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Options for Raising Revenue for Health Care

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The views expressed herein are solely those of the authors and do not necessarily reflect those of the Commission on the Future of Health Care in Canada.

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Highlights

- This paper examines options for raising revenues for health care either through new sources or variations in existing sources.

- Hypothecated taxes, which have been proposed in Britain for health care funding, are rejected on the grounds of high administration costs, the restrictions they place on the provincial budget-making process, and the long-term difficulties of keeping the process of revenue allocation transparent.

- A system of copayments administered through treating a portion of individual use of the health care system as a taxable benefit in the personal income tax is rejected on the grounds that it assumes that overuse of the system can be deterred by charging patients, and requires a large leap in Canadian values in assuming that individuals should personally bear a proportion of their medical costs.

- Increased transfers from the federal government to the provinces, either as a lump sum or through a re-introduction of cost sharing, are rejected on the grounds of being unstable and, for cost sharing in particular, of distorting decision making at the provincial government level without a clear rationale for doing so.

- A proposal is made for a shift in tax room to the provinces, in particular through the GST, administered through a low administration cost, highly efficient system first used in the European Union.

Executive Summary

The *Interim Report* of the Commission on the Future of Health Care in Canada outlines four basic options for dealing with the problem of the fiscal sustainability of Canada's health care system:

- Providing more revenue to the system to "catch up" with a basically sound system that has recently been to some degree underfunded;
- Searching for new revenue sources to deal with what are expected to be rapidly increasing costs in the system, owing to an aging population, and the supply and demand of new health technologies;
- Looking for ways to use the private provision of insurance and services to supplement the public system; and
- Finding greater efficiency in service delivery within the public system (2002, 26-7).

This essay focuses on the first and second options, comparing the enhanced use of existing revenue sources with finding new revenue sources.

Our analysis is grounded in the traditional economic concepts of efficiency and equity. Efficiency requires that the revenue option not unduly distort the workings of the market. Equity presents itself in four variants: (1) vertical equity, that revenue should be raised on the basis of ability to pay; (2) horizontal equity, that the revenue option should treat alike those in like situations; (3) intergenerational equity, that the tax, transfer and government expenditure system should not be structured such that one generation receives benefits far in excess of the taxes it pays relative to some other generation, which bears the burden of financing the difference; and (4) the benefit principle, more controversial than the other three, that to some degree individuals should contribute to health care financing in a way related to their use of the system.

Hypothecated taxes are either add-ons to an existing tax or a stand-alone tax that is publicly committed by the government to be devoted to health care expenditure. Defenders of hypothecated taxes note that public acceptance of an increase in taxation is much higher when the extra revenues are expressly dedicated to health. However, there are drawbacks, and we conclude that Canada does not require a hypothecated tax at this time, on the grounds of high administration costs, the restrictions they place on the provincial budget-making process, and the long-term difficulties of keeping the process of revenue allocation transparent.

A recent proposal in Canada by Tom Kent (2000) was that additional revenues could be found for Medicare through treating individual use of the health care system as a taxable benefit in the personal income tax. The revenue would be collected by the federal government and redistributed to provinces through a cost-sharing system on Medicare expenditures. We question whether the problem of overuse of the health care system is best addressed through the incentives facing patients, rather than health service providers. The notion that individuals should bear some of the cost of the use of the system would require a major change in Canadian

thinking. A similar proposal, by Aba, Goodman and Mintz (2002), like Kent, fails to provide a convincing ethical argument for user copayments. Finally, we note a number of the problems with Kent's proposal for transferring money to provinces through cost-sharing agreements.

We conclude that the best means of ensuring stable funding for provincial treasuries, which is where financing to health care providers must ultimately flow, is through a transfer of tax room to the provinces. Since it is already likely the case that provinces rely more on corporate taxes than is efficient in a federation, and since it is difficult to use the personal income tax as a major instrument of income redistribution if devolved in a significant way to the provinces, sales taxes are the most promising avenue for change.

We suggest, following a scheme first outlined in Hill and Rushton (1993), a transfer of the federal GST to the provinces, to be administered through a system similar to that in place in the European Union. The proposed system, perhaps contrary to much belief, does not require a uniform tax rate or base across different provinces. For administration it relies on interprovincial mechanisms already in place, and if, as likely, it led to the elimination of existing provincial retail sales taxes, it could substantially decrease the administration costs of Canadian public finance. It is efficient in that it does not distort interprovincial resource allocation or encourage tax competition among provinces. It would give provinces stability in funding, and flexibility in their choice of tax mix.

We find this proposal is superior to reliance on federal-provincial transfers, which would need to increase in future decades, with all the political dispute this would entail, to correct what is forecast to be a growing vertical fiscal imbalance.

Introduction

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- Searching for new revenue sources to deal with what are expected to be rapidly increasing costs in the system, owing to an aging population, and the supply and demand of new health technologies;
- Looking for ways to use the private provision of insurance and services to supplement the public system; and
- Finding greater efficiency in service delivery within the public system (2002, 26-7).

This essay focuses on the first and second options, comparing the enhanced use of existing revenue sources with finding new revenue sources. This is not meant in any way to rule out the other two options as possibilities, perhaps superior ones. But we leave to other investigators the questions of whether the system is at present underfunded, and whether there are gains to be had in more efficient use of private or public health care resources.

After a preliminary discussion of key concepts in the analysis of health care funding, our paper constructs an argument in three parts. First, we reject the idea, made recently by various Canadian commentators, that additional revenue for the health care system should be found through collecting at least some revenue from individuals based on their use of the health care system. Instead, we recommend finding extra revenues through the tax system. Second, we argue that it is better that the additional revenues be collected at the provincial level, rather than having them collected at the federal level and subsequently transferred to the provinces. Third, we argue that sales taxes are the field where provinces can raise extra revenues most efficiently and, owing to the large vertical fiscal imbalance between the federal and provincial governments, the federal government can afford to sacrifice some tax room. We propose that the GST is more easily administered at the provincial level than is often assumed, and provide a sketch of how a transfer of this tax field from the federal to the provincial governments might work.

Efficiency and Equity

A useful guide in the examination of public sources of health care funding is given by Normand (1992, 768):

- The cost of collecting the funds should be low
- The system should be equitable
- The funding should be adequate and not be subject to fluctuations
- The system should not lead to conflict with other government objectives
- The public should be satisfied with the system
- The system should not channel funds into low priority programmes or away from high priorities.

When we say that the cost of collecting funds should be low, we mean this in two senses.

First, the system should be *efficient* in the economist's sense of the term. Almost all methods of raising public revenue impose a cost on the economy; the market economy is generally quite effective at allocating labour and capital resources to their most productive uses, and the various taxes levied by government will typically change the incentives of individuals and investors such that at the margin they are directed away from their most productive use. As a result, taxes remove an amount of income out of the private economy greater than the amount of revenue actually received by government. This difference is called the efficiency loss, and an efficient tax system is one that does not cause efficiency losses beyond what is necessary given the amount of revenue to be raised and the equity goals of the government.

Second, the cost of administering the collection of revenue should itself be low. This includes both the cost to the government of administering the revenue source and the cost to the taxpayer of complying with the system. This puts a burden on any advocates of a *new* tax to be added to the existing collection of federal, provincial and local taxes, since the administration costs of the system would be increased, compared to an increase in the rates applied to existing taxes, which would entail no additional administrative costs.

That the system should be equitable generates many questions. There are (at least) four different concepts of equity we should keep in mind, noting that individual citizens are going to place very different weights on these four concepts.

The first notion is vertical equity, which holds that to some degree the financing of public health care should be based upon ability to pay, i.e., the system should be "progressive." While this seems uncontroversial, we make two notes. First, that it is fair to have a progressive system does not imply that more progressivity always equals more fairness. There is a balance to be found between collecting revenues on the basis of ability to pay and requiring those with high

incomes to bear an unfairly high burden of the total revenue needs. Second, note that just because it is a shared value that the tax and expenditure system should be progressive does not mean that each and every component of the system needs to be progressive. For example, the best tax system is likely a combination of a progressive income tax and sales taxes that are roughly proportional in burden. The system as a whole is progressive even though the sales tax itself is not.

The second notion of equity is horizontal equity: those in similar circumstances should be treated the same by the tax system. Again, the idea that revenue should not be collected in an arbitrary fashion is uncontroversial, but we note that in Canada's federal system the concept of horizontal equity is at least part of the rationale for equalization transfers, meant to ensure that individuals in all provinces, regardless of the provincial tax base, have access to comparable levels of public services at comparable tax rates.

The third notion of equity is intergenerational equity. In this case, the idea is to avoid a situation where citizens of one generation pay taxes substantially higher than the benefits they receive from the public sector as a result of their subsidizing the public sector consumption of an older or younger generation. As a hypothetical example, suppose generation Z ran large government deficits during their working years. Further suppose upon retirement generation Z pays low taxes, perhaps because the tax system is heavily geared toward income taxes rather than consumption taxes, and at the same time places high demands on public expenditure through the health care system. The generation working during generation Z's retirement years may consider the system somewhat inequitable as they struggle to finance both generation Z's health care demands and the government debt left by generation Z. Recent estimates by Cardarelli, Sefton and Kotlikoff (2000) show that, for many countries, the generation currently over the age of 50 will receive a net benefit through the tax, transfer and expenditure system financed by those currently under 50, in most Western countries and, to a significant degree, in the United States. In their estimates, Canada stands out as the only country with virtually perfect intergenerational equity at the present time. This is good news, because it means that governments in Canada have the flexibility to be able to consider policies that might conceivably shift the intergenerational balance without fear that they are exacerbating some pre-existing substantial intergenerational inequity.

The fourth concept of equity, very controversial in the field of health care, is the question of whether, at least to *some* degree, it is fair that individuals contribute to the financing of health care in a way proportional to their use of the system. As we show below, some prominent Canadians have advocated this view. However, it is a contested view. Tobin (1970) coins the phrase *specific egalitarianism* for the notion that for *some* goods, like medical care, availability of service should not depend on income. The rationale for specific egalitarianism is that equality in the distribution of a certain set of goods is necessary for all individuals to have an equal opportunity to fully participate in society. This would include civil liberties and the justice system, at least minimum amounts of food and shelter, and necessary medical care.

Health economists have devoted considerable attention to the challenging question of what constitutes equity in health care (Culyer and Wagstaff 1993; Hurley 2000; Pereira 1993; and Wagstaff and Van Doorslaer 2000). There are different levels across which we could think about

equality: equality of health, equality of health care or equality of access, for example. In a paper on options for raising revenue, the key aspect of equity is access (which is not meant to diminish the general importance of the other equity aspects). *Why* equal access matters is subject to debate. Wagstaff and Van Doorslaer (2000, 1815) stress that access matters to us because it is a means to an end – we think equal access is especially important in health care because we think health is a special kind of good, unlike other consumer goods – while Hurley (2000, 89) takes a different approach: “The ethical basis for equality of access does not derive from any necessary relation with its ultimate effect on the distribution of health care or health. It is intimately linked to the notion of equal opportunity or a fair chance.”

A small copayment for health care services, which did not apply to low-income individuals and which had a cap as a proportion of income, would not eliminate availability of health care for anyone. That being said, the notion that use of health care services would become an economic decision for individuals rather than something they simply use when they have a felt need is going to go against the grain of what has become, for good or ill, a value judgment held by many Canadians. We argue below, when we evaluate some copayment proposals, that the proponents have not provided the kind of moral argument that will be necessary to convince the public at large.

Hypothecated Taxes for Health Care

General taxation, social insurance, private insurance and payments by individuals are common options for funding health care worldwide. Hypothecated or earmarked taxes, ones whose revenues are dedicated solely to funding health care, are an option, though rarely used.

The idea has several merits. Hypothecation is a way of connecting citizens with the taxation they pay. A potential problem with the current system of pooled or non-hypothecated taxes is that it obscures the purpose of taxation. The processes by which government currently decides how to allocate revenues to given programmes or areas are decided by government, out of public view. This gives the government great flexibility in what it does, but at the same time promotes distrust and cynicism among taxpayers.

The concept of identifying a particular tax, or part of a tax, has the attraction that it introduces transparency into the financing of a service. There is less resistance from the public for tax increases when they are justified (Le Grand 2000). Research done for the Fabian Society's Commission on Taxation and Citizenship in the United Kingdom on public attitudes toward taxation demonstrated that public hostility to increases in taxation is dramatically reduced if people are told on what the money will be spent (and if they believe what they are told). When asked if they favoured a 1 percentage point increase in personal income tax as a contribution toward the general pool of government revenue, only 40 percent agreed. When asked if they would favour a rise if the money was spent on the National Health Service, 80 percent agreed.

However, there are arguments against hypothecated taxes. This policy is not favoured by departments of finance as it reduces their ability to control expenditure compared with funding from a general pool of revenues (Normand 1992). Also, if it is a new tax rather than a "piggyback" on an existing tax, it incurs high collection and administration costs. A variant of hypothecation is that all the revenue from "sin taxes," i.e., taxes on tobacco, alcohol and gambling (including lotteries), should be earmarked for health funding. This has little advantage over pooling revenue from these sources with other taxes. Furthermore, the revenue from these taxes would likely fund only part of the total health care costs. If one wanted to earmark a single tax or part of a tax to wholly fund the health care, then the only possible candidates are income tax or sales tax.

There seems to be little need for a hypothecated tax for health care in Canada. Where provinces are devoting around 40 percent of their operating budgets to health care expenditure, no single tax could come close to providing the necessary revenues on its own. As for a hypothecated tax to fund incremental spending, the taxation-expenditure link would quickly become cloudy as the government made any adjustments to other taxes or areas of spending. It would increase administrative costs in terms of trying to provide transparency in how the new tax was being devoted to the expenditure side of the budget, and this transparency is necessary to the justification of a hypothecated tax in the first place.

Copayment Systems: An Evaluation of Two Proposals

Tom Kent (2000) proposes a system of copayments for Medicare that he sees as consistent with the provisions of the *Canada Health Act*, where user fees and extra-billing are not (note that Courchene [1994, p. 186-7] proposes, in passing, a plan similar to Kent's). Although the implementation of any system of copayments will raise questions regarding whether it is compatible with the *Canada Health Act*, especially the provision on access (but also the provision on portability), the Act in itself does not provide us with a definitive answer to questions about which systems of copayments would or would not be found acceptable. As economists not trained in the interpretation of federal statutes, we are unable to provide critique of Kent's claim that his proposal falls within the provisions of the Act, although no doubt the claim is based at least in part on the fact that under his proposal low-income individuals would make no additional payments.

As background, Kent notes that Medicare, as it stands, has costs and expectations that are great and rising, with patients who are generally unaware of the costs their personal use imposes on the system (although they are generally aware of the total cost to the taxpayer) and physicians with little incentive to be cost-conscious.

> In short, the ideologues of market economies are right, in the sense that pressure to exceed reasonable needs is inherent in tax-financed health care. Medicare does require a way to contain its costs without breaking the principle of universal access.
> (Kent 2000, 11).

Kent proposes that individuals (or families) receive at the end of each year a statement of the costs of their use of the Medicare system. The statement would be in a format similar to the T4 used in the personal income tax. Medicare use, up to between 5 and 10 percent of income, depending on family size and income levels, would be treated as a taxable benefit for the purposes of federal income tax. Under current federal tax rates, the total increase in income tax should not be more than 2.9 percent of pre-tax income for any individual. Since he proposes that provinces may or may not want to participate, it is not clear whether this marginal increase to federal taxes would be added to the tax base of those provinces that continue to base their personal income tax on federal tax owing (many provinces are departing from the "tax-on-tax" system of gathering provincial personal income tax to a "tax-on-base" system). Note that Kent also proposes increased transfers from the federal government to the provinces for Medicare, the details of which are discussed in the next section of this paper. But for now we note that there is some rationale for collecting this extra revenue at the federal level, since it is accompanied by a proposal to transfer the funds to the provinces.

The rationale for this particular method of tax increase is that:

> Few people may realize how much their own care costs, but all know that Medicare in total is expensive, that it is in some respects inefficient, sometimes abused. The ordinary sense of fairness is not offended by the idea that people should make some direct contribution to the cost of service, according to how much they use it and how much they can afford. (Kent 2000, 12)

Although Kent refers to user fees and extra-billing as "crude devices," in fact this is a proposal for "progressive" user fees (indeed more progressive than the personal income tax, since the proportion of the individual use of the system that is added to taxable income is itself applied in a way that rises with income).

Aside from the federal-provincial relations aspect, dealt with below, there are substantial concerns with Kent's proposal.

First, Kent himself notes that physicians are not always the most cost-conscious users of public funds. Yet his proposal assumes that the major incentive problem facing Medicare is located not with the doctor but with the patient. The vast literature on that crucial problem of health economics – supplier-induced demand – is beyond the scope of this essay, except to note that there are significant questions about any scheme that assumes more rational use of the health care system if only the patient is forced to bear a direct proportion of the costs (see Barer et al. 1994; Evans, Barer and Stoddart 1994; and Evans et al. 1994).

Second, the notion of what constitutes fairness in paying for health care is subject to question. Kent claims that our notion of fairness does not object to people paying for the service based on what they use and how much they can afford. Our tax-financed system already funds health care on the basis of what people can afford, so the major innovation that comes with the "taxable benefits" proposal is to have people pay according to what they use. One could *conceivably* make an argument that Kent is correct: fairness dictates that heavier users of the public health care system should pay more, incomes being equal. The Interim Report of the Commission notes that among the differences in opinion found on how to address the sustainability problem in Medicare, at least one of the four outlooks around which views tended to coalesce was that individuals should bear more financial responsibility for their use of the health care system (Commission on the Future of Health Care in Canada 2002, 11). But Kent's claim that the "ordinary sense of fairness" is not offended by the idea is true only for a portion of the Canadian public, and a deeper enquiry is needed before this value could be used as a basis for health care reform.

Still, we note that Kent's paper is a valuable attempt to deal with the political and economic challenges facing the reform of Medicare, and many of the proposed reforms, in terms of federal-provincial cooperation and the need to more effectively harness the tremendous advances in information technology to the Canadian health care system, are certainly worth careful consideration, although those aspects are beyond the scope of this essay.

Aba, Goodman and Mintz (2002) (AGM) propose a copayment system somewhat similar to Kent's. Key differences are that AGM would have the additional revenues be raised directly by the provinces rather than by the federal government, and would be based on 40 percent of the cost of services to a maximum of 3 percent of annual income above the threshold level of $10,000. AGM estimate that 62 percent of families would pay the full 3 percent. Not only would the plan raise additional revenue, by about $6.6 billion based on year 2000 figures, but the incentive effects for individuals to economize on their use of the system would save about $6.3 billion annually (based on a 17 percent drop in use by those individuals not at the 3 percent-

of-income ceiling – those at the ceiling have no disincentives on health care use, since the marginal cost for them is the same as under the present system, i.e., zero).

Although there would be increased administration costs from this new payment mechanism, AGM stress the positive aspect: an accounting of individuals' use of various parts of the Medicare system should improve accountability.

Like Kent, AGM *assert* that there is something fair about the copayment system without really providing a thorough explanation: "Fairness is improved because individuals who consume public services contribute more to their cost" (p. 2); "When consumption levels of public services vary among people in otherwise similar economic circumstances, then fairness is improved if contributions are related to the cost of those services. Fairness is improved further if individuals who may assume health risks that result in greater health care expenditures contribute more to the costs of the health care system" (p. 5).

Evans et al. (1994) stated:

> If a service is incontestably medical in intent, and is effective, and is regarded by the community as necessary, and can be provided in no other, less costly way, why would one want to impose a user charge? At that point one of the standard arguments against user charges, that they tax the sick, seems wholly justified. Such charges may be highly effective as a revenue raising devise, but why would one regard the experience of illness, and the use of effective care, as an indicator of taxable capacity or ability to pay? No answer ever seems to have been offered. (P. 27)

The proposals by Kent and AGM each ensure that the lowest income individuals will not face additional charges. But under each proposal, the "fairness" rationale for copayment is given no defence, and so there is insufficient reason for departing from our current system of raising revenues for core health care services through general taxation. The remainder of this paper will focus on raising additional revenues through the tax system, and the next section considers whether the additional revenues should be raised at the federal or the provincial level.

Federal-Provincial Tax and Transfer Issues

Provinces bear the burden of paying health care providers in the Medicare system. So any options for raising revenue for health care must ultimately result in an increase in funding to provincial treasuries. We divide the various ways of accomplishing an increase in provincial revenues into three categories:

- increased block transfers from the federal government;
- increased transfers from the federal government based on cost sharing; and
- an increase in the ability of provinces to raise own-source revenues.

We deal with these in turn.

Block transfers from the federal government to the provinces, not tied in any way to levels of provincial funding, have two principal rationales. The first is equalization, which has both equity and efficiency justifications. The equity rationale for an equalization system is the value we seem to share as Canadians that people across the country should be able to receive roughly comparable levels of service delivery by their provincial governments at roughly comparable levels of taxation. Indeed, that is the reason given in our Constitution for Canada's equalization system.

The efficiency rationale for equalization is less known. Canada's economy will be at its most productive if it's labour force is allocated across regions and jobs such that each worker is located where his/her marginal product is highest. In general, competitive labour markets do a good job at generating this allocation, since in equilibrium in each place of employment wages will tend to equal marginal product. As technologies and world trading prices change, so do the values of workers' marginal products. Where labour has become more valuable, perhaps owing to increased demand for a particular service, wages will rise in that sector, and some workers will choose to leave the lower productivity sector for the higher productivity sector, following the higher wages. Equilibrium is eventually reached through the law of diminishing returns, as wages eventually equalize across sectors for any given skill level. But a complication arises when provincial governments have significantly different per capita tax bases, since labour will allocate itself according to the *total* income it can receive in a province; total income would include wages but also the "net fiscal benefit," the difference between the government services the individual will receive and the taxes he/she will have to pay. In this case labour is not being allocated strictly according to productivity, and national income will fall. To put it in a concrete context, it is a misallocation of Canadian labour if individuals move to Alberta not because wages have been rising there, but because that is the only way to take advantage of the benefits that flow from having public services funded by high natural resource revenues and only very low personal taxes. An equalization system, like the one in Canada, should prevent excessive migration to tax-base-rich provinces by equalizing to some degree the net fiscal benefits in different provinces; see Boadway (2000) or Boadway and Hobson (1993) for a defence of the efficiency-rationale for equalization. It should be noted that the efficiency argument for equalization is not universally held – some may wonder if it is in fact efficient to provide the Atlantic provinces with substantial equalization payments on the rationale that we would not want to allow excessive out-migration. Also note that the United States does not have an

equalization system (although some of their federal-state transfers are at least somewhat equalizing); see Courchene (1994, 107-8) for a critique of the efficiency argument for equalization.

Since the purpose of equalization is to equalize net fiscal benefits, it makes sense that the formula is based on the shortfall between a province's tax base and the average tax base of a five-province standard. It also makes sense that the equalization payments are a lump sum to be spent as the province sees fit and are not based on provincial spending.

The other rationale for block transfers from the federal government to the provinces is "vertical fiscal imbalance" (VFI). VFI arises when the federal government has greater capacity to raise revenue through taxation than it actually needs in order to fund spending programs that fall under federal jurisdiction, and provinces are in the opposite situation of not having enough taxation capacity to fund the programs for which they are responsible. Much of the federal-provincial debate over health care funding revolves around the problem of vertical fiscal imbalance, with health care costs rising faster than other areas of government spending and provinces constrained in their ability to raise the necessary revenue to fund it. The Canada Health and Social Transfer (CHST) is the primary transfer designed to correct the problem of vertical fiscal imbalance, being an equal per capita transfer to all provinces. As Hobson and St-Hilaire (2000, 160) note, a method of revenue-transfer is *all* that the CHST is; it does not function as an instrument of social policy.

How large a problem is VFI? Ruggeri and Howard (2001) consider VFI through a lens that compares the future path of federal and provincial revenues and spending based on the built-in growth that would arise from the current tax and federal-provincial transfer systems. They conclude that, under current arrangements, the federal government will see a steady increase in the size of its budget surplus while, in general, provinces will have small and somewhat precarious surpluses over the next 20 years; in other words, the problem of VFI will worsen without some sort of policy change. A significant contributor to the projected increases in VFI is the rate of increase in health care costs, projected at 4.8 percent annually, while total own-source revenue growth for the provinces is projected at only 3.8 percent annually (compared to 4.3 percent at the federal level).

Norrie and Wilson (2000) concur that VFI is likely to increase under current arrangements. In their comparison of dealing with the problem through increased transfer payments from the federal government or through increased tax capacity for the provinces, they note that an advantage to increasing federal-provincial transfers is that the marginal cost of raising tax revenue might well be lower at the federal level than at the provincial. The main drawback of dealing with increasing VFI through increasing federal-provincial transfers is that it provides little guarantee of stable funding for provinces. The history of the past few decades is such that provinces will always be wary of relying even more heavily on transfers, which can be cut, sometimes in very arbitrary ways, whenever the federal government finds itself in some fiscal difficulty (also see Hobson and St-Hilaire 2000, 182-3).

There are other problems that arise with transfers to deal with VFI. If health care costs are likely to continue to rise at rates higher than either other public expenditures or tax revenues

under current rates, then the amount of transfer must continually be adjusted. In such circumstances, as recent history has shown, there is confusion in the public mind as to the degree to which the two levels of government should be held accountable for decisions made on the raising of revenue and the expenditure of funds in health care. Current arrangements may not foster accountability for governments in public health care.

However, federal-provincial transfers based on cost sharing in Medicare would at least partially solve the problem of the level of transfers keeping pace with the increased cost of providing health care. But there are significant concerns with cost sharing as well.

Kent (2000) suggests that the revenue from the income-tax-based copayments discussed above be distributed to provinces through a cost-sharing scheme, initially set at 20 percent of eligible expenditure and rising as high as 25 percent as various federal-provincial co-operative measures are put into place. Kent gives two rationales for cost sharing. First, “the standard and good reason for such support is that without it Newfoundland, say, could not afford much of what Alberta can” (p. 3). But that is a reason for equalization, not cost sharing. Second, the *Canada Health Act* mandates that provinces run some very expensive programs: “Medicare could not have begun, as a similar service for all Canadians, except as a federal-provincial partnership. It can survive only as a partnership in which shared principles are backed by shared costs” (p. 3). But again, this is a rationale for ensuring that provinces have adequate revenues to fund federally mandated public health care, something which can be achieved through either a lump-sum transfer or an (equalized) increase in the capacity of provinces to raise own-source revenues. It might be that what Kent has in mind is the federal government using its financial contribution as a means of enforcing, through the threat of the withholding of funds, of the *Canada Health Act*. This is the view of the National Forum on Health (1996), which speculated that as much as the federal government might use its powers of “moral suasion” to persuade the provinces to uphold the existing principles of Medicare, “unless it is backed by some financial or regulatory clout, there is no reason to believe this would be an effective strategy.”

The CHST is the culmination of a long withdrawal by the federal government in cost-sharing programs for Medicare, welfare, and post-secondary education. The rationale for cost sharing at the time was that the federal government wanted to provide *incentives* to provinces to expand service provision in those fields beyond what the provinces would themselves opt to provide under a lump-sum transfer of equivalent value. In other words, the aim was to provide what economists would call a “substitution effect” – a change in the relative prices of goods in order to encourage a particular activity, in this case particular government programs – as well as an “income effect” – the effect on provincial budgetary decision making resulting from a lump-sum transfer with no changes in the relative costs of programs. But here we would have to ask, in the 2002 context, why we would want to provide provinces an incentive to allocate a greater share of their budgets to health care, at the expense of other programs, than they would in the absence of a shared-cost program. Normally economists justify cost sharing if there is a significant interprovincial externality arising from expenditure in a particular program. But there is no evidence for such an externality in health care, certainly not to the extent that a 25 percent subsidy is required to provincial spending.

There are other problems that arise with cost-shared programs. First, a decision must be made if it is to be closed- or open-ended. The history of open-ended programs is that the federal government came to resent being responsible for providing funding for a program over which it had no control over the amount of spending. If closed-ended, then at the margin the desired substitution effect, if it existed in the first place as a justification for cost sharing, is removed as provinces would find that they were responsible for 100 percent of spending at the margin. Second, cost sharing can cause an inefficient allocation of resources across policy areas, as provinces devote too many resources to those particular programs that fall under the scope of cost sharing at the expense of other programs that may also be effective in achieving the wider policy goals. For example, officials in provincial departments of social services report that there is now a much greater willingness to experiment with different programs in the human services area, integrating training, employment, and income supplements, in ways that were not done during the cost-sharing years of the Canada Assistance Plan, which provided 50 percent cost sharing to a limited selection of welfare programs. Given the very wide range of policy instruments that can be used by governments to achieve the outcome of better population health, it is important that there not be artificial incentives to focus on some instruments rather than others purely because they fall under a cost-sharing agreement.

The third option for increasing the resources in provincial treasuries so as to allow greater expenditure on health care is to provide provinces with increased capacity to raise own-source revenues. To preserve the goal of horizontal equity across Canada, it would be crucial that any new revenue source be fully included in equalization.

The critical problem with increasing provincial revenue capacity is that Canada possesses an unusual tax structure for a federation, with all major tax fields occupied by both Ottawa and the provinces. Economists have often remarked on this fact, and although there are some differences of opinion on some details, there seems to be a broad consensus that (1) corporate income taxes are an inefficient way for provinces to raise own-source revenue, and are a field that is probably best left to the federal government, (2) sales taxes are most efficiently left at the provincial level, with a federal presence in the field not really necessary, and (3) personal income taxes are such a substantial source of revenue at both levels of government that it makes sense to leave it as a shared field.

In an oft-cited review of the issues, Richard Musgrave (1983) asks, in a federal system, who should tax, what, and where. The standard answer from the theory of federal public finance is that those taxes that aim to progressively redistribute income in a significant way, as well as those taxes that apply to bases that are highly mobile across sub-national jurisdictions, should be levied at the federal government level. Provincial governments are best suited for taxing less mobile bases, and will be limited in the degree to which they can pursue income redistribution. From this analysis, it is not surprising that observers suggest that corporate income taxes are best levied by Ottawa, since the corporate income tax base is highly mobile across provincial boundaries. Although the tax base for corporate income for firms operating in more than one province is allocated by the simple formula of the average of the total payroll and the total sales in the province as a share of the national levels, in a recent empirical study, confirming prior work by other researchers, Mintz and Smart (2001) find evidence of substantial corporate tax shifting across Canada in response to variations in provincial corporate tax rates.

If there are problems with corporate taxation at the provincial level, and indeed even internationally as capital becomes even more mobile, then increased provincial personal income taxes or sales taxes become the best option.

But since both taxes are also occupied by the federal government in a significant way, provinces can only increase tax rates in either of these areas if Ottawa is willing to create some "tax room." The case for this can certainly be made in revenue terms, given the evidence of an increasing vertical fiscal imbalance in favour of Ottawa over the next few decades. But we recognize the substantial political issues involved in having the federal government being willing to cede a substantial revenue source.

Our recommendation is for a transfer of sales tax room from Ottawa to the provinces; put simply, the GST should become a provincial tax. We provide a method for administering the GST at the provincial level in the next section, which amounts to an adoption of the Quebec "zero-rating" system Canada-wide. Our rationale for increased sales taxes at the provincial level is that they are the most efficient means of provincial revenue collection. Indeed the GST will prove to be even more efficient than existing provincial sales taxes. We also will show that the proposal would not entail large administration costs.

The proposal is not a radical one. Giving the sales tax field to the provinces was recommended by the Rowell-Sirois Commission and the Carter Commission, and is supported, although the specifics vary, by Boadway and Hobson (1993, p. 154) and Ip and Mintz (1992). However, since substantial concerns are raised about whether such an arrangement is administratively feasible (Bird 1994), it is important that the details be clearly set out.

Increasing Provincial Tax Revenues: A Proposal

Our proposal for transferring the GST to the provinces was first set out in Hill and Rushton (1993), and draws on the recent experience in the European Union (EU) with Value-Added Taxes (VAT) like the GST. We refer readers to the original reference for detailed exposition – in this paper we give a brief outline of the proposed system and some of its implications.

The Europeans faced the following problem. Each country in the EU administered a VAT. The rates differed across countries, as did the base; for example, in some countries basic groceries were subject to the tax and in others they were not. Into such a system came the initiative to end border controls within the Union on goods and services. The European problem was in how to administer a system of VATs without border controls.

Achieving an administratively simple method for running the GST as a provincial tax involves the same problem as the Europeans faced, albeit from a different path. In Canada, we already have a system of interprovincial trade without border controls, and the question is how to place into Canada a system of provincial VATs that might differ in rate and tax base. It had been argued that indeed it could not be done, and the only way we could have the GST at the provincial level, or even as a shared "harmonized" tax with Ottawa, would be with a single national rate and base (Bird 1994; Boadway and Hobson 1993, p. 154, who argue that provinces alone should occupy the sales tax field, resign themselves to the current system of provincial retail sales taxes, on the assumption that a VAT could only exist interprovincially with a single rate and base). Indeed, when negotiations took place on harmonizing sales taxes in the early 1990s, we could speculate that talks broke down when provinces were unwilling to accommodate the federal request for a single national rate and base. But Europe has achieved a method of solving the problem, and it can be applied to Canada.

We begin by noting that the GST is run on the "credit-invoice" method: firms pay GST on their purchases and remit the receipts for a fully refundable credit. Firms collect no GST on foreign exports; in this sense it is a "destination-based" tax, applying to Canadian *consumption* rather than to Canadian *production*. In the end, the entire burden of the 7 percent tax is on Canadian consumers, and indeed that is the whole burden since there are no hidden and carried-forward sales taxes from the production and distribution process, since any GST paid at those levels has also been refunded (we abstract from production by firms so small that they need not register for the GST, since it does not affect the essence of the plan). The incidence of the GST differs from that of non-harmonized provincial retail sales taxes. While much of the retail sales tax is collected from Canadian consumers, there are also non-refundable taxes paid on business inputs. The incidence of the tax on business inputs is complex:

- For goods retailed in Canada where there is competition from imports, the tax on business inputs cannot be shifted forward to consumers, and so is shifted backwards and borne by the less-mobile factors of production, i.e., labour and land rather than capital.

- For goods retailed in Canada where there is a lack of import competition, the tax can be shifted forward to consumers.

- For goods exported abroad, for which there is almost always competition, the tax cannot be shifted forward to foreign consumers, and so is borne by domestic producers, again especially by labour and land. Note that firms do not collect provincial retail sales taxes on exports, even if the exports are only out-of-province.

Since the retail sales taxes are at least partly borne by producers, there can be inefficiencies in the choice of location of production arising from the tax; these are inefficiencies that do not arise with the GST.

Under existing provincial retail sales taxes, no tax is collected on out-of-province exports; like the GST, the retail sales taxes are meant to be destination-based. But the *importer* is expected to pay sales tax in *her* province. Provinces monitor interprovincial shipments with regular exchanges of information, sometimes formal and sometimes informal; the administrative machinery for administering interprovincial trade and sales taxes already exists. Under our proposal, firms shipping interprovincially would continue to collect no sales tax on the sale. The importer would pay no tax on the import, but simply declare the value of the shipment and the tax that ordinarily would be owing along with the claim for credit that the firm would normally file for within-province purchases.

A crucial point is that such a system allows different provinces to levy different rates of VAT, or even, as Alberta might choose to do, no sales tax at all. No tax revenues from this provincial VAT system would need to flow across provincial boundaries, and so there is no need for any sort of central clearing house of payments across Canada. Further, provinces could have a different final tax base. Under the scheme, if Manitoba decided to tax children's clothing but Saskatchewan chose not to, no administrative complications would arise.

The proposed system would be more efficient than Boadway and Hobson's (1993) proposal to simply continue with retail sales taxes. It is simpler than Bird and Mintz's (2000) proposal for harmonizing the provincial sales taxes with a continuing federal GST (their proposal for how to harmonize is very similar to what is proposed here, see p. 280), and further adding a new tax for provinces and municipalities, a "business value tax" that is similar to a VAT except origin-based rather than destination-based, and applying to the income generated by each firm (its "value-added") rather than on the final value of consumption. (Note that Bird and Mintz propose an origin-based tax on the basis that provinces will want to tax business income somehow, especially if, as Bird and Mintz recommend, responsibility for corporate income tax is shifted to Ottawa. The taxation of business income is justified at the provincial and local level on the basis that to some degree a "benefit tax" is required – when the public sector is providing valuable inputs to the production process, the users of those inputs should pay some of the price).

The proposal for shifting the GST to the provinces has the advantage of transferring to provinces one of the most efficient taxes on the menu available, one that would not have the interprovincial competition issues that the corporate tax has or even the personal income tax, especially when provinces attempt to make the income tax relatively progressive. It does not entail the creation of a new tax, and would indeed likely lead to the elimination of an old tax – the retail sales tax. So administrative costs are reasonable. And even though the GST is more a proportional tax than a progressive one, recall our earlier comment that what matters is that the

overall system is progressive, not each and every component. As opposed to new federal taxes that could subsequently be transferred to provinces, the sales tax proposal allows individual provinces more flexibility in choosing the tax mix their residents will face, rather than a uniform federal tax (although note that Zeckhauser [1994] suggests the introduction of a federal VAT in the United States to pay for a proposed Canadian-style health care system). Finally, as opposed to a new hypothecated tax or a new copayment mechanism, our proposal does not presuppose that Canadians need to pay more in taxes – it allows the possibility of increased revenues without insisting upon them.

Conclusion

As Bird and Mintz (2000) note, the exchange of tax fields between the federal and provincial governments requires a lot of cooperation, and efforts to ensure that there are transitional funding arrangements for any province that looks to lose through the transition. It is also critical that equalization continue to be applied in an effective manner. Given the acrimonious debates during the past decade over federal “off-loading” and inadequate federal-provincial transfers, we are not so naïve to think that Ottawa would easily transfer a major revenue source without some kind of trade-off, and that jeopardizes our main goal, which is to get more funds to provincial treasuries. But since it has not been established that the Canadian system of public finance as a whole is underfunded, and indeed with large and growing surpluses predicted at the federal level, we believe that Canadians’ interests are best served by a re-allocation of public funds between levels of government, rather than adding new revenue sources. There is simply not a strong enough case to be made for a hypothecated tax or treating a portion of Medicare use as a taxable benefit through the personal income tax.

The implementation of the plan would need strong political leadership at both levels of government: in Ottawa to be willing to give away a significant source of revenue, and in the provinces to work with a tax that had been rejected as an option when first introduced (although rejected in the context of a federal insistence on a national uniform tax rate and base). But, even with this political hurdle, it is surely preferred to the *continuous* debates that come from federal-provincial transfers (Norrie and Wilson 2000; Hobson and St-Hilaire 2000). A transfer of GST also avoids the problem that is often at the root of VFI – the superior ability of the federal government to collect taxes – since interprovincial distortions are minimized with a destination-based consumption tax like the GST.

There do not exist any politically straightforward ways of increasing the funds at the disposal of provincial governments, and so we look to a solution that is at least efficient, administratively reasonable, does not shift the equity in taxation in the combined federal-provincial system, and lowers the potential for future political disputes.

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