Financing Health Care in Canada

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Our “system” has a funding problem going forward – medium term will require more revenue.

We’re not alone.

Improving efficiency and quality will help but will likely not be enough.

Long term will require both a diversification of revenue and restructuring of the role of private insurance.
Fiscal versus Economic Sustainability

- Economic sustainability: how much do we want to spend on health?
  - Open for debate.
- Fiscal sustainability: do we have the revenue base to finance the system we have in place?
  - No.
Canada is not unique

Source: OECD Health Data, 2009
Growth rates over different periods

Source: OECD Health Data 2008
What are the revenue options out there:

- Increase personal, consumption or business taxes
- Cost share with patients
- Allow various forms of private financing
- Diversify the public funding mechanisms
  - E.g. Social insurance
Data from OECD suggest rev/gdp has fallen
Comments on Raising Taxes

- Likely most progressive revenue source
- Political reality, however, is that this is unlikely in near term.
- What polling we have suggests that Canadians are much more willing to consider diversified funding than general tax increases.
Canadians may be more supportive of a CPP/QPP model than other ways of raising revenue ....

% saying “very” or “somewhat” good idea

Source: Ipsos-Reid poll for CMA, March 2010
Cost Sharing:

- E.G. Quebec proposed Health deductible/User Fee
- $25 dollars every time you go to the doctor
- Subject to a cap – 1% of “net” income where net income includes a deductible based on your family size.
- Pros: Makes people aware of use, some revenue
- Cons: Sick pay more, not much revenue
Why so little $? (Forget et al., 2002)

Fig. 2: Annual per capita expenditure (hospital and physician) by decile, Apr. 1, 1997, to Mar. 31, 2000.
## Private Financing

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<th>Driver of market development</th>
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<td>Substitutive</td>
<td>Public system inclusiveness (proportion of the population eligible for public cover)</td>
<td>Covers people excluded from or allowed to opt out of the public system</td>
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<td>Complementary (services)</td>
<td>Scope of benefits covered by the public system</td>
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<td>Complementary (user charges)</td>
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<td>Covers statutory user charges imposed in the public system</td>
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<td>Consumer satisfaction (perceptions about the quality of publicly-financed care)</td>
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<td>Ireland, Poland, Romania, Spain, Sweden, UK</td>
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Source: Adapted from Mossialos and Thomson (2002b) and Foubister et al (2006)
Economic Evidence on Private Supplemental

- Economic Theory on Effects of Private Insurance is ambiguous

- Empirical Evidence tends to lean one way:
  - Physician shifting
  - Less attention to public lists
  - Increased demand
  - Cream skimming
  - No reduction of cost
  - Often increase in tax expenditures
Economic Evidence on Private Complementary

- Increased use of public services as complements to private care
- Less efficient use of public system if it undoes public cost control measures
Social Insurance

- A method of raising revenue
- Contributions are usually related to salaried wages (and are always independent of risk)
- Contributions may be shared between employers and employees
- Revenue is earmarked for health care
- Collection agent is usually arms length from government
- Participation is mandatory (for the population or specified groups)
Social Insurance and/or Pre-Funding as a Potential Solution for Canada

- Use a social insurance framework to fund part of health care – prescription drugs and/or long term care would be a good place to start.
- Could be pre-funded or pay as you go.
- Would keep all CHA tax-financed services intact. *Don’t undo the current system.*
Why prefunding? Why Drugs?

- Consider role of insurance versus savings and redistribution.
- When does insurance work?
- Focus on drugs for now. Why?
Drug spending growth has been larger than most areas of health care

Source: CIHI, National Health Expenditure Database
Almost all elderly are using prescription drugs

From: S. Morgan
Health Serv Res. 2006 April; 41(2): 411–428.
All health care: very skewed
  - 75% of physician and hospital expenditure for 65+ concentrated among the top 10% (Manitoba)

Drugs: much less so
  - <40% of drug expenditure for 65+ concentrated among top 10% (BC)
Possible phasing for SI:

- Use 2014 negotiation to agree on framework for diversified public funding. Option: have feds act as collector and have funds replace some of CHT.

- In provinces with public coverage for the elderly: raise eligibility age over time coupled with phasing in of drug coverage through SI. This leaves coverage for current elderly in place.

- In province with general coverage: coverage could be more explicitly linked to SI funding stream.

- Need to couple this with a body to evaluate technology and best practice!
Pros

- Builds on an extensive framework of payroll based payment for non-CHA services (social insurance)
- Direct link between benefit and payment – evidence from Europe suggests this contributes to greater public support.
- Could free up one of the fastest growing portion of most provincial health budgets.
- Assures next generation that they will not be saddled with growing health care costs (at least not as much).
Social insurance frameworks tend not to be quite as progressive as income general taxation. The tax base matters.

But more progressive than indirect taxation such as GST.

Taxes affect economic activity – potential for job loss.
Differences in financing across jurisdictions

Fig. 2.2b  Breakdown of contribution mechanisms by country, 2005

Legend:
- Tax
- SSC
- PHI
- OOP
- Other

Countries: NL, FR, EL, BE, SI, SK, CZ, GR, DK, SE, UK

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Conclusions

- Best predictor going forward: we will spend more on health care tomorrow than we do today.

- Discussion needs to address what the best way to pay for this will be.

- My view of evidence supports diversification of public financing in the short term over private financing. Couple this with stronger evaluation of technology and practice.

- In the longer term, restructuring of complementary nature of our insurance is also required.
Thank you.
## Country abbreviations

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Interesting test case for all the reasons given above (eligibility, spending by age, growth rate)

- 2010-11 spending: $3.5 billion
- 2010-11 expected growth rate of ~7% (vs. 6% in health spending generally)
- 8 percent of Provincial Ministry of Health and Long-Term Care spending

Prefunding would require a yearly contribution (on average across income groups, etc) of between $320 and $1800 depending on the future growth rate of prescription drugs.

Big cost! But the cost will be there regardless of how we fund it.
Trend in Health Care Spending
Fig. 2.5 Private health insurance as a percentage of total expenditure on health in the European Union, 1996 and 2005