



True North in  
Canadian public policy



# **Toward a more fair medicare:** **Why Canadian health care isn't equitable or** **sustainable and how it can be**

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# Executive Summary

Health care is expected to loom large at the July 2016 meeting between the prime minister and provincial and territorial premiers. The Trudeau government has committed to a new health accord and there are plenty of unanswered questions about the goals and design of such an agreement. Reducing wait times, improving access to doctors and medical technology, and better controlling costs are no doubt to be part of these discussions especially as concerns mount about the sustainability of health care spending.

It will also be important, however, to assess how the current health care system is living up to the principle of universality. The truth is the current model of health care financing is less universal and egalitarian than Canadians have been led to believe.

Canada's single-payer model for hospital and physician services leaves little public monies left over to help low- and middle-income Canadians cover the costs of uninsured services and treatments such as drugs, dental, and out-patient services. The result is Canadians must pay these costs through private insurance or out-of-pocket spending irrespective of income or family circumstances (see table). Put simply: Canada's current system of public health insurance is a mile deep and an inch wide.



## Total health care expenditures and financing sources in Canada, 2014 (billions)

	Total spending	Public financing (%)	Private financing (%)
Total health care expenditures	\$215.7	70.8	29.2
Hospital services	\$63.5	90.5	9.5
Physician services	\$33.3	98.5	1.5
Drugs	\$33.8	36.3	63.7
Other institutions	\$22.6	70.3	29.7
Dental services	\$13.2	6.2	93.8
Capital	\$11.7	72.2	27.8
Vision care services	\$4.2	8.7	91.3

*Source: Canadian Institute for Health Information, 2015, National Health Expenditure Trends, 1975-2015.*

Other countries are able to provide universal coverage for a broader range of health care services while minimizing the cost to taxpayers by relying on a different mix of user fees and public subsidies for private insurance. Herein lies a lesson for Canada.

This study examines how health care is financed in Canada, how its financing differs with comparable jurisdictions, and how the present imbalance between public and private financing *actually* makes Canada's health care system less egalitarian and universal and frankly more American than we may think.

It then sets out recommendations to draw on greater private financing for hospital and doctors' services from high-income Canadians in the form of patient cost-sharing in order to enable governments to extend public financing to low- and middle-income families to help cover the cost of presently uninsured services and treatments. Ottawa would need to amend sections 18-21 of the *Canada Health Act* to authorize the provinces and territories to enact these new cost-sharing measures.

The result would not be to undermine universality but rather to strengthen it. Governing is about making choices on how to use scarce public resources and the present health care financing model is both increasingly unsustainable and failing live up to the principle of universality. The goal of the prime minister and the premiers should be to make progress on both fronts by using private financing to broaden universal health care coverage and minimize the strain on government budgets.

# Sommaire

On s'attend à ce que les soins de santé occupent une place importante à la rencontre de juillet 2016 entre le premier ministre canadien et les premiers ministres provinciaux et territoriaux. Le gouvernement Trudeau s'est engagé à négocier un nouvel accord sur la santé, mais de nombreuses interrogations concernant les objectifs et la conception d'un tel accord n'ont pas encore trouvé de réponse. La réduction des temps d'attente, l'accès amélioré aux médecins et aux technologies médicales et un meilleur contrôle des coûts feront sûrement partie de ces discussions, notamment parce que la viabilité des dépenses de services de santé est un enjeu de plus en plus préoccupant.

Il sera également important, toutefois, d'évaluer dans quelle mesure le système de soins de santé actuel adhère au principe de l'universalité. En fait, le financement actuel des soins de santé repose sur un modèle moins universel et égalitaire qu'on l'a fait croire aux Canadiens.

Le modèle canadien de payeur unique axé sur les hôpitaux et les médecins ne dégage que très peu de fonds pour aider les Canadiens à revenu faible et moyen à assumer les coûts des services et des traitements non assurés comme les médicaments, les soins dentaires et les services ambulatoires. Pour bénéficier de ces services, les Canadiens doivent souscrire à une assurance privée ou utiliser leurs propres ressources, quel que soit leur revenu ou leur situation familiale. En termes simples, le système public actuel de soins de santé au Canada est très étendu mais incomplet.

## Dépenses Totales De Soins De Santé et Sources de Financement au Canada, 2014 (Milliards)

	Dépenses totales	Financement public (%)	Financement privé (%)
Dépenses totales de santé	215,7 \$	70,8	29,2
Services hospitaliers	63,5 \$	90,5	9,5
Médecins	33,3 \$	98,5	1,5
Médicaments	33,8 \$	36,3	63,7
Autres institutions	22,6 \$	70,3	29,7
Soins dentaires	13,2 \$	6,2	93,8
Immobilisations	11,7 \$	72,2	27,8
Soins de la vue	4,2 \$	8,7	91,3

En s'appuyant sur une combinaison de frais modérateurs et d'aides publiques pour l'assurance privée, divers pays sont en mesure d'offrir une couverture universelle plus complète en matière de services de santé tout en réduisant au minimum les coûts pour les contribuables. Il y a là une leçon à tirer pour le Canada.

Nous examinons dans cette étude le financement des soins de santé au Canada, ce qui le distingue de ceux de pays comparables et la mesure dans laquelle l'actuel déséquilibre entre le financement public et privé *rend effectivement* le système canadien de soins de santé moins égalitaire et universel et, franchement, plus américain qu'on pourrait le croire.

Nous formulons ensuite certaines recommandations relatives à la participation financière accrue des Canadiens à revenu élevé sous forme d'un partage des coûts des services hospitaliers et médicaux entre le gouvernement et le patient, afin d'élargir le financement public aux services et aux traitements non assurés actuellement et d'aider les familles à revenu faible et moyen à assumer ces coûts. Ottawa se verrait alors dans l'obligation de modifier les articles 18 à 21 de la *Loi canadienne sur la santé* pour autoriser les provinces et les territoires à adopter de nouvelles mesures de partage des coûts.

Le résultat n'affaiblirait pas le principe de l'universalité, bien au contraire. Gouverner, c'est faire des choix sur la manière d'utiliser les ressources publiques limitées, et l'actuel modèle de financement des soins de santé est de plus en plus insoutenable, tout en étant incapable de respecter le principe de l'universalité. Le premier ministre canadien et les premiers ministres des provinces devraient chercher à avancer sur les deux fronts : donc, recourir au financement privé pour renforcer la couverture universelle des soins de santé et réduire la pression sur les finances publiques.

# Introduction

The Trudeau government has promised a new health accord with the provinces and territories and there are plenty of unanswered questions about the goals and design of such an agreement.

There is no question though that health care reform is needed. Health care spending in Canada continues to climb with no end in sight. A combination of an aging population, advancements in medical technology, rising incomes, and other factors have put health care costs on an unsustainable trajectory. The risk is that health care will come to consume more and more public dollars at the expense of education, infrastructure, and other productive investments in what has been described as a “looming fiscal squeeze” (Ragan 2012).

Not only is current health care financing increasingly unsustainable, the health care system is less universal and egalitarian than Canadians have been led to believe. Canada’s single-payer model for hospital and physician services leaves little public monies left over to help low- and middle-income Canadians cover the costs of uninsured services and treatments such as drugs, dental, and out-patient services. The result is Canadians must pay these costs through private insurance or out-of-pocket spending irrespective of income or family circumstances. Put simply: Canada’s current system of public insurance is a mile deep and an inch wide.

Other countries are able to provide universal coverage for a broader range of health care services while minimizing the cost to taxpayers by relying on a different mix of cost-sharing (such as co-payments or co-insurance) and regulation and public subsidies for private insurance. Herein lies a lesson for Canada. Changing the mix between public and private financing could allow the government to extend public financing for low- and middle-income families to help cover the cost of presently uninsured services and treatments and better achieve the principle of universality without placing greater strain on provincial budgets.

*Canada’s health care system is less egalitarian and universal than we may think.*

That is the subject of this study. We examine how health care is financed in Canada, how its financing differs with comparable jurisdictions, and how the present imbalance between public and private financing *actually* makes Canada’s health care system less universal than we may think.

The study’s first section will document how health care spending is increasing throughout the OECD, including in Canada, and will continue to rise due to a

combination of factors such as aging demographics. The second section will provide a basic primer on the mix between public and private health insurance in Canada and how it compares to similar jurisdictions. The final section will set out recommendations to better leverage private financing in Canadian health care.

We are *not* proposing to challenge the principle of universality. To the contrary. Governing is about making choices on how to use scarce public resources and the present health care financing model is both increasingly unsustainable and failing live up to the principle of universality. The goal of the prime minister and the premiers should be to make progress on both fronts by using private financing to broaden universal health care coverage and minimize the strain on government finances.

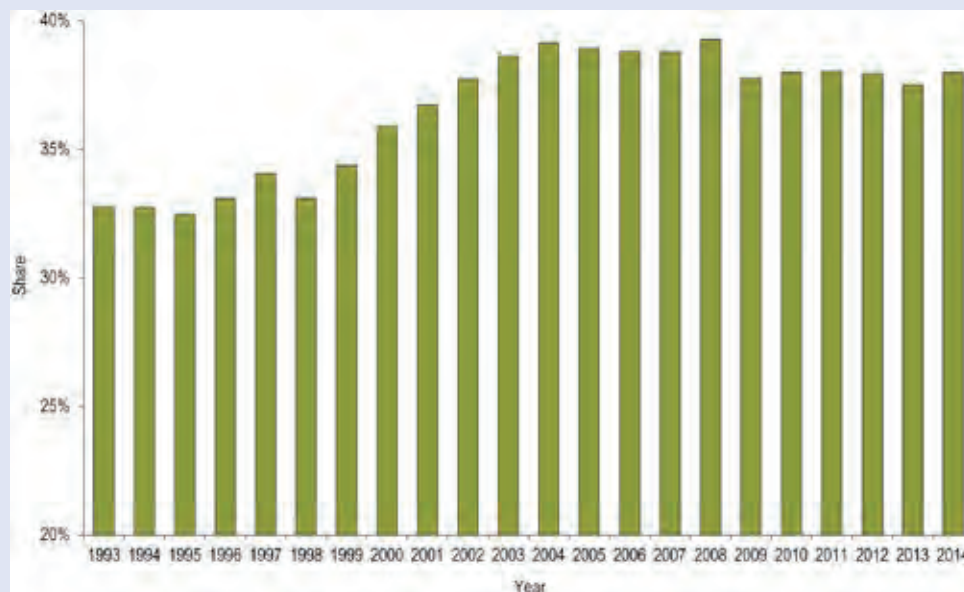


# Rising Health Care Spending: An Inescapable Reality

Health care spending is rising in Canada. It is hardly a controversial observation. A large body of analysis has documented its rise over the past two decades. The story is increasingly well known.

Health expenditures now represent a major share of provincial spending – reaching nearly 40 percent across all provinces and territories (see figure 1). Even in recent years when spending growth has been better controlled, we have still witnessed a continued rise in health care expenditures. A report by Deloitte, for instance, forecasts health spending to grow faster than GDP between 2014 and 2018, meaning that health care's share of the overall economy will continue to rise over the short term (Purdy 2015). The Parliamentary Budget Office (2016) has recently reported that overall provincial spending is unsustainable mostly due to health care spending. The point is: rising health care costs are an inescapable reality for Canadian politicians, public servants, patients, and taxpayers.

**Figure 1: Provincial/territorial health expenditures as a share of total provincial/territorial government programs, 1993–2014**

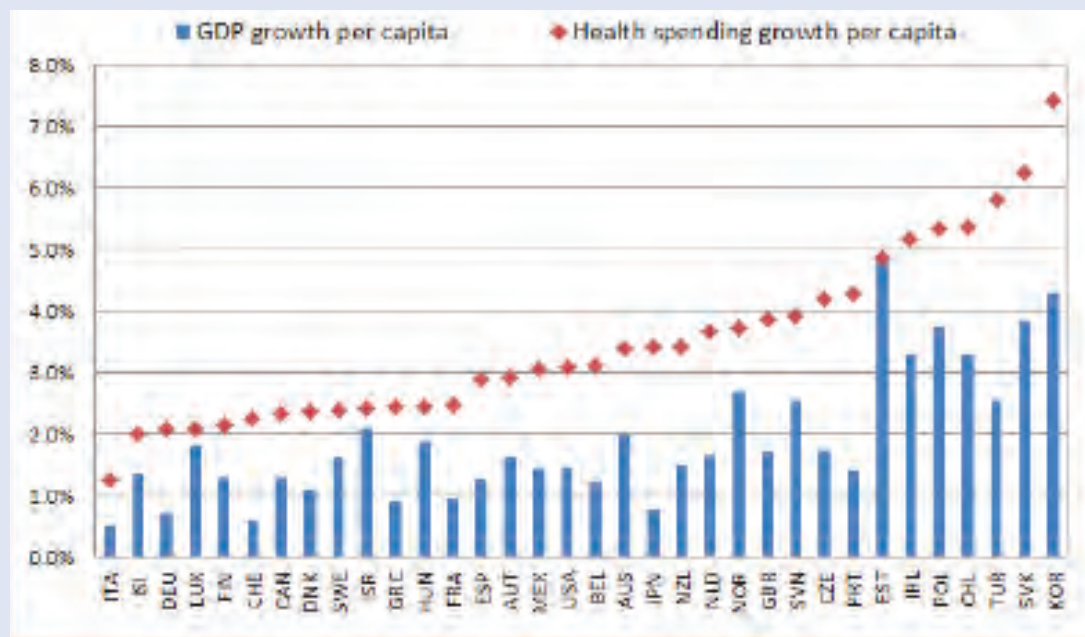


*Note: Financial Management System data is estimated for 2009 to 2014.*

*Source: CIHI 2015, Figure 8. Data from National Health Expenditure Database, Canadian Institute for Health Information; Financial Management System, Statistics Canada; provincial public accounts, budgets, main estimates.*

What is less familiar to most Canadians is that this trend is far from unique. Most industrialized countries are facing a similar challenge with respect to health care spending. And it is far from a new trend. The average annual growth rate of public health spending has exceeded GDP growth in *all* OECD countries for the past 20 years (see figure 2).

**Figure 2: Average annual growth rate of health spending and GDP per capita, 1990–2012 (or closest year)**



Source: OECD 2015d.

The Organisation for Economic Co-operation and Development warns that this trend will become unsustainable for most governments.<sup>1</sup> Health care represents on average about 6 percent of GDP in OECD countries and is projected to consume an additional 2 percentage points over the next 20 years (OECD 2015b). The clarion message from this research is that health spending “will become unaffordable without reform” (OECD 2015b).

This warning is consistent with a broader body of research here in Canada. A recent study published by the Fraser Institute examined the sustainability of health care spending in Canada and finds that even under a moderate-growth scenario health care expenditures will exceed 45 percent of provincial spending by 2030 (Barua, Palacios, and Emes 2016). The C.D. Howe Institute’s Bill Robson (2001; 2007) estimates that governments will need to spend as much as \$1.4 trillion in 2007 dollars to afford health care costs over and above services that general revenue will cover for the period up to 2040. A previous MLI study estimates that health care spending as a share of GDP will increase by 3.5 percentage points by 2040 (Ragan 2012). And the Parliamentary Budget Office (2016) estimates that health care spending will climb from 7.3 percent in 2015 to 12.5 percent of GDP by the end of the century.

Something will invariably need to give – leading to some combination of tax hikes, deficit spending, or fewer resources available for productive investments. As economist Chris Ragan (2012) writes in a previous MLI study: “there are only two broad fiscal choices available [in response to an aging population]: spending programs can be reduced or eliminated or taxes can be increased. There is nothing else.”

And Canada will not be alone. Analysis by the European Commission (2014) anticipates that 13 EU countries – including Austria, the Czech Republic, Finland, France, Germany, Ireland, Malta, the Netherlands, Poland, Portugal, Slovenia, Spain, and the Slovak Republic – are at risk of serious fiscal sustainability challenges due to rising health care costs. Similar research has raised real questions about the fiscal sustainability of US entitlement programs such as Medicare and Medicaid (Orszag 2011; Antos et al. 2015). The key takeaway is that no country is immune to rising health care costs and the resulting strain on government budgets.

# The Perfect Storm: What is Driving Health Care Costs?

The trajectory is clear. But the causes are more complicated. A confluence of factors are contributing to this steady increase in health care spending in the industrialized world.

There is a clear consensus in the health-related research that the four drivers that explain the increases in health care spending are (1) an aging population, (2) new medical technologies (including new drugs), (3) rising incomes leading to higher expectations and demands, and (4) institutional characteristics of incentives and regulations (see table 1).

**Table 1: Key determinants of health care expenditures**

Determinants	Description
Aging population	Health care spending generally increases as a person ages, notably from the ages of 55 and older for men and 60 and older for women, coinciding naturally with higher morbidity at older age.
Medical technologies	New technologies (including new drugs) are a scientific and medical marvel but have the consequence of driving up health care costs. These technologies are often more expensive than previous treatments, and their introduction leads to an expansion in the types and numbers of patients treated.
Rising incomes	It is broadly accepted that the correlation between GDP-per capita levels and per-capita health care expenditures is a major part of the story about rising health care spending. That is, put more simply, when countries grow richer, health care expenditures go up.
Institutional characteristics (rules and regulations)	Research has found, for instance, that the lack of competition in health care contributes to what is known as “Baumol’s cost-disease” whereby inflationary pressures exceed general inflation in the broader economy.

*Sources: European Commission and the Economic Policy Committee 2012; Barbasb and Glied 2010; Gerdtham and Jönsson 2000; Erixon and Marel 2011.*

There is not, however, agreement on the relative weight of each of these contributing factors. The research is contradictory and can be difficult to interpret. There is good reason that one economist once referred to the “black box” of the determinants of health care expenditures (Barros 1998).

A 2011 report published by the Canadian Institute for Health Information finds that population aging is a modest cost driver and that the real source of escalating costs is inflationary pressures stemming from salaries and drug costs (Marchildon and DiMatteo). A 2012 report produced by the European Commission attributes a much greater importance to aging as a primary driver. And a 2011 study by the World Health Organisation finds that rising incomes are a major contributor to rising health care expenditures (Xu and Saxena).

Yet, in virtually all cases, the results are nuanced and reflect these confluence of factors – all of which interact in some way or another – rather than a singular cause. This finding is intuitive. We are getting richer, older, and living longer due in large part to medical technology. This is a recipe for rising and increasingly unsustainable health care spending. It is a perfect storm.

# The Role of Health Care Systems: More Different Than We Think

As mentioned, the institutional characteristics of a health care system – the mix of public and private financing, for instance – is a critical determinant in how a jurisdiction manages the pressures of age, wealth, and technology. It is not to say that countries are immune to these forces or can fully mitigate them but rather that the design, structure, and operations of the health care system can make it better or worse.

What comprises a health care system? There is a tendency in some policy discussions to minimize the differences across health care systems. It is a natural inclination. Health care typically involves many of the same basic features such as hospitals and clinics, doctors and nurses, technologies and drugs, and patients and taxpayers. What could be different? The truth is quite a lot.

There is a range of institutional models for how health care is financed and delivered around the world.<sup>2</sup> There are even differences among countries that, like Canada, adhere to the principle of universality. These nuances are critical to understanding how different jurisdictions are positioned to manage rising health care costs and how Canada's health care system is particularly ill-prepared. As one OECD (2015b) study puts it: "good institutions are essential for governments to control health spending and to stimulate value-for-money in this field."

Different countries have responded to growing concerns about the sustainability of health care spending with different types of reforms. Some have sought to limit supply through delivery reforms such as volume purchasing, price fixing, or rationing (Conference Board of Canada 2004). Others have tried to restrain demand through financing reforms such as cost-sharing or shifting to a greater role for private insurance (Docteur and Oxley 2003; Tambor et al. 2015). Many have experimented with reforms that touch upon both supply and demand (Joumard, André, and Nicq 2010).

This study is primarily focused on the role of public and private financing and sets aside the matter of health care delivery. Other MLI research has examined the role of private delivery in other jurisdictions and found that it can provide more choice for patients, greater competition for the system overall, and ultimately better outcomes (Lundbäck 2013). But the goal here is to focus on the interaction between public

insurance and private insurance (including the use of different cost-sharing models) and how a greater role for private financing can expand universal coverage for low- and middle-income Canadians for key services and treatments without worsening provincial budgets.

*Increased private financing can expand universal coverage for low- and middle-income Canadians without worsening provincial budgets.*

The Canadian policy debate about health care financing almost invariably leads to comparisons with the US model due to geographic proximity and public awareness. There is a tendency to reject such a comparison on the grounds that the US system is inequitable and lacks universality and not a proper comparator for

Canada. But the reality is, as we will see in the next section, Canada's health care financing does have similarities with the US model and not good ones.

Think about health care and various ways that we come into contact with the system for a minute. We interact with the health care system when we have an operation at a hospital or when we pick up a prescription drug at the pharmacy or use out-patient services such as physiotherapy. The question is: who finances the health care system?

A large number of countries use a mix of public insurance and private financing to cover the cost of health care under the policy umbrella of universality. This means that every citizen has basic health coverage in some form or another. Some jurisdictions provide basic, publicly-funded health insurance for those who cannot afford private insurance or require some form of patient cost-sharing (see table 2). Others subsidize the cost of private insurance in a heavily-regulated market. The point, though, is that many jurisdictions have found ways to leverage private financing for health care while maintaining universal coverage (Colombo and Tapay 2004).

**Table 2: Three different models of user fees/cost-sharing reform**

Co-insurance	A fixed percentage of the cost of a health care service (such as 5 percent)
Co-payment	A nominal fee not necessarily associated with the cost of a health care service (for instance, \$15 for every doctor visit)
Deductible	A patient pays up to a ceiling known as the deductible and then the insurance plan kicks in

The goal of different cost-sharing models or private insurance for health care financing in universal systems is typically two-fold: first, it enables the government to extend some level of public coverage across a broad range of services and treatments while minimizing the cost to taxpayers; and second, it diminishes the tendency for patients to use the health care system for non-essential or unnecessary services or treatments.

The first goal is achieved by broadly spreading public resources across the health care system and leveraging private financing either through means-tested cost-sharing arrangements or a combination of regulations and public subsidies for private insurance. These countries are thus able to ensure universal access to a broad range of services and treatments while minimizing the cost to taxpayers. Put differently: universality and public financing are not synonyms – private financing can contribute to the public goal of universal and affordable access to health care (Globerman 2016).

The second goal has been to curb health care demand by imposing some of the cost for services and treatments on patients. The purpose is to cause patients to internalize health care costs and thus discourage unnecessary services or treatments. Economists refer to this as “pricing sensitivity” and there is clear evidence that cost-sharing models can have an effect on health care demand with minimal or no effect on health outcomes (Brot-Goldberg et al. 2015). A report produced for the European Commission, for instance, found “strong evidence that patient cost sharing leads to significant reductions in the use of health care” (Cox 2007, 22). Another study published by MLI found a similar change in behaviour in a US-based experiment involving the introduction of co-insurance without significant effects on people’s health (Laporte 2014). The key challenge is designing a role for cost-sharing or private insurance that does not also discourage patients from seeking necessary services or treatments or become a barrier to access for low-income citizens.

What does this mean in practice? Let us be concrete. Switzerland’s health care system, for instance, relies upon a heavily-regulated private insurance market to mostly finance its services. Citizens are compelled to purchase health insurance plans with generous subsidies for low-income earners. Basic insurance plans cover a broad range of services, including in-patient and out-patient physician and hospital care (including physician home visits), long-term care (partial coverage), prescription drugs, and complementary and alternative therapies. Simply put: the system guarantees universal access to a broad range of services in exchange for some responsibility for user co-payments and deductibles (Lundbäck 2013).

Differing health financing models is one of the reasons that we find variation in public expenditures on health care around the world (see table 3). Governments play different roles – in some cases, providing



some level of public coverage through government financing, and, in others, facilitating health care coverage through a combination of regulation and public subsidies. The reality is that most jurisdictions rely upon a mix of public and private financing in order to provide broad, universal access and control the cost burden imposed on the state. And more and more countries are turning to private financing to provide for health care services and treatments in the face of increasing fiscal unsustainability (Hossein and Gerard 2013; Tambor et al. 2015; Docteur and Oxley 2003).

**Table 3: Health care spending in OECD countries, total/public/private as a share of GDP, 2013**

Country	Total	Public	Private
OECD average	8.9	6.5	2.4
Austria	10.1	7.7	2.4
Belgium	10.2	8	2.3
Canada	10.2	7.2	3.0
Chile	7.3	3.4	3.9
Czech Republic	7.1	6.0	1.1
Denmark	10.4	8.8	1.6
Estonia	6.0	4.6	1.3
Finland	8.6	6.5	2.2
France	10.9	8.6	2.3
Germany	11.0	8.4	2.6
Greece	9.2	6.0	3.1
Hungary	7.4	4.8	2.6
Iceland	8.7	7.1	1.7
Israel	7.5	4.4	2.9
Italy	8.8	6.8	2.0
Japan	10.2	8.5	1.7
Korea	6.9	3.8	3.0
Mexico	6.2	3.2	3.0
Netherlands	11.1	9.7	1.4
New Zealand	9.5	7.6	1.9
Norway	8.9	7.6	1.3
Poland	6.4	4.5	1.9
Portugal	9.1	6.1	3.1
Slovak Republic	7.6	5.6	2.0
Slovenia	8.7	6.2	2.5
Spain	8.8	6.3	2.5
Sweden	11	9.2	1.7
Switzerland	11.1	7.3	3.7
Turkey	5.1	4.0	1.1
United Kingdom	8.5	7.3	1.5
United States	16.4	7.9	8.5

Source: OECD 2016.

Cost-sharing is one option that governments have used to leverage non-public financing for health care. Shifting costs to the private sector in the form of private health insurance is another. What is private health insurance? The OECD (2004a; 2004b) defines it as insurance schemes financed through private insurance premiums. Take up of private health insurance tends to be voluntary and premiums are often not means-tested unless it is subsidized by government. The OECD classifies private insurance into four types:

- 1.) Primary private health insurance – This refers to private-health insurance that represents the only available access to health coverage because (1) there is no public coverage or individuals are not eligible for public coverage or (2) individuals are eligible for public coverage but have chosen to opt out.
- 2.) Duplicate private health insurance – This refers to private health insurance that offers coverage for health services already included under public insurance while also offering access to different providers (such as private hospitals) or levels of service (like faster access to care). It does not exempt individuals from contributing to publicly-financed health insurance.
- 3.) Complementary private health insurance – This refers to private health insurance that complements coverage of publicly-insured services by covering all or parts of the residual costs not otherwise reimbursed (such as cost-sharing or co-payments).
- 4.) Supplementary private health insurance – This refers to private health insurance that provides coverage for additional health services not at all covered by public insurance.

These different models and variations of private health insurance can be seen in different jurisdictions around the world. The United States depends on a mix of primary and supplementary private financing. The United Kingdom uses duplicate private financing to bolster its National Health Service. France relies on complementary private financing to help fill the gap between public insurance and out-of-pocket expenses. Germany exhibits a mix of primary, complementary, and supplementary private financing. And Canada limits the role for private health insurance to financing supplementary services (OECD 2015c).

Total health care expenditures is a useful comparator for the purposes of evaluating how different jurisdictions are spending on their health care systems. But it becomes more complicated to compare the mix between public and private financing given that countries rely on different models of cost-sharing and private health insurance. Differences in what services are covered by public and private insurance, the role of private financing vis-à-vis public health insurance, and the methods for co-payments or deductibles or reimbursements limit the scope for apples-to-apples comparisons (Colombo and Tapay 2004). As we discuss in the next section, Canada's mix of public and private insurance is unique compared to most other countries (Blomqvist and Busby 2015).

Still there are some basic observations that one can draw. A confluence of factors – including an aging population, new medical technologies, and rising incomes and patient demands – are driving up health care costs and making them increasingly unsustainable. Public expenditures on health care are expected to continue to rise and will eventually crowd out investments in other areas such as education and infrastructure. The design, structure, and operations of a jurisdiction's health care system can partially mitigate these trends but likely cannot fully offset them. Countries have thus been experimenting with cost-sharing and a greater role for private insurance to better manage demand and limit the pressure on public expenditures (OECD 2015b; Business and Industry Advisory Committee 2011). Short-term analysis suggests that this can be an effective means of controlling public spending on health care but there is little evidence of its long-term effect at this stage (OECD 2015b; Tambor et al. 2015).

It is not surprising, then, that the role of private financing in health care is receiving increasing academic and political attention in light of growing pressure on government budgets (Remler and Green 2009; Busi-

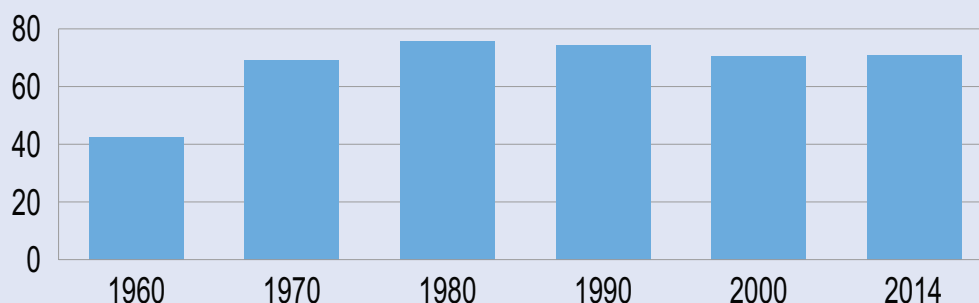
ness and Industry Advisory Committee 2011; Skinner and Rovere 2011). Shifting a greater share of financing to the patient in the form of cost-sharing or private insurance can reduce the burden on the public system and the evidence from countries such as Switzerland is that such a policy reform would not need to come at the expense of universality and can lead to broader coverage and better outcomes.

## Canada's Health Care System: Less Universal Than We Think

What does all of this mean for Canada? The reality is that Canada's health care system is particularly ill-prepared for rising expenditures. The explanation partly lies in how the system is financed and its overdependence on public insurance in certain areas and its weak public support for coverage in others.

The share of health care financing derived from publicly-funded insurance started to climb significantly between 1960 and 1970 as a result of the enactment of the *Medical Care Act* in 1966 and its implementation in 1968. Previously there had been some experimentation with publicly-insured hospital services but otherwise most health services were paid for out-of-pocket.<sup>3</sup> Public insurance now represents roughly 70 percent of health care expenditures and private financing covers the other 30 percent but these macro figures fail to tell the full story (see figure 3).

**Figure 3: Canada's public expenditures as a share of total expenditures on health care**



Sources: CIHI 2015; OECD 2014.

Our health care system is often characterized as “single payer” because provincial-based public health insurance covers all medically-necessary hospital and physician services and private financing for these services is largely prohibited under sections 18–21 of the *Canada Health Act* (Clemens and Esmail 2012). The share of public expenditures for these specific areas exceeds 90 percent (see table 4).

**Table 4: Hospital and physician services and financing sources in Canada, 2014 (billions)**

	Total Spending	Public Spending	Public Spending as a Share of Total Spending
Hospital services	\$63.5	\$57.5	90.5
Physician services	\$33.3	\$32.8	98.5

Source: CIHI 2014.

The dominance of public expenditures in these two areas is the core of the Medicare model and the objective of universality in the Canadian health care system.<sup>4</sup> But hospital and physician services are only a portion of health care services and treatments. These expenditures only represent 45 percent of total health care spending according to the latest data from the Canadian Institute of Health Information (2015). The share of total health care spending from these two areas has averaged 43.4 percent over the past 15 years and never exceeded 56 percent over the past quarter century (CIHI 2015).

It begs the question: what is the rest of health care spending comprised of and how is it financed? Most other health care services are privately financed – through private health insurance or out-of-pocket spending<sup>5</sup> – and are not subject to the *Canada Health Act*'s definition of universality.

Consider financing for drugs (prescribed and non-prescribed), for instance. Total expenditures on drugs reached \$33.8 billion or 15.7 percent of total health care spending in 2014 – making it the second largest overall expenditure following hospital services. Yet public financing only covers 36.3 percent of total spending on drugs. All other drug costs are financed through private insurance or out-of-pocket spending (CIHI 2015).

The share of public financing is even smaller for dental services. Total expenditures on dental services were \$13.2 billion or 6.1 percent of total health care spending in 2014. Public financing only covers 6.2 percent of total spending on dental services. All other dental expenses are financed through private insurance or out-of-pocket spending.

*Medicare is a mile deep and an inch wide.*

The list goes on. There is a wide range of health care expenditures for which public financing only represents a small share of total costs and otherwise Canadians and their families are responsible for paying the bill (see table 5). The significant gap between public and private financing should challenge people's perception about Canada's single payer and universal health care system. A deeper analysis tells a different story than is often presented by politicians and the news media. Medicare can be properly characterized as a mile deep and an inch wide.

**Table 5: Total Health Care Expenditures and Financing sources in Canada, 2014 (billions)**

	<b>Total spending</b>	<b>Public financing (%)</b>	<b>Private financing (%)</b>
Total health care expenditures	\$215.7	70.8	29.2
Hospital services	\$63.5	90.5	9.5
Physician services	\$33.3	98.5	1.5
Drugs	\$33.8	36.3	63.7
Other institutions	\$22.6	70.3	29.7
Dental services	\$13.2	6.2	93.8
Capital	\$11.7	72.2	27.8
Vision care services	\$4.2	8.7	91.3

Source: CIHI 2015.

Canada's health care system effectively dedicates major public resources – almost \$100 billion in 2014 – to hospital and physician services and leaves little left over to assist Canadians with paying for remaining health related expenses. One might contend that this is a reasonable distribution because hospitals and doctors are essential services and other parts of the health care system such as drugs, dental, and out-patient services are not. But this is a false distinction. The primary reason that such a distinction was initially drawn at the conception of Canada's public financing regime was due to fiscal capacity. It is worth noting, for instance, that the initial experimentation in Saskatchewan actually included dental services and they were ultimately excluded from medicare when it expanded nationally.<sup>6</sup> Another reason is that the health care system was largely seen as “curative” rather than “preventative” because advances in pharmaceuticals and other treatments were still embryonic. The upshot is that we have maintained an outdated financing structure that is costly, inequalitarian, and ill-prepared for the coming demographic and technological pressures.

*More than half of our health care system functions like the US model prior the Affordable Care Act.*

And it is also out-of-step with how most other jurisdictions pay for health care. The present imbalance between public and private financing in Canada is different than most other jurisdictions where governments pay more for drugs, dental, and continuing care services but there is more private financing in the form of cost-sharing or private health insurance in hospital and physician services (see table 6). The result here in Canada is a model of highly universal yet expensive public coverage for roughly half of health-related costs and more stratified and uneven private financing for the rest.

More than half of our health care system basically functions like the US model prior to the reforms enacted under the *Affordable Care Act*.



**Table 6: A comparison of health care expenditures and financing in different countries**

Country	Activity	Source of Finance	
		Public	Private
		<i>percent of total health spending, 2011</i>	
Canada	Total	70	30
	Hospital	92	8
	Doctors	99	1
	Medical Goods (drugs and other out-patient costs)	35	65
	Type of private insurance	• supplementary	
UK	Total	83	17
	Hospital	N/A	N/A
	Doctors	N/A	N/A
	Medical Goods (drugs and other out-patient costs)	N/A	N/A
	Type of private insurance	• parallel and complementary	
Switzerland	Total	65	35
	Hospital	79	21
	Doctors	60	40
	Medical Goods (drugs and other out-patient costs)	67	33
	Type of private insurance	• primary, though publicly mandated • supplementary/parallel	
Australia	Total	68	32
	Hospital	79	21
	Doctors	74	26
	Medical Goods (drugs and other out-patient costs)	45	55
	Type of private insurance	• parallel and supplementary	
Netherlands	Total	85	15
	Hospital	90	10
	Doctors	90	10
	Medical Goods (drugs and other out-patient costs)	69	31
	Type of private insurance	• primary, though publicly mandated • supplementary	

Source: Blomqvist and Busby 2015, table 2. Data from OECD Health Statistics and authors' calculations.

This is worth emphasizing: the present mix of public and private financing is inequalitarian to the extent that it publicly subsidizes the cost of hospital and physician services for all Canadians irrespective of income or wealth, and then offers minimal support for low-income Canadians to pay for services not covered by public insurance. It is even more regressive to the extent that the non-taxation of employer-provided health and dental benefits disproportionately benefits high-income earners.<sup>7</sup> Now roughly four out of 10 Canadians do not have access to private-health insurance and are thus responsible for covering a wide range of health care services with out-of-pocket spending (Allin and Hurley 2009). The result is that less affluent households, unattached individuals, and senior couples tend to spend a greater share of their disposable income on health care than the average Canadian and usually with minimal public support (Statistics Canada 2009, 11). And it is rising. Between 1998 and 2009, out-of-pocket expenditures on health care services increased by 2.9 percent annually and the percentage of households spending more than 10 percent of their total after-tax income on health care rose by 56 percent (Sanmartin et al. 2015).

As one health scholar writes: “some people [are] covered through private health insurance via their employer, some people [are] covered by governments because they are on welfare or elderly [due to some provincial assistance programs], and a big chunk of the population [is] going without” (Flood 2014). The status quo is not only unsustainable, it is unfair.

# How to Strengthen Universality and Save Money in Canada’s Health Care System

Thus far we have shown that a combination of factors are driving up health care costs around the world and that governments are grappling with how to manage these pressures with different reforms including drawing on more private financing for health care services. Experimentation with different forms of private financing in these jurisdictions has generally not been done at the expense of universality. The experience has been to use some combination of means-tested cost-sharing and public subsidies for private health insurance to ensure that citizens have access to affordable and broad health coverage through a balance of public and private financing.

Canada is an anomaly. Its unbalanced mix of full public insurance for hospitals and doctors but limited and non-universal private financing for other health care services such as drugs, dental, and out-patient care poorly positions us for future health care spending pressures and provides for unequal and costly access – particularly for low- and middle-income Canadians.

Thus the financing of the Canadian health care system seemingly represents the worst of *all* worlds – limited coverage, high costs, and increasing unsustainability. The federal minister of health is right to have recently stated that structural reform rather than more public funding is key to improving the system (Speer and Crowley 2015).

Canadian governments could enact a range of reforms to better leverage private financing to pay for health care services. The goal of such reforms would not be to undermine or fully replace public insurance but rather to expand the role of private financing to reduce the strain on government spending and allow it to target public financing on those who need it. It is even possible that governments could consider a major reform package that ultimately broadened the coverage of services under public financing in exchange for a greater balance between public and private financing across the health care system.

Such a policy shift would be consistent with the Trudeau government’s recent changes to federal child care benefits whereby universal coverage was scuppered in exchange for means-testing and more generous payments for low- and middle-income families. The prime minister said that this change was partly motivated by the belief that public support should not go to wealthy families like his own (Bryden 2015). The government could thus encourage the provinces to adopt a similar set of reforms with regards to health care financing.

The first step would be for Ottawa to repeal sections 18–21 of the *Canada Health Act*, which presently disallow patient charges – including any charge for an insured health service authorized or permitted by the provincial plan that is not payable by the plan – in the health care system (Clemens and Esmail 2012). Such a legislative change would enable the provinces to experiment with different forms of patient cost-sharing for services and treatments that are currently covered by public insurance.

Provincial experimentation with cost-sharing could be means-tested or have broader application. Any cost-sharing model would not require disruptive change and could easily be incorporated into the existing health care system.<sup>8</sup> Exemptions or limits could be introduced for those with chronic illnesses or for low-income earners (Docteur and Oxley 2003). Cost-sharing could be implemented in different forms.

A co-insurance model would require patients to pay a fixed percentage – up to 5 percent for instance – of the cost of services received. The fee rises in conjunction with the cost of the service usually up to a limit or threshold. This is similar to how most private insurance plans operate with respect to drug purchases.

The co-payment model is an alternative to co-insurance to the extent that a patient pays a flat fee per service which does not necessarily bear relation to the cost of the service. It is designed to partly offset the cost on the public system but is mostly in place to ensure that patients are cognizant that using the health care system imposes a cost. This model is present in Sweden where universality covers a broader range of services but is less deep than in Canada (Lundbäck 2013).

A system of deductibles would see the patient pay the total costs of health care services up to a ceiling that functions as a deductible. Thereafter any costs of services to the patient would be covered by public insurance. This model is partly present in Korea, which uses a combination of co-payments and deductibles to finance a wide range of health care services that includes dental, vision, and even Chinese medicine (Peng and Tiessen 2015).

Irrespective of which model governments choose, the outcome of cost-sharing would be the same. A greater share of costs would shift to the individual so that the patient is responsible for paying a portion of hospital and doctor services. This would lower the burden on public financing and can thus reduce the strain that health care spending is placing on government budgets. It could also create the conditions for a broader rebalancing of public and private financing across the health care system and allow for an expansion of public insurance to offset some costs for uninsured services such as drugs, dental, and out-patient services.

The primary objection to the introduction of user fees/cost-sharing is undoubtedly concerns about equity or access to care – the charge is, in effect, that requiring individuals to pay a portion of their health care costs is inequalitarian. Yet this argument is disconnected from how the current health care system functions. Presently scarce public resources are fully covering hospital and doctor costs for wealthy Canadians and are not helping low- and middle-income Canadians defray the costs of drugs and other uninsured services.

*Scarce public resources fully cover hospital and doctor costs for wealthy Canadians while low- and middle-income Canadians pay for the costs of drugs and other uninsured services.*

Not only could any cost-sharing model be structured to address legitimate concerns about equity and access to care (such as means-testing and limits for those with chronic conditions), it could make the system more egalitarian by extending the principle of universality to a broader range of services. This is the reason that this idea – similar to the argument that the federal government has made about child care benefits – could have support across the political spectrum. The analogies to the Trudeau government's shift from universality to means-testing for child care benefits may be a model for a similar reform to health care financing.

A more ambitious option would be to also adopt the recommendation of the federal Advisory Panel on Healthcare Innovation to change the current tax treatment of employer-provided health insurance in ex-

change for broadening tax-based support for the purchase of private health insurance by individuals and families (Health Canada 2015). The panel set out a substantive “tax swap” whereby the federal government would cease treating employer-provided health and dental insurance as non-taxable and in turn would use the resulting fiscal room (nearly as much as \$3 billion per year) to redesign the Medical Expense Tax Credit into a refundable tax credit to help defray the costs of buying private insurance and paying out-of-pocket health expenses. The refundable tax credit would be available to all Canadians irrespective of a person’s employment or income and could come in the form of a cash transfer for low-income Canadians who do not pay income tax (Laporte 2014). The goal would be to better target public support for the purchase of private health insurance.

Ending the non-taxation of employer-paid premiums for health and dental insurance would harmonize the treatment with other employer-provided benefits such as life insurance and parking. It would also eliminate a distortion whereby those with workplace health and dental insurance receive a government subsidy and those without it must purchase health insurance with after-tax income (Dhalla et al. 2011). And it would free up roughly \$2.7 billion to help more Canadians – namely those without a workplace option – purchase private health insurance (Department of Finance Canada 2016).

The risk of this option is that it leads to a decline in private health insurance and a rise in out-of-pocket expenditures because employers respond by dropping their plans and Canadians choose not to purchase individual plans. Such an outcome would obviously undermine the goal of shifting a greater share of health care financing from public to private. It would depend in large part on the generosity of the new tax credit and how many people used it to purchase individual plans.

*Four in 10 Canadians presently must pay for non-insured health care services with out-of-pocket spending.*

Evidence from Quebec – which has treated employer-paid premiums for health and dental insurance as a taxable benefit since 1993 – provides limited insight into how Canadians would respond to such a policy change. Research shows that Quebec’s tax change was associated with a one-fifth decline in employer-provided health insurance which was offset only 10–15 percent by the purchase of individual plans (Finkelstein 2002). But the

Quebec government did not combine the new tax treatment of workplace health insurance with broad-based tax support so it is impossible to know whether that gap could be further closed. The lesson is that any consideration of a tax swap between taxing workplace health insurance and offering a new tax credit to defray the purchase of private insurance for all Canadians would require careful thinking with respect to design and implementation.

It has the potential though to level the playing field between those who have employer-provided health insurance and those who must purchase it on their own, and ensure that public subsidies are directed to those Canadians who require the most help – namely the four in 10 who presently must pay for non-insured health care services with out-of-pocket spending. As part of the Trudeau government’s focus on low- and middle-income Canadians, it ought to therefore study the Advisory Panel on Healthcare Innovation’s recommendation.

# Conclusion

Health care spending in Canada and around the world is climbing and is projected to continue rising for the foreseeable future due to aging demographics, advances in medical technologies, and other factors. Governments are grappling with how to finance these rising costs without sacrificing quality or access or undermining other public priorities such as education and infrastructure.

The prime minister and the premiers are set to meet to discuss how to reform Canada's health care system to reduce the fiscal strain on government budgets and achieve better outcomes for Canadians. This study has sought to help these governments think about health care financing in Canada, how it compares to other models used elsewhere in the world, and how it ought to be reformed.

The key lesson is that Canada's unbalanced mix of full public insurance for hospitals and doctors but limited and non-universal financing for other health care services such as drugs, dental, and out-patient care not only poorly positions us for future health care spending pressure, it provides for unequal and costly access – particularly for low- and middle-income Canadians. Canada's publicly-funded, universal health care system is more costly and narrower than most Canadians realize. We are not living up to the promise of universality. Reform is certainly needed.

*We are not living up to  
the promise of universality.  
Reform is needed.*

Allowing a greater role for private financing in hospital and physician services can enable governments to broaden public financing to a wider range of health services and target public resources to those who actually need support. The result would be a more universal health care system without imposing a greater burden on government budgets.



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# Endnotes

- 1 The subject of *unsustainability* has received considerable academic and governmental attention. Different organizations such as the European Commission and International Monetary Fund have slightly different definitions. The basic concept refers to the capacity to sustain current policies at broadly the same levels of taxation and spending without incurring significant public debt. For more on the definition and measure of sustainability, see Livio DiMatteo, 2011, “The Sustainability of Canadian Provincial Government Health Spending.”
- 2 The OECD conducted a survey of 29 countries to better understand their health coverage and financing arrangements. See Valerie Paris, Marion Devaux, and Lihan Wei, 2010, “Health Systems Institutional Characteristics: A survey of 29 OECD countries.”
- 3 For more on the historical evolution of medicare, see CIHI, 2005, *Exploring the 70/30 Split: How Canada’s health care system is financed* and Sean Speer and Brian Lee Crowley, 2015, “Better Health Care for Canadians.”
- 4 The *Canada Health Act* states that: “the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions.”
- 5 Out-of-pocket spending represents 14 percent of total health care financing in Canada. Private health insurance is 13 percent. See OECD, 2015, “Country Note: How does health spending in Canada compare?”
- 6 It is worth noting that the decision to limit public coverage ran contrary to the recommendations of a 1964 Royal Commission which called for much more comprehensive public health insurance. See Health Canada, 2004, “Royal Commission on Health Services, 1961–1964” and Janice MacKinnon, 2013, “Health Care Reform from the Cradle of Medicare.”
- 7 A May 2013 analysis by the Congressional Budget Office found that similar tax treatment of employer-provided health insurance in the United States disproportionately benefited high-income earners with 60 percent of the benefit going to those in the fourth and fifth income quintiles.
- 8 One MLI study considers using the existing income tax system to collect partial payments in order to minimize the administrative complexity (MacKinnon 2013).

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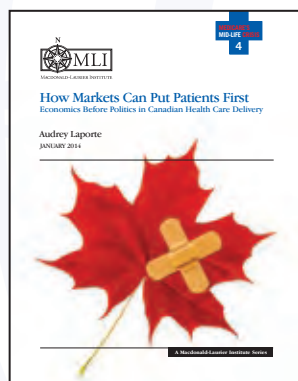
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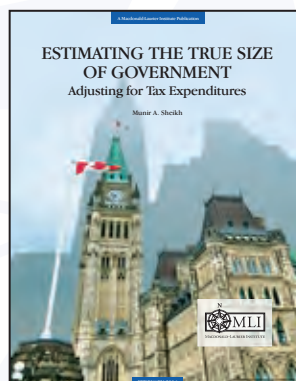
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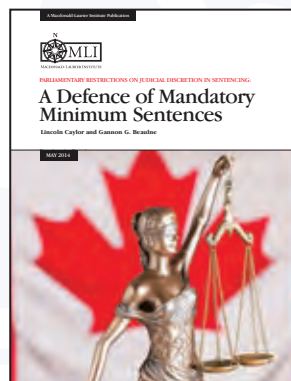
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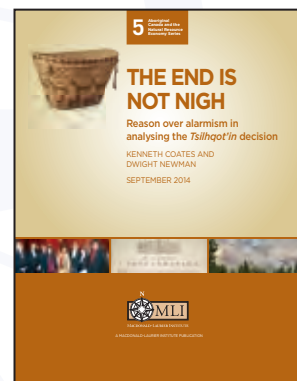
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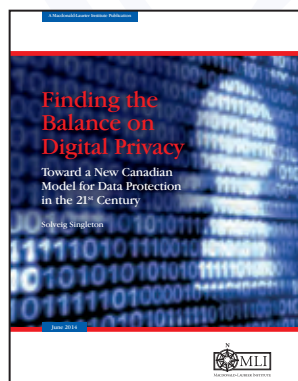
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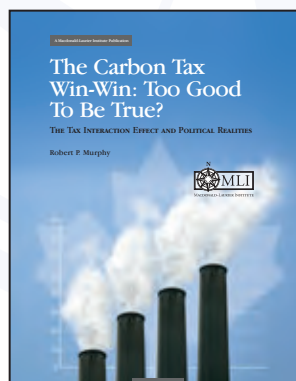
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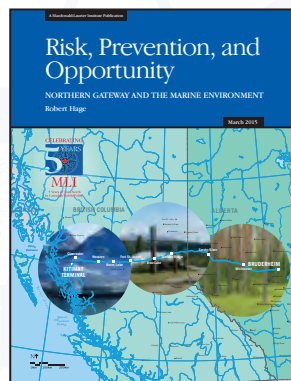
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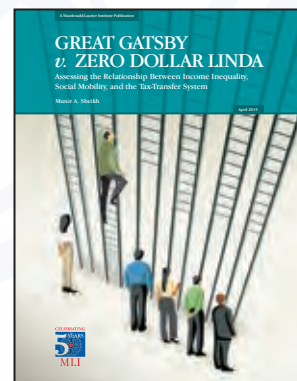
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