UNREVISED

FINANCING OPTIONS FOR FUNDING AN INCREMENTAL INCREASE IN FEDERAL SPENDING ON THE HEALTH SECTOR

Material Prepared for the
Senate Standing Committee on
Social Affairs, Science and Technology
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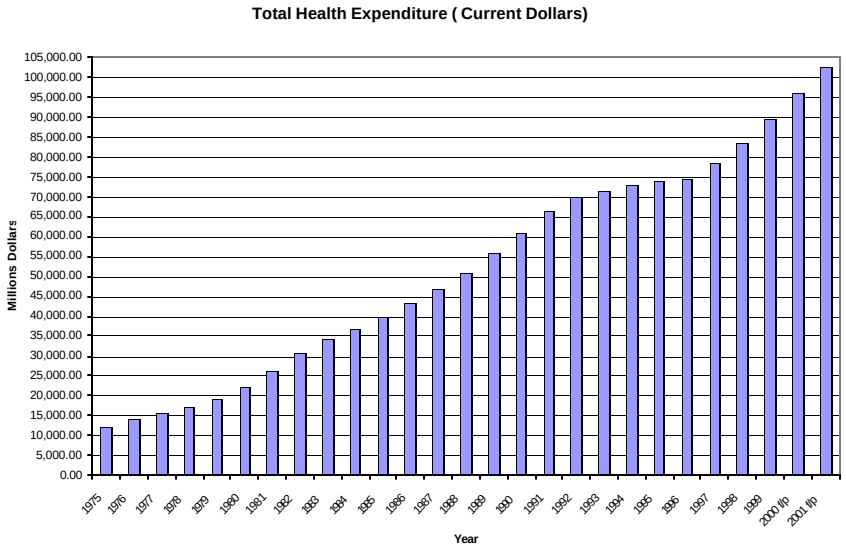
TO BE REVISED

A. INTRODUCTION

As set out in other studies in the Health of Canadians – The Federal Role (A Report by the Standing Senate Committee on Social Affairs, Science and Technology), the sustainability of our present financing of health care is under challenge because of pressures on our health care resources caused by rapidly rising costs and the need for additional funding, as well as the need to put in place organizational reforms to improve efficiency and effectiveness.



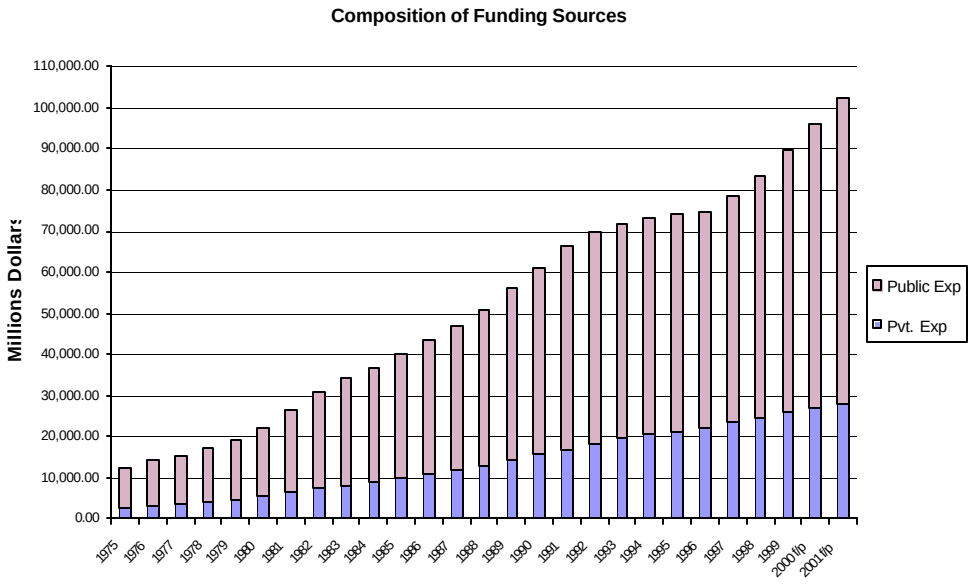
Source: CIHI

In considering how additional financial resources might be provided for the health care system, there are a number of financing options available to Canadian governments. To pay for the increasing costs of our public health system, and on the reasonable assumption that these cost increases are so large that they cannot be met from existing revenues, governments could simply increase the level of one or more of the existing taxes. Alternatively, governments could employ new taxation measures linked specifically with the funding of the health system. New variable health premiums, dependent on income level, could be levied, or Canada could follow other countries that have employed social health contributions which are earmarked payroll taxes with the contributions shared between employers and employees. Expanded private health insurance premiums could be used, with the costs paid for either by the employee or the employer or shared between the two. Other new financing approaches include medical savings accounts (accounts into which money is set aside specifically for future personal medical needs), or out-of-pocket consumer payments or user-charges that can be a flat charge covering part of the cost of services, a percentage of the medical service received (co-insurance or co-payment), or with upper limit up to which the patient is responsible before the insurance covers the cost (deductibles).

All new funding that may be devoted to meeting heath care spending involve a reallocation of our society's resources – taking funds away from individuals through new

or higher taxes or through new charges, and using them to fund the existing program and its relentless cost increases, and to possibly provide expanded benefits. This reallocation through higher taxes and charges therefore has costs – not only through the direct effect of new taxes and charges, but indirect effects on the economy through possible lower investments and spending in other areas caused by these higher taxes. Accordingly, the costs as well as the benefits of new health system spending deserve careful scrutiny.

In Canada, a mixture of both public and private funding sources is now used in the health sector. In general, contributions by governments to the system are paid out of general revenues, and therefore come predominantly from personal income taxes, corporate taxes, and consumption or sales taxes. While a substantial part of government revenues are used to pay for health costs, there is no direct link between the taxes imposed and the benefits provided, and few Canadians have a clear idea of the costs of the system or how those costs are now met. Some provinces collect "health taxes" that are unrelated to health costs and are essentially simply a named tax. The continuing expansion of costs, driven by technology and demographics, are imposing serious constraints on the delivery of health benefits under the system, and on the budgets of governments who must deal with the cost increases. Organization of the health system is diverse, and contains elements from both the public and private sectors.



Source: CIHI

The type of financing system employed directly impacts the distribution of the burden of financing the system, and can influence the distribution of the benefits. An analysis of the financing options must carefully examine who pays into the system, and how, and who accesses the services.

Important elements of health care – relating to the supervision of the health system and the delivery of benefits – are within the constitutional authority of the provincial governments. Accordingly, the provincial governments are largely responsible for the design and management of health services and the largest part of the public funds devoted to the system are raised and spent by the provinces. However, the federal government has a substantial and vital role in both assisting in the financing of the public costs of health care, and in establishing and maintaining national standards.

Overall, the present Canadian system reflects a mixture of approaches and organizational structures that make the system hard to analyze or rationalize. Most medical and hospital services are paid for entirely by public funds, while other health services (dentistry, drugs, home care, alternative medicine etc.) are in large part paid for by individuals, sometimes with government assistance or through private insurance. While direct spending on health services for individuals is almost exclusively a provincial responsibility, the federal government contributes significant and growing financial support, both through block transfers to the provinces and through federal spending on research and infrastructure. Some basic standards are set under the Canada Health Act, but most administration of a diverse and fragmented system is carried out at the provincial level.

Based on its traditional position, the federal government also has important responsibilities in assisting in the co-operative restructuring of the health care system and its financing so that it will continue to meet the needs of Canadians in a way that will not overwhelm government finances and give rise to an unacceptable tax burden on Canadians. This restructuring should serve to increase the efficiency and effectiveness of the system, assist in managing costs in relation to health outcomes, and make Canadians better aware of the link between their personal health care and the taxes that must support that care. To minimize the inevitable economic costs of higher taxes and charges associated with higher health care costs, the additional revenue requirements must be structured so as to do the least damage to the economy and its tasks of job creation and income growth.

However, the restructuring must also be carried out so as to continue to meet two basic objectives of Canada's national health care program:

(i) ensure that all Canadians have access to essential hospital, doctor and other covered health services regardless of their incomes, and

(ii) ensure that no Canadian suffers undue financial hardship as a result of requiring health care services.

Within the broad context of the present financing of the health care system, the issue considered in this paper is how the federal government might raise the additional revenue required to finance its expanding contribution to present and increasing health care costs, and how this federal financial support should be structured, allocated and managed. For the purposes of this discussion – and without deciding the issue – it is assumed – as set out more fully in Volume 5 of The Health of Canadians –The Federal Role- that this

increased federal contribution will require $5 billion annually in new revenue, plus an additional amounts for the further growth in all federal funding over time.

This report deals with a wide range of issues and options relating to the federal role in financing of health care. However, it takes as its main point of reference the principles and recommendations set out in Volume Five of the Report on The Health of Canadians-The Federal Role, by the Standing Senate Committee on Social Affairs, Science and Technology, released in April, 2002.

B. FINANCING AND IMPORTANT SOCIO-ECONOMIC ISSUES

The financing of health care – who pays and how - is a vital issue which cannot be solved in isolation from other important questions about Canada's health care system. Important policy, management and control, organizational and other issues are related to the financing question, and improvements and rationalization of the present health system requires a broad integrated solution incorporating many different elements, not simply additional funds.

But within the overall issue of the structure and management of the total Canadian health care system, the task of this paper is to examine and comment on alternative methods of organizing and financing the federal government's increasing role in supporting the public heath care system. This analysis therefore does not deal with the related issues that are relevant in a renewed, integrated and successful health care system and that are discussed in the rest of the report, The Health of Canadians – The Federal Role.

The fact that total health care costs are increasing at rates in excess of both the Consumer Price Index and the Gross National Product has profound implications for the long term financing of such costs. Because public health costs are increasing faster than the growth in government expenditures and taxes, health costs are absorbing an increasing share of government resources and are imposing strains on other government priorities.

Annual costs are being driven higher by two main factors:

- a demographic factor, relating the aging of Canada's population and the fact that older people consume far higher health costs than younger people.
- a technical factor, as ever newer (and generally expensive) ways of treating disease and extending life are discovered: rapidly rising pharmaceutical and diagnostic costs are two primary examples.

Based on these causes, even conservative projections of future health care costs show that they will be increasing by perhaps one percentage point or more than the increase in GDP for the indefinite future. To put this in perspective, and using only the demographic factor, the present value of the unfounded liability of excess health costs (costs that are projected to be in excess of the current ratio of such costs to GDP) over the next fifty years is estimated at $580 billion.

(***Tables and References)***

The fact that health care costs are expected to increase at rates well above economic growth raises some important issues of intergenerational fairness, as the young people of today may face years of escalating taxes to pay for the rising costs of providing services to previous generations. Of course, health care costs are not the only issue – one must recognize the equivalent of an unfounded liability for Old Age Security pensions and many other items. A recent OECD study however indicated that the total impact of aging on the budgets of Canada's federal and provincial governments could amount, in 50 years, to 9 percentage points of GDP.

The demographic, efficiency and equity issues that should be considered when analysing the financing options available are briefly outlined below.

Demographic Issues

It is worthwhile to consider how the change in the relative proportions of the elderly, and the younger working members of the population affects not only the level of demand for health services, but also the financing of the public health system. Age related variations in health needs means that demographic changes affect both the overall level and composition of health care expenditures.

The use of general revenues to fund the public health care systems could involve significant subsidisation of the health needs of the elderly, by the younger working population. As the younger generations anticipate receiving similar subsidisation benefits after retirement, this system of inter-generational subsidisation has met relatively little opposition. However, demographic changes are progressively leading to an increasing proportion of retirees, requiring subsidies from a shrinking pool of tax-paying workers. Thus the continued viability of a public health care system, funded primarily by the working-age individuals, and the expectation that younger generations would benefit from it in their later years, is now coming under question.

Efficiency Issues

The type of funding system used can affect the success of cost containment actions as well as the wider economy through the direct and indirect costs of taxes and levies imposed to fund the services. It can also impact technical efficiency, which is concerned with getting the most out of every dollar spent in the system and is directly related how services are purchased.

The health system is Canada is based upon a fee-for-service system that is especially susceptible to explosive expenditure growth. This is because there is no incentive in the system for cost containment on either the demand or the supply side. Nor are there any incentives to lower the cost of service delivery. Thus there is considerable interest in building some form of incentives into the payment system that would reduce excessive demand as well as promote the search for products and procedures that are more cost effective.

Equity Issues

A careful investigation into the division of the burden of financing the system among households must be made to determine the effect of an incremental tax increase on the different socio-economic groups in the society. The financing system is said to be vertically equitable or progressive if higher income earners contribute a larger proportion

to the system. Horizontal equity requires that individuals with the same level of well-being before the tax, should face have the same level of well-being after the tax is imposed. Measuring "well-being" is extremely difficult, as this would include non-monetary factors.

The equity issues in the health care reform debate center on equity in

(i) redistribution – what are the vertical and horizontal measures of the method of financing the health system and the destination of the spending. If a the revenues from a more regressive tax system disproportionately benefited low income people, then such individuals may be better off than in a system that had a more progressive form of financing but less expenditure on low income earners.

(ii) access to health services –does the way in which the system is funded affect access to health care. (as for example, would cost-sharing reduce the use of medically necessary services?).

C. FINANCING THROUGH GENERAL TAX REVENUES

The economic impact of funding the public costs of health care out of general federal and provincial government revenues, depends on the structure and level of the total tax system.

As previously noted, the public costs of health care can be met from either general government revenues, or from some form of specifically designated or dedicated tax that is considered - more or less loosely – as being allocated to cover health costs. Further, that part of the costs of health care –for non-covered services- is the responsibility of individuals and is met out of their own resources, possibly with support from governments or from private insurance.

In general, the use of tax revenues –even dedicated taxes – does not directly impact the demand for health services or its overall costs. However, systems that require some personal contribution to otherwise covered individual health care costs ("cost-sharing") may reduce demand, and therefore the overall costs of the system.

The implications of the projected increases in health care costs over a lengthy period are so serious that any present revisions to the current financing of health care must explicitly take these trends into account in determining present policies.

Any new system of health care financing should be flexible and robust – flexible enough to handle changes in the level of financing required, and robust enough to be able to sustain a further major escalation of costs. The inter-generational equity issues raised by burgeoning health costs will at some point require recognition. Health services are primarily a provincial responsibility, and there are significant differences in the proportion of older people in the various provinces, giving rise to different provincial financing requirements. (See later discussion on federal block transfers to the provinces dealing with this issue)

Above all, the inescapable fact of rising health care spending means that more attention should be paid to long-term issues of redesigning the system to improve its efficiency. The continuing escalation of health costs means that the provision of a set amount of increased financial support cannot by itself "solve" the health care financing crisis: more far reaching and fundamental changes will be needed to cope with long term financing and other problems.

The Case for Prefunding

Prefunding involves setting aside funds now to meet all or part of projected future cost increases in health care, so as to enable Canada to maintain a relatively stable (or at least more stable) annual net expenditures on health, measured as a percentage of GDP. Excess revenues gathered now for such a prefunding would be placed in a special account, to be made available later for stabilization purposes. Unfortunately, the costs of

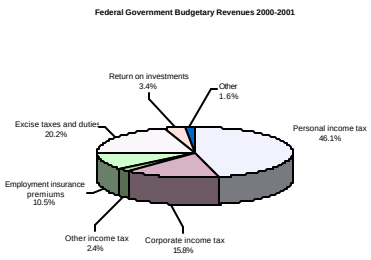
full prefunding (to maintain fully stabilized costs) are high, especially when the stabilization is attempted over a period of thirty or forty years during which Canada's population will be getting significantly older. Accordingly, there may not be the popular will to implement a long term prefunding plan now when the urgent need is seen to be paying for immediate cost pressures in the system. And the question could be raised as to why health costs only should be prefunded – what about other costs (and even revenues) that will also vary with the changing demographics?

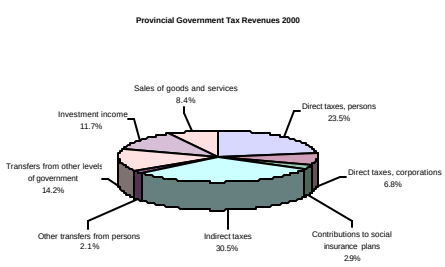
However, it may be more practical to consider the prefunding of some elements only of health costs, specifically those relating to uncovered health services for the aged such as home and institutional care. Such prefunding might be accomplished through a government plan financed by current taxes, or through private insurance coverage that received tax support (the premiums being deductible, earnings on accumulated funds exempt from tax, but ultimate payouts being taxable.) Such a scheme would assist individuals to save for what can be an important part of their retirement health costs on a tax efficient basis, and ultimately would relieve the public system of some costs that it now incurs in subsidizing some of those who need such services.

A further variant of this approach was proposed in the Clair Report in Quebec, which recommended that a separately-managed fund be established to prefund the costs of both home and institutional care for individuals who no longer have the ability to care for themselves. The fund would be financed by a mandatory premium (tax) on personal income from all sources, and would primarily be for the benefit of those whose disability to care for themselves was long-term (over six months). A large proportion of these would be the elderly. Overall, the plan would provide an improvement in and integration of existing services for long-term disability, with a substantial prefunding element so as to avoid a rapid rise in costs for an aging population.

While full prefunding of health costs is not likely an immediate possibility for Canadians, the long-term implications of an aging population on total health care costs, and on the taxes that support them, deserve more recognition. At a minimum, it should move us towards a more efficient health system, with adequate funding that is adjusted to demand increases, so that future health care cost increases will be at least slightly more manageable.

Financing Incremental Expenditures from General Tax Revenues





Source: Ministry of Finance

Taxes can take the form of either direct taxes, levied upon individuals, households or firms, or indirect taxes applied to transactions and commodities. In addition, indirect taxes can be general, such as the VAT, or an excise tax applied to specific goods.

In dealing with the financing of *incremental* health spending –new federal financial support for the system- the additional costs could be raised from any of the main federal tax revenue sources described below, with the principal likely effects being discussed under each tax noted.

The tax system not only determines the amount of government revenue available to fund public expenditures, but also distributes the burden of the tax among individuals. With this in mind, the social costs of funding increased public health expenditures from general revenues, through an increase in one or more of the Canadian government's main tax sources, must take into account efficiency, equity and demographic issues. In addition, there are a number of characteristics peculiar to the health system that should also be considered when comparing the available tax options. These include

1. Health Consumption Issues: Levels of consumption of health services does not resemble the consumption of other goods, as consumption of health services is largest near the end of life when income is at its lowest levels. Thus there is a mis-match between individual resources and health consumption, requiring pooled contributions to fund the system.

2. While the elderly do consume a proportionately larger proportion of health resources than any other age group, an aging population is not the immediate primary driving factor behind rising health expenditures. Studies have concluded that the most important present cause of rising health costs is technological change, particularly the technological change associated with the treatment of age-related illnesses. In the longer run, however, the pressures caused by an aging population will exert a powerful influence on costs.

Different taxes have different impacts for equity and efficiency issues, and policy formation requires a balancing of these influences when considering how best to fund an increase in the level of federal support for the health system.

<u>General Tax Revenue Financing vs. Dedicated/Designated Taxes.</u>

Presently the government funding of the health sector comes from general tax revenues. However, with designated or dedicated taxes, the revenues raised are identified as being reserved for use for a particular purpose. The identification can either be fairly loose – as is the case with existing provincial health "premiums" or the allocation can be more firm, where the revenue from a specific tax must by law be held for the dedicated purpose, with any excess of revenues over costs held over for spending on that purpose in a subsequent year. The designation can be so strong as to require the revenues to be held in trust, and not form part of the general revenues of the government. Segregating the

revenues from a particular tax, and using them only for a designated purpose, can have both advantages and disadvantages.

Funding the health sector from general revenues means that the revenue base is broad but the allocation to the health sector is politically determined, while a hypothecated or earmarked tax draws revenue fom a smaller base and is less susceptible to political manipulation.

The dedicated tax increases the visibility of the link between tax contribution and service provided, thus making it easier to raise additional revenues through taxation. It also can improve the overall transparency of the system and the accountability of those that manage it. However, dedicated taxes on a relatively narrow base are more susceptible to cyclical behaviour, and changes in the spending might be dictated more by the amount of revenue collected, than by policy changes. In practice, many so-called "earmarked" tax revenues are merged with other government revenues thereby removing the visibility advantage of the hypothecated tax.

For an earmarked tax to be truly effective, the revenue raised but not only be separated from general revenues, the tax source should provide growing revenue, at least at the same rate, but preferably in excess of the growth in national income.

With respect to a significant incremental spending by the federal government on health care, there would be obvious advantages in terms of transparency and accountability if this spending could be directly linked to a specific tax that was required to fund the spending.

Table 1: Advantages and Disadvantages in using Dedicated Taxes

	Advantages	**Disadvantages**
Dedicated Taxes	• Identify to the public that the program has specific costs that must be met out of tax revenue. • Strengthen the link between the benefits and the costs to the public of a program, thereby enabling the public to make informed choices and tradeoffs, with a heightened sense of responsibility. • Provide a justification for a levy that would otherwise be identified simply as a new or increased tax.	• Can distort overall priorities of government and weaken ability to adjust revenues, spending to new conditions. • Would require special efforts for the federal government to ensure that revenue from dedicated federal tax is actually used by provinces –who control most health spending – on designated purposes: important issues of accountability, control, and incentives are relevant.

The federal government already has a substantial annual commitment to financing health care through payments to the provinces through the CHST, and through specific

additional programs such as medical research and infrastructure support. While the CHST is a single block grant to the provinces, some 70% of the CHST –based on the funding that it replaced – might be regarded as being related to the support of the health system. The CHST payments from the federal government to the provinces have been increased significantly over time in response to needs and provincial requests, with the increases centred on the growing costs of health care. However, these increases have been determined arbitrarily, and continued growth in the CHST has not been an automatic part of the system.

In The Health of Canadians – The Federal Role, it is proposed that in future, that part of the CHST that is related to health should be automatically increased each year to allow for increases in costs. The proposed increase might be achieved by linking the health portion of the CHST to the federal revenues derived from about five percentage points of the present GST, so that this part of the federal transfer would automatically change with the change in GST revenues. (GST revenues, in general, can be expected to increase as the population increases and as living standards and consumption, and therefore the GST base increases.

REVISE AFTER FURTHER DATA ON CHST BECOMES AVAILABLE FROM FINANCE!

It would be difficult at this point to associate in the minds of the public the existing level of federal support – the 70% of the CHST – with a part of an existing tax – five percentage points of the GST. Accordingly, this link between part of the GST revenues and the existing CHST health grant would be primarily for the purpose of achieving an automatic growth in the federal base health care funding at a rate which might be roughly linked with the increase in the GDP. However, the issue remains whether any further increased financing role for the federal government in the health area can be delineated separately from the existing level of support, and then associated with a new federal levy.

DISCUSS POINT THAT CHST ALLOCATION MIGHT BE SWITCHED FROM PER CAPITA TO INCLUDE SPOME BIAS IN FAVOUR OF THE AGED TO GIVE SUPPORT FOR THOSE PROVINCES WITH A LARGER THAN AVERAGE OLDER POPULATION.

DIRECT TAXES

Direct income taxes include the personal income tax, the corporation tax, and property taxes.

1. *Personal Income Tax*

   This is a tax on both labour and capital income. The personal income tax meets general equity goals if the effective tax rates are similar for persons having

comparable taxable incomes, and if persons with higher taxable incomes face higher effective tax rates. This also leads to a redistribution of income from the richer to the poorer. However, if tax rates are higher for higher income earners, the progressivity of the personal income tax can be reduced if some forms of income are tax exempt, or some forms of non-income earning expenditure are tax deductible.

Increases in the federal personal income tax to fund health costs would have adverse effects on labour supply, savings and investment, and the willingness to undertake risk, and these adverse implications increase as marginal personal tax rates increase. Thus there are significant efficiency costs associated with increasing the personal income tax. Basically, a tax on incomes imposes a "double tax" on savings, since the income out of which savings are made is subject to income tax, and then the returns on the savings are subject to additional tax. With these negative incentive effects, individuals and households save less for future consumption as income tax rates increase, thus potentially increasing their dependence on government transfers. The reduction in savings also has important negative implications for investment and job creation.

The personal income tax derives proportionately more revenue from the working population than from the retirees, so changing demographics that see a rise in the proportion of retirees would be associated with a decreasing tax base and smaller revenues for any given set of personal tax rates..

Some or all of the costs of additional federal health funding could be met from a dedicated segment of the personal income tax, as for example a special income surtax or a structured separate income tax that is collected in addition to regular income taxes Such taxes would apply to all income, as opposed to just labour income.

(Indicate tax rate increases necessary to raise $5B of federal gov't tax revenues)

Canada already has higher personal income tax rates than the United States. These higher average and marginal rates make Canada less attractive on this account for the more skilled, high-income workers, and can induce emigration of these valuable human resources because of tax considerations.. The higher personal tax rates in Canada also raise the cost of investment capital in Canada derived from personal savings, and therefore discourage investment and improvements in productive capacity, and therefore productivity and future growth. While a number of factors (higher government debt and social spending) are likely to mean that Canada will continue to have for some time higher personal tax rates than the U.S., it is nevertheless good policy to avoid increasing the spread between US and Canadian rates, and in the long term to reduce these differences. Accordingly, there are major policy reasons for not imposing a significant increase in personal tax rates and widening the personal tax gap with the U.S.

Federal Health Insurance Premiums

As an alternative, a special premium tax could be introduced to fund some segment of health costs, with the tax being applied to total income from all sources. Such a special tax could have its revenues legally designated to pay only for specified health costs. The tax itself could be a uniform percent of income over a given exemption level, a flat amount per capita, or involve "step rates"- premium charges that would be uniform within an income bracket, but be higher for upper income brackets than for lower (thus increasing in steps as total income increased).

A flat per capita health premium tax does not affect marginal tax rates, and therefore has less impact on labour supply, savings and investments than a graduated personal income tax. If a step rate health premium is used however – with say three or four flat amounts varying by income bracket, the effect on marginal rates is concentrated at the "break points" in the scale, where the rates change. The step-rates premium therefore has less impact upon labour supply and savings decisions than a progressive income tax. However, with proper notch provisions the effects of this can be modified.

The revenue from a step rate health tax would grow with the population and with inflation (on the assumption that the rates are indexed.) To get more buoyant revenues that would grow at rates in excess of GDP, it may be necessary to index the rates by GDP growth rather than inflation.

(INCLUDE FURTHER INFORMATION FROM FINANCE ON STEP RATE HEALTH PREMIUMS AND REVENUE RAISED)

2. Payroll Tax

In a number of countries, the social health insurance is funded by an earmarked payroll tax. As a payroll tax is applied to only labour earnings, it has a smaller tax base than the personal income tax, hence for any given level of revenue, a higher rate is need for the payroll tax. Increasing payroll taxes also increases labour costs which can have a negative impact upon employment levels, and also reduce international competitiveness. While a payroll tax avoids some of the negative effects that an income tax has on savings and investment, it can still distort labour markets and adversely affect employment levels. A dedicated payroll tax however has the advantage that it can be more readily identified in the public mind as being related to health spending than a portion of the income tax revenues could be.

Under a payroll tax, there is also a significant inter-generational redistribution of income from the working population to pensioners who do not pay a payroll tax. Consequently, demographic changes would have a stronger impact upon revenues from the payroll tax than from the personal income tax, and as the proportion of dependents (retirees) increases, the burden borne by the working population to

finance the system also increases. The issue as to who bears the burden of this tax is not straightforward. For example, employers can shift the burden to employees by giving lower wages or shift the burden to consumers in the form of higher prices for goods and services.

Payroll tax and Social Health Insurance

This category of taxation, which is widely used in other countries to fund health care costs, would include government health "premiums" which are not related to actual benefits. Social health insurance contributions are compulsory levies usually placed upon the working population and shared between the employer and the employee. As these levies are frequently only applied to labour income, leaving capital income exempt, the social health insurance system is generally more regressive than the income tax-financed health system. In countries where there is a ceiling on the social insurance contributions, the system is more regressive than in countries in which there is no ceiling on payments, and removing exemptions from contribution for pensioners and other low-income individuals also makes the system more regressive.

(Indicate tax rate increases necessary to raise $5B of federal gov't tax revenues)

3. Corporate Income and Capital Taxes

The incremental costs of increased federal health spending could be met from an increase in corporate taxes. However, the base for corporate taxation is both smaller than the base for a payroll or income tax, and is much more variable. Further, increasing corporate tax rates would have a very negative impact on rates of return in Canada, and therefore discourage investment and job formation: even existing businesses could be influenced to relocate outside of Canada in response to what would be a very significant increase in tax burdens. The corporate tax is generally considered, for these reasons, as an unsuitable tax for raising additional revenues to finance the health system.

(Indicate rate increase needed for $5 billion when info is available from Finance)

<u>INDIRECT TAXES</u>

Indirect taxes include sales tax, value-added tax, excise tax, and import duties. Indirect taxation can be less progressive than direct taxation because they generally bear on consumption, which constitutes of larger proportion of the income of poorer individuals than of richer individuals.

Consumption Tax

Consumption taxes are usually charged as a percentage of the price of the good, and thus the distribution of the burden of payment of the tax is dependent on consumption patterns and not on income levels. As poorer individuals consume a larger proportion of their incomes than richer persons, the burden of a consumption tax fall disproportionately more on poorer individuals than a progressive income tax. (When the relative effects of a consumption tax and income tax are measured over a lifetime, the difference between them on this account is reduced.)

The consumption tax however has no adverse incentive effects on savings as does the personal income tax, and is therefore more efficient in an economic sense. In addition, the tax base is largest for the consumption tax and thus to raise any given level of revenues, the consumption tax rate increase required is smaller than the personal income tax rate increase required. However, consumption taxes in Canada are not uniform across all goods and services. As such, they create distortionary effects on consumption patterns and indirectly upon production decisions. One other disadvantage is that it may be more difficult to create a transparent link between a proportion of the consumption taxes paid and the benefits received. Lastly, consumption taxes in the United States are lower than in Canada, and thus the potential diversionary impact of raising consumption taxes (trans-border shopping) should be considered.

The major consumption tax in Canada is the federal GST. Because of its broad and generally non-distortionary coverage, it would be the most suitable consumption tax to increase to pay for increased federal spending on health care. Further, a mechanism already exists (the GST Tax Credit paid to low income individuals) to minimise the adverse distributionary effects of the tax on the poor.

(Indicate amount of GST increase to pay for $5 billion health support)

D. FUNDING ALTERNATIVES TO INCREASED TAXATION-

Given the significant tax burden of the existing combination of federal and provincial general taxes, a number of alternative funding sources have been proposed. Many of these proposals seek to increase fairness in the system and restrict unnecessary usage by having more frequent users of the system, contribute proportionally more to its funding.

Financing Systems Impacting Demand for Health Services

Strong arguments have been made by a number of commentators that in the absence of any mechanism linking the use of health services to personal contributions to fund such services, there will be excessive demand – demand for services that are all not necessary for favourable health outcomes, and that therefore cost sharing would improve the efficiency of the system by directing scarce resources to where they are most needed.. Accordingly, it is put forward that the cost pressures on the present publicly funded health system could be alleviated through Canadians being asked to pay, directly or indirectly, for even a small portion of the covered health costs that they consume. Such payments would, it is argued, result in Canadians thinking more carefully about the need for medical and other health services for relatively minor illnesses. If Canadians became more frugal in their demand for health services, there might be a significant reduction in health costs, and the financing of the system would be made easier. (In several models, such restraint would more likely have the effect of restraining future cost increases rather than reducing existing costs.)

Based on the findings in a number of studies, a recent publication (Funding Public Provision of Private Health, by Aba, Goodman and Mintz) estimates that requiring individuals to pay some modest level of costs for medical services instead of having them provided as a "free good" would reduce the demand for health services provided by doctors and institutions by 17%. As noted later, any practical plan of private "co-payments" would involve maximum contributions based on income, and full relief for those with low incomes: taking into account that a number of people would therefore not be subject to effective co-payments for additional services, the publication estimates that a total reduction in costs of 13 ½% would be achievable. However, there is a debate about the precise amount by which co-payment systems could reduce health care usage in the long run.

As noted more fully in the section on the selection of taxes to pay for health costs, all taxation has adverse effects on personal disposable income and incentives. In order to maintain a growing economy providing rising incomes and employment, it is necessary to restrain unnecessary government spending to keep taxes as low as is consistent with satisfying the demand for needed public services. Helping to finance health costs through systems that involve some modest level of personal financial responsibility for some health spending can decrease the aggregate demand for health services, and therefore costs and associated taxation. It would also make individuals more aware of the costs of public health care and thereby encourage greater personal responsibility and

understanding. This would actually improve health outcome by redirecting health resources to where they can make a significant difference in health outcomes.

Characteristics of Co-Payment Systems

In a Canadian context, any major and systematic cost-sharing system would likely involve:

- Reporting to individuals some or all of publicly funded health costs paid on their behalf, so that each person would know the aggregate health spending incurred by them that was paid out of public revenue. This in turn would require a comprehensive costing system that would determine and report confidentially to individual beneficiaries their share, based on usage, of the charges for the majority of public health care expenses.

- Some level of personal payment for at least some health costs ("co-payments").

- Relief from co-payments for low-income individuals, so that reduced or no payments would be required from those not able to cope with such costs.

- A cap or limit on co-payments for those with substantial health costs, so that the costs of catastrophic illnesses do not bear excessively on individuals.

- Providing all needed health services without significant up front payments: the co-payments would be dealt with separately, and later.

The reporting of publicly funded health costs to individuals for whose benefit the costs were incurred has been regarded by many as an important step in establishing greater accountability and transparency for health care spending. Such a reporting system could have value even in a system without co-payments, because it would provide a reminder to individuals of the costs they incur and of their social responsibility for those costs. It could also serve as part of an integrated management and accounting system for public health costs, allowing better identification and control over such spending, and as a means of linking health outcomes with costs.

However, the reporting of health costs by individual would raise some important issues:

- Not all publicly funded health costs can be allocated to individuals. There are important training, research, and administrative costs that cannot be readily assigned to individuals.

- If a system of reporting was linked to requiring co-payments, then consideration must be given as to whether the disincentive effect of co-payments are justified in those situations where health care has important externalities (immunizations) or where present spending can reduce future costs (diagnostics).

The effect of co-payment or user charges on the equity of utilisation of the health system must also be considered. Cost-sharing arrangements- depending on the type and level -

could reduce both necessary and unnecessary demands upon the health system. Accordingly, questions have been raised concerning the negative impacts of co-payments upon health outcomes. In addition, the reduction in utilisation – again depending on the characteristics of the system used- could be higher among low-income groups. Cost-sharing arrangements also do not consider the supply-side factors that influence demands, as for example where health care providers paid on a unit of service basis induce increased utilization by prescribing additional visits and procedures.

Introducing co-payments and other forms of user fees charges invariably leads to some additional administrative costs, although as noted the information systems required for co-payments may have other benefits. There is also the costs of implementing exemption schemes to ensure continued access to services for the poor and most vulnerable groups. These administrative costs constrict the cost saving potential of such systems.

Alternative Plans for Introducing Personal Responsibility for Health Care Costs

Canada is the only industrialized country in the world that provides complete first dollar public health services, and indeed effectively prohibits charging user fees for covered health services.

As noted above, requiring some element of personal responsibility for health costs can be an important feature in controlling such costs, and therefore may be an option to be considered. Noted briefly below are the outlines a variety of plans to achieve some level of personal cost responsibility.

a) Medical Savings Accounts

Under what might be regarded as the pure or classical model, medical savings accounts (MSA's) simply provide a pre-payment mechanism for individuals to save for their own health costs. Individuals are required (or given incentives) to contribute a portion of their income on a periodic basis into an account solely established to meet the health costs of themselves and their families. Costs incurred by the individual (and his or her family) are then paid for out of that account, with any balance remaining being reserved for future costs, or otherwise held for the individual's benefit. The incentive to conserve usage of the system comes from the future benefits which an individual may attain from having a positive balance in his medical savings account. However, in Singapore where this form of funding is used, the MSA must be complemented by mandatory catastrophic risk insurance to provide protection for extraordinary costs. Premiums for this are deducted from the medical savings account. Where necessary, health services for low-income individuals can be financed from a national fund.

This form of the MSA may offer an alternative to private health insurance for the self-employed and employees of small firms that find it difficult to pay for insurance. As the MSA does not pool contributions to the health system, there is no redistribution of costs: subject to the catastrophic insurance protection, each individual remains responsible for

his own expenses. Instead, the MSA distributes resources over the individual's life cycle. Income tax relief for required MSA payments may make the system more attractive but at some cost to the government through foregone revenue.

Medical Savings Accounts are especially appealing to policy makers who seek to assert individual responsibility for the funding of health care. The MSA impacts upon health system costs from the demand side, but does nothing to curb supplier-induced demand.

b) Modified Medical Savings Accounts

The terms of an MSA can be modified in a number of ways. For example, the required contribution to the individual MSA accounts can be made by the government, rather than by the individual. This involves a redistribution of benefits in two ways:

- The costs of the government's contributions must be met out of government revenues, and the related taxes will bear differently on individuals.

- The likelihood of individuals incurring health costs is not uniform, but varies by age, gender, state of health, occupation, etc.

As a result, government funded MSA accounts tend to benefit the young and healthy, who have a high likelihood of not requiring their MSA balances for health costs and therefore can carry them forward and possibly use them for other purposes: they disadvantage the sick and the old because they have to pay their share – through taxes – of the costs of the government's contributions, but obtain no net benefit.

Another variation is that once an individual has exhausted the funds in his or her MSA, he may be responsible for a portion of any health costs attributed to him, but usually up to some limit. Costs in excess of this co-payment tier would then be covered in full through some government or insured plan. Again, such a mechanism has the effect of redistributing resources from the sick to the well: it does have some incentive effect on usage, but also has other effects that have to be considered from an equity viewpoint.

Under the MSA approach discussed by the Mazankowski Report in Alberta, a set amount would be deposited to each individual's MSA each year. This amount might be the individual's Alberta Health Premium plus some additional funding from the government, especially for low-income individuals who may not pay the full premium. The MSA would then be charged with the individual's health costs for the year. If costs exceeded the balance, the individual might be subject to some penalty, but the government would cover the balance of the costs. If the costs came to less than the balance in the account, the individual could carry the positive balance forward and possibly use it for broader purposes. The Mazankowski report recognised the redistributive effects of this proposal, but still considered it worth further exploration and modification.

c) Variable Premiums with a Savings Account

The Mazankowski Report also suggested that an approach using "variable premiums" should also be considered by Alberta. Under this plan, an individual's Alberta Health care premiums would be deposited in a personal health care account, along with a subsidy for the aged. The account would be charged with a portion (say 20%) of the costs of the individual's health costs, with some exemptions for high cost surgery and chronic illnesses. If the account is exhausted, the individual is charged an insurance supplement, but the government then covers further costs. The maximum payment by an individual would be caped at 3% of taxable income. Positive balances in the account could be carried forward, and may be used by the individual for an expanded list of purposes.

Both plans listed for consideration in the Mazankowski Report would heighten awareness of health costs and provide some deterrence to demand. However, both involve some administrative costs, elements of complexities (as for example integrating families into the system, dealing with immigrants and emigrants, etc) and some redistribution in favour of the healthy and away from the sick. Both would also involve significant administration costs.

d) Contributions through the Tax System

1. Including health benefits in taxable income

   A variety of plans have been suggested, under which health benefits paid by an individual would be included in his or her income for tax purposes. This would result in the individual paying tax on such benefits at his or her marginal income tax rates. Such plans usually contemplate a cap on the additional tax, usually some modest percentage (3%) of income, and special relief for low-income individuals.

   Including health care payments for individuals in their incomes results in a progressive tax on covered costs, but compared to the present system would involve much higher burdens on the sick, elderly and other special groups than the young and healthy. Although, the system could have special allowances that prevent the additional financial burden to vulnerable groups.

   Tying the system directly into the personal tax could result in some savings, but risks distorting taxable or net income that is used for other purposes (i.e., if significant health benefits are included in an individual's income, he or she could find their child tax credit or GST credit reduced.). Again, there would be numerous complexities to be considered including he treatment of family groups, other dependents, etc.

2. Co-payments through Personal Income Tax Payments. *(Aba/Goodman/Mintz)*

   Under this approach, an individual would be required to contribute a portion (about 40%) of the public health benefits paid on behalf when filing income taxes, up to a percentage (3%) of taxable income. Thus the greater the burden an individual places on the system, the higher would be his or her contribution to the system. However, those individuals and families with a taxable income below a minimum established level, will not be required to pay any tax on health benefits received. This exemption limit could also take into account the size of families and more specifically, the number of children and elderly members in the household. As money is raised from these health contributions, and demands on the health services are lowered because of co-payments, reducing public costs, the federal and provincial governments can then lower personal income tax rates.

   While this tax would be administered through the income tax system, it would be a separate calculation and would not affect income for tax purposes. In order to implement this system, a pricing mechanism must first be established that would cost services. This information could increase administrative efficiency in the system leading to further cost reductions. The system would avoid the technical and psychological problems of including benefits in income for tax purposes. However, it would still redistribute resources from the sick and aged to the well and young.

3. Health Tax Credit or a "Tax Credit for Wellness" (*Reuber and Poschmann*)

   A further alternative would involve each individual receiving either a standard deduction or tax credit for health, with a portion of the health costs incurred for the individual being charged against the account. If the account had a positive balance, the individual might be able to carry it forward, possibly using it for a broader range of purposes. If the account was exhausted, the individual might face having to pay a percentage of the costs of a next layer of allocated costs, and would then be fully covered above that. An interesting feature of this proposal is that the amount of the deduction or credit would vary by age, sex, and health status, in an attempt to remove the unfairness of providing everyone with a standard amount.

   This approach could involve a significant net costs to governments because of the deductions or credits allocated to individuals, which would be offset to some extent by whatever reduction in demand occurred because individuals would, in some sense, be spending their own money on health costs (within limits).

   However, it has the substantial advantage that, from a perception standpoint, it could be regarded as a bonus for wellness, rather than the tax on sickness that might be used (rather unfairly in some cases) to characterise other co-payment plans.

In all of the above plans, there can be some significant redistribution effects, basically in favour of the well (and the young) and against the sick (and aged). This effect can be

minimised if the plan employs exemptions, co-payment ranges, credits etc. that are not uniform flat amounts for everyone, but instead are graduated by age, sex, medical condition, etc. This may however increase the complexity of the plan.

Further, analysis of the incidence of illness shows that most individuals consume relatively little in the way of health services in any one year, while a few consume very large amounts. There is therefore extreme variability in health costs amongst individuals, even amongst those with the same age, gender and health characteristics. No amount of profiling of exemptions, etc., can eliminate the random effects of unpredictable illnesses on individual costs under such co-payment systems.

e) Changing the definition of covered costs

In general, Canadians at present have an "entitlement" – without cost – for a wide range of covered services, but have to bear personally the bulk of the costs of other health services (such as home care, drugs, dentistry, etc.) (Some support for a limited number of these costs is provided through numerous and not well-integrated provincial government assistance plans for low income and other Canadians.) The rationale for determining which health costs are to be publicly funded as opposed to privately paid for is not strong: any comprehensive review of the public health system would involve a review of the present division of costs in relation to perceived health priorities and the management of the system. Such a review could result in some in some presently covered costs being delisted and shifted to the responsibility of individuals, with a resulting saving in expense: it could also result in some presently excluded services being covered.

To digress, there are powerful efficiency arguments in favour of exploring some form of co-payment mechanisms in the health system, offset by equity considerations. These equity considerations in turn are influenced by the fact that Canadians now have "first dollar" coverage for all covered health services, and there is a perception of unfairness if this cover were modified in such a way that illness would bring with it some appreciable personal costs. If Canada did not already have a comprehensive publicly-funded health system, it might well be argued that any new system should involve some personal financial responsibility for health costs (likely other than major illnesses and procedures), and Canadians would likely accept this as reasonable and an improvement to the efficiency of the system. But since we already have total coverage of eligible services, it is quite possible that we are in a situation where we can't get there from here: there are broad questions of perception and concern that would have to be addressed in introducing most co-payments systems into the present system.

f) Point of Delivery User Fees

These allow the health service providers to charge a fee representing a part of the cost of the service to individuals at the point of service. User charges are said to be regressive

because of their negative effect upon equity in the system. The higher the share of user fees in the system, the greater the funding burden falls upon the unhealthy, generally more vulnerable members of the population, in contrast to tax-financed systems which place a heavier burden on the high income earners. There is also a fear that significant user charges will deter both necessary and unnecessary utilisation of health services, especially among low-income individuals. The additional disadvantage of point of delivery user fees is that they can prove to be much more of a deterrent to low-income individuals, who may have to pay now for services and obtain some reimbursement later.

g) Private Insurance Plans

A large number of countries use some form of insurance coverage as part of their health care system: individuals pay premiums to and receive benefits from various insurers, usually under plans with standardized basic coverage and mandated premium groups with all individuals being eligible for cover.

Various systems can cover some or all health costs through insurance arrangements, involving either public or private insurers, personal premiums, and schedules of covered benefits. Such plans may or may not involve co-payments, and some may fit in with managed health care systems.

Private insurance coverage could be used to supplement or replace publicly funded health care, possibly with individuals who opt out of the public system receiving a tax rebate. The advantages of such a system, which is increasingly used in other countries, include:

- Private insurers are able to offer a range of coverage and premiums (likely subject to the coverage always including some basic elements), so that individuals can select the cover and cost that they prefer.

- Private insurers will have an incentive to try to control costs, through managed health care arrangements, preventive procedures, bulk purchasing of services, etc., perhaps in more innovative ways than the public system.

- To the extent that the private insurers arrange for additional health care providers, the overall pressure on the total system may be lessened.

- The insurance arrangements establish a clear link between costs (premiums) and benefits for those participating.

- Insurance categories can assign higher premiums to risk categories where the insured has control of the risk (as smokers), thereby inducing better health outcomes and lower overall costs.

The disadvantage is that a system of private insurance coverage would move away from the single payer base of the present system, could involve additional administrative costs, and may pose issues for the remaining public system. Further, experience in other

countries has indicated dissatisfaction about the tendency of some insurers to try to avoid recognising and reimbursing some costs.

However, a totally decontrolled and competitive insurance system also creates issues of coverage and fairness. Particular insurers will tend to set different premiums for different categories of insureds, and competitive pressures will force insurers to define more strictly risk categories assigned lower premiums. The result may be that high-risk individuals – including the chronically sick, the elderly, etc – may be placed in risk categories with extraordinarily high premiums. A stable system with competitive insurance products may involve broad mandated categories, with insurers unable to decline insurance cover to individuals within each category.

While widely used in other countries as part of the overall organisation and financing of heath care, private insurance systems would be difficult to use at the federal level in Canada because of the provincial responsibility for health services. Individual provinces might wish to examine such systems, however.

Provincial vs. Federal Responsibility

Virtually all of the co-payment and user charges dealt with above are plans that would likely be best considered at the provincial level, since the provinces are responsible for the overall administration of the system. However, such plans can impact costs to which the federal government has contributed, and may give rise to questions as to their compatibility with the principles in the Canada Health Act. Accordingly, the consideration being given to various types of such plans by Alberta and other provinces has very important implications for the federal government and its financing contributions to the system.

COMPARATIVE ASSESSMENT

When the public health system is financed primarily through progressive personal income taxes, there is significant redistribution from the high income earners to the lower income earners who tend to use the system more. The mix of the more progressive direct taxes determines the degree of progressivity in the tax-financed system, and the more regressive indirect taxes employed. Studies indicate that countries that use predominantly direct taxes to fund the public health system have less progressivity in their direct tax system than countries which depend more on indirect taxes.

Thus high income earners would benefit from a shift from a tax-financed system, to the implementation of user fees where contribution is related to usage rather than income. In addition, if exemption schemes are implemented to ensure continued access for the poorer members of the society, then the shift from a tax-financed system to user fees causes redistribution of income from middle income earners to high income earners. If the population as a whole, start perceiving that the tax-financed system is not able to

provide quality and timely care, then support for a tax-financed system diminishes and the middle income earners will support the high income earners' demand for lower taxes and more private payments into the system either through user fees or private insurance.

With a step-rate premium, individuals make premium payments are also linked to taxable income levels. However, there is no link between premium payments and usage of the health system. Thus this system of financing is also more progressive than user fees with higher income groups pay higher premiums, regardless of usage of health services.

Social heath insurance, like the tax-financed system, links contributions to income and not use of health services. Thus the social health insurance is more progressive than user fees. However, the income base for social insurance does not include savings, as with the personal income tax. Savings contribute a larger proportion of wealth for higher income earners and the social health insurance is more often than not, more regressive than the tax-financed health system.

It is argued that general tax-financed systems contain costs better than social health insurance systems or earmarked tax-financed systems, because the transparency of the social health insurance system weakens resistance to contribution increases than tax increases if the increase is believed to be related to increasing efficiency in the health system.

With both tax-financed systems and social health insurance, income level determines the individual's financial contribution to the system, but in no way obstructs or assists with access to health services. This is not the case when private payments, either through private insurance, user fees or other cost-sharing arrangements are implemented to fund the health system.

With the introduction of cost-sharing mechanisms, it is argued that fairness in the system is enhanced as more frequent users of the system contribute proportionately more. In addition, depending on how the cost-sharing is implemented, efficiency and accountability of the system are also enhanced as in the case where costs for health services have to be determined.

Table 2: Comparative Analysis of Funding from Tax Sources for Federal Government incremental expenditure on the health sector.

	Advantages	Disadvantages
Personal Income Tax	• Tax on both labour and capital income offers a wide tax base. • Progressivity in the income tax schedule means higher income earners contribute more than lower income earners regardless of health.	• Impacts upon savings, labour supply decisions thus affecting efficient allocation of resources. • Changes in demography that increase proportion of retirees affects revenues.

		• Lower rates in the U.S. puts Canada at a disadvantage at attracting high-skilled, high-income workers.
Payroll Tax	• An earmarked tax, easy to link the tax increase to the benefits provided and thus is a politically "easier" sell. (European experience)	• Smaller tax base than the income tax, thus a higher rate needed to generate same level of revenues. • Demographic changes would have a stronger impact as the tax base is only composed of the working population.
Consumption Tax	• Has the largest tax base, smaller increase in tax rate necessary to raise any given level of revenues. • Amount of tax paid should correlate with income as consumption is correlated with income. • Demographic changes has the least impact upon revenues • Least distortions to the economy hence lowest efficiency costs. • More regressive than the income tax.	• Difficult to link benefits with the tax. • Lower rates in neighbouring U.S. might impact upon domestic consumption levels.
Step-rate or Income Based Premium	• Payments based on taxable income thus high income earners contribute more to the system. • Revenue raised can expand list of services covered by public insurance. • Administratively easy (and cheap) to implement compared to other alternatives. • Relatively easy to garner political support for this system.	• No link between use and payments, thus no impact on demand for services or costs to the public sector.
Modified Medical Savings Accounts	• Individual awareness of health costs should reduce excessive demand on the system. • Health Care Providers would have to calculate the cost of services, thus increasing accountability and efficiency in the system.	• Increased government revenues needed to fund the government proportion of contributions. • The biggest winners are the young and healthy who will accumulate savings. There

		is little gain for the chronically ill, and elderly members of society.
Variable Premiums with Savings Account	• Individual awareness of health costs should reduce excessive demand on the system.	• Complex administration could lead to significant costs
Health Benefits as Taxable Income	• Individual awareness of health costs should reduce excessive demand on the system. • The patient does not face health costs up front so cash flow problems do not hinder access to services as might happen with user-fees. • Contribution to the system based on both income level and health status. • Health Care Providers would have to calculate the cost of services, thus increasing accountability in the system.	• Administering this system could be quite complex and have significant administrative costs.
Credit for Wellness	• Individual awareness of health costs should reduce excessive demand on the system. • Contribution to the system based on both income level and health status. • Health Care Providers would have to calculate the cost of services, thus increasing accountability in the system.	• Additional government revenues needed. • The biggest winners are the young and healthy who will accumulate savings. There is little gain for the chronically ill, and elderly members of society.
Co-payment through the tax system.	• Individual awareness of health costs should reduce excessive demand on the system. • The patient does not face health costs up front so cash flow problems do not hinder access to services as might happen with user-fees. • Contribution to the system based on both income level and health status. • Health Care Providers would have to calculate the cost of services, thus increasing accountability in the system.	• The biggest winners are the young and healthy who will accumulate savings. There is little gain for the chronically ill, and elderly members of society, thus affecting political support.
Point of Delivery User Fees	• Individual awareness of health costs should reduce excessive demand on the system.	• The more vulnerable groups are placed at a disadvantage compared to the young and healthy. • Contribution does not take

		into account income flow. • Can have negative impacts on the demand for necessary services, leading to poor health outcomes.

Funding the Incremental Expenditure within the Existing Canadian Tax Treatment

Present tax support for health costs

The present income tax system does provide for some level of support for health costs incurred by individuals for expenses not covered under the basic public plan. This is done chiefly through a medical expense tax credit for unusually high health costs incurred by individuals, but there are other special provisions for the disabled and others.

The specific measures include:

Medical Expense Tax Credit: Individuals receive a non-refundable tax credit (which can be applied to reduce income tax) of 16% of qualifying health costs in excess of the lesser of 3% of net income or $1,676 (figure for 200l). Combined with similar provincial tax credits, an individual with sufficient income and tax would receive a total benefit of about one-quarter of excess qualifying costs.

Refundable Medical Expense Supplement provides increased tax assistance for low-income individuals with unusually high medical expenses. The benefit, which is refundable if it is in excess of federal tax, is 25% of allowable costs to a maximum of $500, and is only available to low income individuals with some earned income.

Disability Tax Credit is available for those with severe and prolonged disability:
The credit is now about $750 for those qualifying.

Attendant Health Care Expense Deduction provides a limited deduction –up top 2/3 of earned income- for the costs of attendant care necessary to perform in the labour force.
The above special provisions reduce federal and provincial income tax revenues by about $1 billion annually. The credits and deductions noted above could be expanded to provide even greater levels of support, which could be helpful in particular circumstances, as for example home care. But the existing tax measures are not well integrated with the rest of the system. The non-refundable credits can only be claimed by those with sufficient income and tax, and therefore are of little use to the lowest income individuals: the refundable mechanism for low-income individuals would need to be extended to overcome this. Further, the benefits are largely delivered after an individual has incurred the costs, meaning that he or she must find the resources to pay the initial expense. And identifying and monitoring the relief provided through such measures

provides difficulties. Overall, there are limits on the effectiveness of using the tax system to deliver targeted relief for non-covered health expenses.

However, the largest aspect of tax support for health costs is not the above measures, but rather the non-taxation of health care premiums paid by the employer on behalf of individual employees, while the costs remain deductible by the employer. The exemption from tax of such employment benefits reduces federal and provincial tax revenues by something in the order of $2 billion a year.

The existing exemption may be regarded as unfair in a number of ways. Those employees covered by employer health plans gain an advantage not available to those who are not, and the amount of the benefit is the largest for those with the most elaborate and generous plans and the highest incomes. The exemption of these benefits effectively provides a substantial subsidy to those obtaining benefits (dental care, eye glasses, drugs, etc) not covered under the basic public health system, while others obtain no such advantage. Consideration could be given to removing this exemption for benefits from employer health plans, particularly if the resulting government revenue was directed to strengthening our public health plan.

It has sometimes been argued that the removal of this exemption would discourage employers from providing health insurance benefits. However, it is noted that employer health plans have in general grown over recent years even as premiums and costs escalated markedly, and it seems unlikely that an increase in the after tax cost of the benefits would significantly lessen private health plan coverage although it would reduce the after tax income of those employees now receiving tax-free benefits.

E. COUNTRY COMPARISONS

Table 1: Funding National Health Care Systems in the OECD.

Country	Description	Source of Public Funds
Australia	• Medicare provides everyone with free access to medical services in public hospitals, independent of income. • Both the States and the Commonwealth provide funding, but delivery is the primary responsibility of the States. • A parallel private insurance market, which is strictly regulated by the Commonwealth, exists to provide supplemental coverage. The purchase of private insurance is concentrated among wealthy households. • Premiums for private insurance are community rated to ensure equitable access. • Unexpected out-of-pocket payments and the rising cost of premiums for privately insured persons has resulted in reduced demand for private health insurance despite significant tax incentives to purchase private insurance.	• General tax revenues constitute about 80% of Commonwealth expenditure, sourced primarily from income taxes. The States receive all GST revenue. The GST replaced most State and Local taxes as of July 2000. • The remaining 20% of Commonwealth expenditure is funded through a health levy on taxable income of 1.5% above a certain income threshold, and 2.5% if the individual has no supplemental private insurance, this providing an incentive to purchase private insurance. • Block transfers from the Commonwealth to the States are capped for 5-year periods and are based on population and performance measurements.
Denmark	• Primarily public and decentralized system where three administrative levels, the state, the county and the municipality each play an important role in the funding	• About 82% of health sector expenditure is financed from both central government (State taxes) and local (county and municipal) general tax revenues (OECD 2002).

	and delivery of health services. • The responsibility of financing and planning health services rests with 14 counties and 1 hospital authority located in the Copenhagen metropolitan area. • Free access to hospital and general practitioner services is available to all Danish citizens, health examinations and dental treatment is free for all up to age 18. • Pharmaceuticals provided in hospitals are free of charge but those provided in the private sector require some form of co-payment.	• The majority of the public sector funding for the health sector, about 80%, comes from local (county and municipal) tax revenues. The remaining 20% comes from subsidies from the State which are calculated annually and are correlated to the size of local tax revenues. Expenditure on the health sector accounts for approximately 70% of local tax expenditures. • Annual meetings between the Ministry of Health, the Ministry of Finance and the Representatives from the county and municipal councils are used to negotiate the local tax rates and hence revenues raised by local bodies, the level of state subsidies to the counties and municipalities, and the level of financial equalisation at the local level. • The State's ability to control local tax revenues through the setting of tax rates, allows it to have significant influence over the development of the health sector and the local government's delivery of health services. In addition, the State identifies priorities in the health sector and designates proportions of its funding to these specific activities. Thus the local bodies do not have complete control over the State subsidies. • The major component of tax revenues is the personal income tax which is progressive but is only levied on 59% of income earned. • Because of the variations in the tax base in the different

		counties, a significant amount of redistribution of income occurs between counties and municipalities based on age distribution, number of children in single-parent households, number of rented flats, unemployment rates, immigrants from non-EU countries, the number of people living in socially deprived areas, the proportion of single elderly people. The size of this financial equalisation is decided upon at the annual negotiation. • Co-payments are necessary to cover dental care, physiotherapy and pharmaceutical purchases made outside of the hospitals. About ¼ of the Danish population purchases Voluntary Health Insurance (VHI) to cover these co-payment expenses. • Danmark, a non-profit association, covers over 95% of those insured. Premiums are not tax deductible.

France	• 3 main health insurance schemes cover 96% of the population. The population has no choice of insurer, and allocation to a scheme depends on place of residence and employment status. Since 2001 there has been no variation in the benefits offered by the 3 schemes • Over 90% of the population have complementary Voluntary Health Insurance (VHI).	• The health sector is funded mainly through earmarked taxation (national not local taxes) and social insurance contributions. • Earmarked taxes include the CSG, a flat rate tax applied to total income at 5.25% (3.95% for pensions and unemployment benefits); corporate taxes paid by pharmaceutical companies based on sales and promotional expenditure; and excise taxes on tobacco, and alcohol. • There is no ceiling on social insurance contributions for salaried workers industry and commerce. Employers contribute about 12.80% of gross earnings and the employee's contribution is 0.75%. Rates for the self-employed and farmers are lower and there are ceilings on contributions for these workers. • For those with low incomes, the CMU provides complementary VHI coverage. A little more than half the workers purchase complementary VHI through their employers. There is no tax relief for CHI premiums. • There is no annual out-of-pocket payments ceiling per individual, however, all co-payments are eligible for re-imbursement by complementary VHI policies. There are also co-payment exemptions for patients with chronic illnesses and hospital procedures over a certain limit.
Germany	• 88% of the population is covered by statutory health insurance (SHI), 9% of the population is covered by substitutive full-cover private health insurance; and	• Tax revenues account for a minor part of public health expenditures (less than 10%). Over 90% of public health care funding comes from Social Health Insurance (SHI)

	2% receive free government health care. Less than 0.2% are uninsured. • Persons with incomes in excess of a certain ceiling can opt out of the SHI and purchase substitutive private health insurance. There is no private insurance available to cover patient's co-payments for medical services and benefits. • Patients are required to make co-payments for drugs; the first 14 days in hospital or rehabilitation care per calendar year; ambulance transportation; non-physician care (15%); and crown and denture treatments. Preventative dental treatments require no co-payment.	contributions which are proportionate to earned incomes. • The average SHI contribution rate is 14%. Contributions are based on labour earnings only and are shared equally between employers and employees. For persons with income below a minimum threshold, only employers contribute (10% of income earned). • Non-working spouses and children of SHI members are covered without any surcharge. Retirement and Unemployment funds take over the role for the non-working population. • Germany has the largest VHI market in Europe. Unlike SHI, separate health insurance premia must be purchased for non-working spouses and children, thus making it a less attractive option for families and single-income couples. Health Insurance premia are deductible from taxable income. Since 2000, an additional 10% surcharge has been added to substitutive private health insurance to build up financial reserves that are used to subsidise premium rates for clients as they get older. Thus regulation has led to considerable smoothing of private health insurance premia over the insured's life-span. • User fees account for approximately 11% of total health expenditure, but a number of checks and balances are in place to limit these payments. i) low income earners and those on unemployment benefits and social welfare only pay co-payments for hospital treatments, ii) Up to the age

		of 18, co-payments are only required for ambulance transportation and crown and dentures treatments, iii) There is annual out-of-pocket payments limit of 2% of gross income, iv) Chronically ill individuals who have already paid 1% of gross income for drugs, non-physician care and transportation, are exempt from making further payments for treatment of that illness, v) In a few cases when out-of-pocket payments are exceptionally high, health care expenditures can be deducted from taxable income.
Sweden	•	• Tax revenues represent over 70% of the total health care expenditure. • County tax revenues constitute the bulk of this, accounting for 66% of total health expenditure. Expenditure on the health sector account for nearly 85% of county budget expenditures. • State grants from the central government account for another 7-11% of total expenditure. State grants are allocated according to a weighted capitation based on indicators of health needs such as sex, age, occupation, income, housing tenure etc. Most of the state transfers are earmarked. • Nearly 25% of the total health care expenditure is met by the national social insurance scheme. Social insurance contributions are made up 8.5% of employee salaries, paid for by employers and employees paid about 8.2% of their wages. (2000 data)

		• Those wishing faster access to treatment obtain voluntary supplementary health insurance. Less than 2% of the population has supplementary insurance…premiums are not tax deductible. • User charges for most medical services take the form of flat rate payments. There is a nationally set ceiling on the total any one citizen can pay in user fees over a 12-month period, however the local governments set the payment rate schedules. The central government also determines the ceiling on co-payments for prescribed drugs.
United Kingdom	• All legal residents are covered by National Health Service (NHS), but nearly 12% of the British population also has supplementary private health insurance. • The NHS is primarily funded by revenues from the central government, but the purchase of health services is the responsibility of local bodies such as the local health groups (LHGs) and the primary care trusts (PCTs). •	• Only general revenues from national taxes are used to fund the NHI. General tax revenues account for about 80% of NHS funding. Local tax revenues however do support home care and residential care for the elderly programs. • National Insurance contributions account for about 12% of funding to the NHS. Insurance contributions are based on labour earnings and shared between the employer and employee (10% and 11.9% respectively). There is no ceiling on national insurance contributions. The self-employed make fixed weekly payments plus a % of profits. • Voluntary supplementary private medical insurance are for the most part purchased by employers for employees, although employers must still make National Insurance contributions based on the value of the private medical

		insurance benefit and employees must pay tax on the health bene fit. • User charges are levied on prescription drugs, ophthalmic services and dental services

The federal government has had a major role in initiating designing, and financing our public health care system. Now that that system is under challenge because of increasing costs and consequent resource constraints, the federal government has the opportunity – and the obligation – to work co-operatively with the provinces, who have the primary responsibility for health care management, to meet the new challenges facing the system for the benefit of all Canadians.

But the appropriate federal role with respect to the financing of the public health care system is not simply to provide more funds to the existing system. As costs continue to grow and as other issues such as accessibility and efficiency receive increasing attention, any new federal funding initiative must be integrated with a package of changes – discussed in detail in this Report- in order to provide better health care for Canadians on an affordable basis.

Nature of New Federal Financing

For the purposes of this paper, it is taken as given that the federal government will wish to devote an additional $5 billion annually to support Canada's public health care and to help carry out significant reforms of the system. It is also assumed that this additional federal cost will require new and specific federal taxing initiatives, for the following reasons:

- the existing balance of federal revenues and expenditures will not readily permit the additional expenditure without running the risk of creating an overall deficit, and
- in any event, the increased federal contribution to the system – over and above the existing levels of federal support – should be identified with a specific and corresponding tax measure so as allow Canadians to recognize the costs of the new support.

The existing financing system, which is based on substantial federal and provincial contributions, has obscured the relative roles of the two levels of government, and has led to confusion as to who is responsible for the system. Greater transparency and accountability will be achieved for both levels of government if a specific federal tax or charge is combined with a specific new federal financial support that pays for specific improvements in the system.

Source of New Federal Financing

This paper has reviewed all of the main tax fields open to the federal government to finance an incremental expenditure in support of the system. All taxes involve costs – the direct costs of reduced resources on those who are called to pay the tax, the increased costs o administration and collection in getting in the revenue, and the indirect costs to the economy –reflected in lower levels of economic activity, investment, growth and jpob creation – that the tax will cause.

All taxes therefore involve important trade offs between the benefits of the tax – enabling the government to pay for programs desired by Canadians – and the detriment that the tax

will create. And it is important that Canadians understand this trade off and have the information to hold governments accountable for the balance of interests that it creates.

While there is no such thing as a "good" tax, there are specific objectives which a new tax or charging initiative designed to pay for a specific public benefit should meet:

- the tax should have the least possible adverse effect on economic activity and growth in relation to the revenues sought to be raised.
- the tax should involve modest administrative costs of compliance for taxpayers and collection costs to governments
- the justification for the tax should be clearly apparent to the public, by associating the revenue with the benefits of the spending
- the tax should have revenues that are stable, and robust (in the sense that they will grow at at least the rate of GDP, enabling the funds for the new tax measure to meet the likely increasing costs of the program.
- the tax should be equitable, so that the cost is apportioned fairly and reasonably over the groups that will be called upon to pay it.
- the tax should be perceived to result in some tangible improvements to the system and to health services, so as to justify its collection.

Based on the above criteria, it appears that the following two types of taxes may be the most suitable for consideration as sources for new federal revenues to meet new federal health initiatives:

- an increase in the rate of the GST (along with a corresponding increase in the GST Credit for low income Canadians): this tax increase would only fall on consumption, not incomes; would not raise marginal tax rates on investments or savings, would be spread over a huge and stable tax base that would grow at about the same rate as the GDP, and could be fairly distributed amongst Canadians.

- a per capita variable health premium, paid by those paying federal income tax (after a low income exemption). This tax would be levied at different flat amounts depending on the tax bracket of the taxpayer. But in general, it would only have a moderate effect on marginal rates, and could raise substantial amounts from a relatively stable base.

To do;

MENTION WHAT $5 BILLION IS FOR, IN GENERAL TERMS

MENTION CONDITIONALITY OF $5 BILLION

IT IS PRESUMED THAT THE FOLLOWING MATERIAL FROM THE ORIGINAL CONCLUSION CAN BE DELETED, AS THE POINTS WILL BE DEALT WITH ELSEWHERE IN THE REPORT

If the federal government is to provide increased funding for health care in Canada,

- how should the amount of the additional support be determined?
- under what conditions should the higher support be paid to the provinces?
  - deliverables? –restrictions on use?
  - adherence to standards?
  - avoidance of having the provinces simply absorb any additional support into general revenue?

Alternatives to be discussed include:

(i) transfer of additional block grants (within or without the CHST) to the provinces, subject to conditions (and a note on the enforcement of conditions)

(ii) transfer of tax points to the provinces (which would have substantially different inter-provincial allocation effects, and which would be hard to tie conditions to.)

(iii) payment of specific grants, tied to costs or achievements in specified areas

(iv) payments to support general health system infrastructure (info systems, change management, research, etc.)

(v) dividing the existing federal support to the provinces into two sections: one would be a grant of so much per senior (age 65 or over), while the balance would be the remaining part of the present grant, divided amongst the provinces on the basis of population under age 65. The effect would be that the present level of federal support would be continued, but with provinces having more than the national average of seniors benefiting (and others losing.) This approach would help the sustainability of health services in those provinces with excess seniors.

How can the federal government be assured that the funding will make an appropriate difference in the health services to Canadians?

Deal with accountability issues: how can the federal government obtain verifiable assurance that new funding has been used for designated purposes and has not simply replaced existing levels of provincial funding?

<u>Final thoughts.</u>

A new approach to the financing of health care can only be implemented as part of a revised health care system, with appropriate focus on efficiency, effectiveness, …/

The federal role in this new system rests on providing input into a federal-provincial co-operative effort to both improve the system and its delivery of quality health services to Canadians, and restrain the negative economic effects of escalating costs.

Questions to be raised include:

- should Canadians be made more sensitive to the costs of the system, and how those costs are related to taxes?
- should alternative systems try to restrain demand?
- can we devise a simple system that will raise the necessary funds for incremental federal support of the system in a way that is related to specific federal incremental taxes?