050189

In a Public Health article on SARS,[1] two errors have been identified: BUN should be urea and creatine should be creatinine.

Reference
1. Borgundvaag B, Ovens H, Goldman B, Schull M, Rutledge T, Boutis K, et al. SARS outbreak in the Greater Toronto Area: the emergency department experience. *CMAJ* 2004;171(11):1342-4.

DOI:10.1503/cmaj.050190