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# PAYING FOR THE HEALTHCARE WE WANT

MARK STABILE <sup>1</sup>

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## THE PROBLEM

Well before the great recession of 2008, Canada's healthcare system was sending out signals that it had a financing problem. Healthcare costs in Canada have outpaced growth in tax revenue and gross domestic product (GDP) for much of the past few decades. While there have been times of faster and slower growth (during the 1990s while the federal government balanced the budget, healthcare cost growth slowed significantly), on average between 1980 and 2006 the annualized growth in healthcare expenditures was 7.5%. The average annualized growth in GDP over that same period was 6.1%. The result is that we now spend considerably more on healthcare, both in absolute terms and as a percentage of GDP, than we did in 1980.

On the whole, this is certainly a good thing. Healthcare has improved tremendously over this time period with new technologies, procedures, and medications that have helped many people. No doubt, some of the spending increase has been wasteful, some of the care may be excessive or of marginal benefit, and some may even be harmful, but the overall story is one of success. Most of us would not want to return to the healthcare system we had in 1980.

Over this same period, governments have increased the proportion of their budgets that they spend on healthcare. The Ontario government spends approximately 40% of its total budget on health: in 1980 this figure was less than 30%. This increase is a function of many things: shares consist of both a numerator (healthcare spending) and a denominator (all public spending) and these are subject to changes in economic growth, tax policy, and policy decisions on spending for other things. But, overall, healthcare has become the most significant item of public spending by provinces. Again, there are many good reasons for this, and Canadians have indicated time and again that they prefer a majority publicly-financed, universally-accessible healthcare system that provides high quality care based on need. This is, however, an expensive proposition, hence the financing problem described above.

It is important to note that this problem is in no way unique to Canada. Across the OECD, in countries with systems that are similar to ours, and in countries with systems that are quite different, healthcare costs are growing faster than GDP. Indeed, when one looks at the countries that we typically

**Mark Stabile** is Founding Director of the School of Public Policy and Governance at the University of Toronto and Professor of Economics and Public Policy at the Rotman School of Management. He is also a Research Associate at the National Bureau of Economic Research, Cambridge Massachusetts and a fellow at the Rimini Centre for Economic Analysis, Italy. From 2003 – 2005 he was the Senior Policy Advisor to the Ontario Minister of Finance where he worked on health, education, and tax policy. He has also advised the Governments of both Canada and Ontario on health care reform.

compare ourselves to in terms of economic development – including the UK, continental Western Europe, and the broader commonwealth – there is no country in which healthcare costs have grown more slowly than the overall economy.

This is both comforting and concerning. It is comforting because it suggests that it is not the Canadian Medicare model that is at the root of the problem. The problem is universal. It is concerning because it suggests that efforts to make our system work better – more efficiently, more equitably, and with better quality – while clearly important and necessary, are not on their own likely to solve our financing problem. All of the healthcare systems in the developed world are trying to make their systems more efficient, less wasteful, etc. Many are far ahead of Canada in terms of important reforms to payment and delivery within the public system. Once again, none have succeeded in getting healthcare costs to grow more slowly than GDP.

It is also worth noting that the financing problem I have described does not suggest that the healthcare system is not economically sustainable. There is no single right answer to the question “how much of our GDP should we spend on healthcare?”. Most wealthy countries spend around the same as Canada. A few spend a little more. All have seen growth in the amount spent on healthcare. Rich nations have the luxury of spending on things they value and if Canadians are getting valuable care from their healthcare system, there is no reason why we should not spend more on health and less on other goods. But we do need to figure out how we are going to pay for it.

Economic sustainability is not the same as fiscal sustainability. What is clear is that, across Canada, governments cannot afford to pay for the healthcare system we have now, along with all other public expenditures, employing only the current revenue base. Most provinces are in significant deficit. All are dependent on large transfers from the

federal government continuing past 2014. Some efficiencies are certainly possible, but if we want more healthcare in the future, we will almost certainly need to pay more for it. So where should the money come from? Public or private sources?

## OPTIONS FOR REFORM

Given that we will almost certainly be spending more on healthcare tomorrow than today (forecasts across the OECD are in agreement that healthcare costs in the developed world are going up, not down, over the next 50 years), we need to decide how we will pay for it. The options for increasing revenue fall into four broad categories:

- 1 Increase the taxes we already have in place.
- 2 Cost-share with patients in the form of user charges, deductibles, etc.
- 3 Allow for more private financing/ insurance.
- 4 Diversify public funding streams with new public revenue models.

Note that none of these options preclude finding more efficiencies, reducing waste, and improving quality in the system – we need continually to do all of these as well!

### Raise taxes

Option one, raising taxes, is certainly a possibility. Taxes as a share of GDP have come down in Canada over the last decade, so there is an argument to be made for raising certain taxes again. The benefits of general taxation are well established, but the public resistance to tax increases remains, so I will not spend time on them here.

### Cost-sharing

There have been several proposals over the years to increase cost sharing with patients.

<sup>1</sup> I would like to thank my co-authors for work that I draw on for this article: Irfan Dhalla, Colleen Flood, Jacqueline Greenblatt, Sevil Marandi, and Carolyn Tuohy. I would also like to extend a special additional thank you to Carolyn Tuohy for an ongoing collaboration and exchange of ideas that has significantly influenced my thinking.

Most recently, Quebec proposed a healthcare deductible on doctor visits. There are two main arguments in favour of such a proposal. First, if one believes that there is inefficient use of healthcare services that is patient driven, then imposing some price on care will increase efficiency. Second, cost sharing has the potential to raise revenue.

Economists, including myself, have argued that using cost sharing to raise revenue is not likely to be a particularly fruitful policy option. There are several reasons for this. First, cost-sharing systems are expensive to set up and administer. Second, given our values in Canada, we mostly agree that any system of cost sharing should exempt the poor and people who are very sick and need to make heavy use of healthcare services. However, since the poor and sick are the biggest users of healthcare (the two often go together) exempting them from user charges (which I agree is a good idea) significantly reduces the revenue that can be raised by such a system. These two points together mean that cost sharing is unlikely to solve our revenue problem.

#### Increased private funding

Canada's public-private spending mix has hovered around 70% public, 30% private for several years. This is on the low side of public financing compared to many OECD countries. One reason for this is the nature of the public-private mix in Canada. In WHO parlance, Canada has complementary private insurance: private insurers cover items/sectors of health that are not covered publicly. For example, since pharmaceuticals outside the hospital are not covered publicly for many Canadians, a large share of Canadians have private insurance to cover such expenses.

Given the large role that pharma plays in modern medicine, it should not be surprising that Canada's private share of financing is relatively high. Jurisdictions such as the UK and Sweden have supplementary private insurance systems in which private insurance

is available to cover items that are also covered by the public system. Individuals choose private coverage because it offers some amenities not provided publicly, such as shorter waiting times, nicer facilities, etc. (they cannot, though, opt out of paying for

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## Private supplemental insurance does not offer a ready solution to the problem of increasing public healthcare costs

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public care through general taxation).

Some have suggested this option as a solution to Canada's public healthcare financing problems. A few points are worth noting here. First, countries that have such systems in place still have the same financing issues that Canada has: public healthcare costs are growing faster than GDP. Therefore, the existence of this type of private insurance does not, in and of itself, eliminate financing problems. Second, these countries generally have a higher share of public health spending (usually above 80%) and broader public coverage than Canada does. Private systems there are generally small, covering around 10% of individuals. Their share of total health expenditure is even smaller, often at only around 1%. Third, what evidence there is on the relationship between public and private supplemental systems suggests that private insurance does not decrease costs in the public system. If anything, public expenditure often increases through complementary utilization, increased overall utilization, and the fact that tax subsidies for private insurance are built into many tax codes (including ours: employer contributions to employee health insurance are not taxable).

Therefore, while it is fair to say that countries can have private supplemental insurance and remain committed to public,

universal and accessible insurance (both the UK and Sweden would be good examples of this), private supplemental insurance does not offer a ready solution to the problem of increasing public healthcare costs.

#### New public revenue models

The final option for increasing revenues available for healthcare is to diversify the public financing stream. I have argued elsewhere, along with colleagues from the University of Toronto, that one possible expansion would be to incorporate more social insurance funding into the Canadian healthcare system.<sup>2</sup>

## A national body that evaluates both medical technologies and best practices, across sectors and types of providers, is a key element

Many European countries use social insurance funding – characterized by a clearer link between funds collected and benefits received – to finance parts of their system. The experience in such countries suggests an increased willingness to pay on the part of citizens if they clearly perceive the connection between premiums and benefits. Often collection systems are arm's length from the government. Individuals are required to pay a monthly amount that is scaled to earnings, which is used to cover the cost of the health services provided. In many European systems employers are also required to contribute on behalf of their employees. The fund is usually kept separate from general tax revenues, although in some jurisdictions, general taxes are used to augment the fund where necessary.

Public finance theory suggests that earmarking funds in this way is not optimal and

can create inefficient restrictions in public allocations. However, the benefits of providing increased public funding to sustain and extend public coverage (funding prescription drugs through a social insurance pool might be the ideal place to begin), of tapping into willingness to pay for increased healthcare costs among Canadians, and of potentially increasing the redistribution of risks and income among Canadians through a broader Medicare basket, outweighs, in my view, the costs of such a scheme. Given the limitations of the other possibilities for increasing revenue, this final option has the greatest potential both to improve the scope and quality of the healthcare system, and to meet with (limited) public approval.

#### WHAT SHOULD BE COVERED BY PUBLIC FINANCE?

Raising more revenue will not, on its own, be sufficient to sustain the healthcare system over the long run. It must be coupled with a strong movement towards evaluation of what should and should not be publicly funded, and a rebalancing of the role of the private sector to cover care that does not meet the criteria for public funding. A national body that evaluates both medical technologies and best practices, across sectors and types of providers, is a key element in making sure that public revenues are allocated to the most effective forms of medical treatment. When a drug provides significant benefit at a modest cost (e.g. insulin for diabetics), it would be covered for all who stand to benefit. When practice decisions by physicians result in high costs and little benefit, they would not be reimbursed (e.g. MRI scans for minor headaches and back pain).

Canadians will have to recognize that the public sector cannot cover all tests and treatments regardless of how minimally effective they may be. Where the potential benefits of diagnostic testing/treatment do not merit public funding, it is reasonable to expect that individuals who still choose

<sup>2</sup> See Flood, C., Stabile, M. & Tuohy, C. (eds.) (2008) *Exploring Social Insurance: Can a Dose of Europe Cure Canadian Health Care Finance?* McGill-Queen's University Press, and Stabile, M. & Greenblatt, J. (2010) "To Prefund Pharmacare for Canadian Seniors... or Not?" *IRPP Study No. 2*.

to pursue such care should be free to do so outside the public system, using personal resources.

All of these changes are possible without undoing any of the current structure of Canadian Medicare, including any changes to the Canada Health Act. The remaining challenge is getting from here to there.

#### A ROADMAP FOR CHANGE

There is a role for strong federal leadership in moving towards these changes in Canadian Medicare. The 2014 negotiations offer the opportunity for the federal government to foster coordination on both evaluation and on diversifying funding streams. Along the way, there is scope to address the growing perception among the young of intergenerational inequities (in financing and care) by gradually shifting the nature of public coverage. The following steps could be part such a transformation:

- 1 Use the 2014 negotiation to agree on a framework for diversified public funding. Options here include having the federal government act as the collection and redistribution agent for social insurance premiums and using these funds to replace some or all of the current Canada Health Transfer. If the federal government were to take on collection, it could also phase in tax point transfers to the provinces to increase the overall amount of funding available while keeping its revenue share about the same. The federal government does not, though, have to act as the collection agent. It could promote this change while taking a back seat in terms of implementation.
- 2 In those provinces where drugs are covered for the elderly but not the general population, eligibility by age could be gradually phased out by raising the eligibility age over time, while

simultaneously phasing in drug coverage through social insurance premiums. This would leave coverage for the current elderly in place but reduce the claim of the baby boom on a drug plan funded by younger generations, thereby improving intergenerational equity.

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- 3 In those provinces with more general drug coverage, such as Quebec and BC, the coverage budget could be more explicitly linked to social insurance premiums and phased in over time.
- 4 The federal government could establish, or require the establishment of, a national evaluative body (it need not be a federal body). This body could build on the experience and expertise of existing provincial bodies (although thus far the existing provincial bodies have not reached the scale that would be required to properly evaluate technology and best practice at the level of, for example, the National Institute for Health and Clinical Excellence in the UK). Buy-in to the recommendations

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of this body could be required for receipt of federal transfers through both the Canada Health Transfer and any future social insurance framework. A benefit of a national organization for evaluation is that there would be greater consistency in coverage across Canada. Currently, provinces that deem technologies ineffective are often pressured into reversing decision because the same technology is offered elsewhere in Canada.

- 5** As public coverage for all truly medically necessary services increases, the role of private insurance would change, with complementary insurance covering those items deemed insufficiently cost-effective for public coverage. The private market for this care and coverage would likely be small but sustainable. There are many items/treatments which are unlikely to yield sufficient benefit to secure public subsidy, but for which there is significant consumer demand.

If these changes were adopted, the Canadian healthcare system in 2020 would have kept the best of what we have, and built in elements – diversified public funding, effective evaluation of technologies and practices, and universal access to important medical care regardless of type – that other successful societies have adopted and tested. It would allow all Canadians access to those services most essential for improved health, not just those we deem important today, but those that will emerge going forward. Perhaps most important of all, it would put in place sufficient revenue to fund broad-based public healthcare, alongside structures to ensure that we only fund those services that are the most valuable. ■

<sup>3</sup> Measurement of patients' satisfaction and of subjective quality of experience has been extensively studied, particularly in the context of chronic diseases. A good review of the question can be found at <http://phi.uhce.ox.ac.uk/home.php>.