References
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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References
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