Controversy

# Funding Canada's health care system: a tax-based alternative to privatization

**Michael Gordon, MD; Jack Mintz, PhD; Duanjie Chen, PhD**

Canada's government-funded health care system is under fiscal attack. Despite the mandate of the Canada Health Act, which was meant to assure universality, comprehensiveness, equitable access, public administration and portability, strains are affecting the efficacy of the system that had, until recently, served Canadians well.[1–3] Health care funding has been curbed as a result of federal and provincial efforts to eliminate deficits. Under the guise of restructuring, governments have provided less money to the system. The results have been hospital closures, staff layoffs and diminished access to certain components of health care.[4]

## The cry for privatization

To counter the impact of diminished funding, some physicians and commentators have called for substantial privatization of our health care system, suggesting that the system will fail to meet the needs of Canadians without an infusion of new financial resources.[5–8] It is argued that an option to purchase health care would provide additional resources to the system, including the selling of services to US patients.

Privatization supporters maintain that the principles of universality and equitable access conflict with a patient's autonomy to choose to pay privately and with a physician's choice to provide preferential treatments to those payers.[6,8,9] They contend that the publicly funded system with a private tier would relieve the pressure on the public sector and thereby would benefit all Canadians.

## Arguments against privatization

The main argument against privatization is that it would undermine the Canada Health Act.[10,11] Although some medical services are already privatized (e.g., hospital accommodation, drug costs other than for defined populations, some rehabilitation services and long-term care), these services are marginal to the primary services available to all Canadians. Another argument is that the quality of the public system would be threatened in 2 ways: first, better quality services would be offered privately, where resources are more plentiful; second, public resources would shift to subsidize the private system, as has been the case in the United Kingdom and Australia.[12–17]

Even though limits on the degree of private care exist in the United Kingdom's and Australia's publicly funded systems, it may be impossible for Canada to resist the US market-driven health care industry because of our close economic ties. Privatization critics point to the threat of increased US-style "corporatization" of health care, with its problems of access, bureaucratic costs and compromised quality of care.[18–22] Perhaps most important are the concerns about undermining ethical principles, especially fairness, according to which health care is provided in Canada.[23,24]

*Editorial*

*Éditorial*

**Dr. Gordon is Vice-President of Medical Services and Head of Geriatrics and Internal Medicine at Baycrest Centre for Geriatric Care, Head of the Division of Geriatrics, Mount Sinai Hospital, a member of the Joint Centre for Bioethics, University of Toronto, and Professor of Medicine, University of Toronto, Toronto, Ont. Dr. Mintz is Director of the International Centre for Tax Studies and Arthur Andersen Professor of Taxation, Joseph L. Rotman School of Management, University of Toronto. Dr. Chen is Associate Director of the International Centre for Tax Studies, Joseph L. Rotman School of Management, University of Toronto.**

*This article has been peer reviewed.*

*CMAJ* 1998;159:493-6

*Articles in the Controversy section appear in the form of a debate. An invited response to Dr. Gordon and colleagues' article, by Steven Lewis, begins on page 497. Their rebuttals follow on page 500.*

## Alternatives

One alternative to privatization is to continue with the existing publicly funded system and finance it through a combination of enhanced federal and provincial general taxation. The main problem with this approach is that Canada's tax burden is quite substantial, especially its high marginal income tax rates. Given the reluctance to raise general taxes, there has been a gradual decrease in government health care funding accompanied by downsizing and restructuring that has resulted in the undermining of quality and timely care.[4]

The introduction of user fees for selected components of health care is another option. User fees might enhance the health care system's efficiency as users and providers become conscious of the costs imposed by their use of the system. Although such systems appear to work successfully in countries such as Norway,[25] there is ample evidence that user fees disproportionately inhibit access to needed care in lower socioeconomic groups.[26,27] In Canada, user fees have been introduced to non-Canada Health Act-insured services such as medications within the Ontario Drug Benefit Program. The impact on the use of necessary medications is not yet clear.[28]

## A health benefits tax

A more equitable alternative that would encourage more efficient use of health care resources would be to assess a contribution paid by individuals according to the health care benefits they receive.[29–31] As a means to increase funding, such a process could significantly meet the financial needs of the system while endorsing the principles of accessibility, universality and public administration.

The system's guiding principles would include that it be equitable, progressive, non-punitive, easily administered and flexible. The contribution would be assessed by the provinces, using information on health care services provided to the population, but administered through the federal/provincial income tax system. The contributory system would require close cooperation between federal and provincial governments so that the latter could continue to be responsible for the structure and services of health plans and the former could continue to provide the necessary leadership and support.

## Models of funding

There are 2 approaches to taxation of health care benefits. The first is to assume that the tax is a contribution to cover the cost of the program. Under this approach, a flat-rate tax would be assessed on an individual's billable health benefits, subject to a maximum (e.g., $2000 per year) to recognize that individuals may have extraordinary health expenditures that compromise their ability to pay taxes. The flat-rate tax, although conceptually simple, conflicts with the principle of a "tax based on the ability to pay" — people in lower-income groups might face a greater burden relative to their annual income than wealthier people. To relieve the burden on low-income earners, incomes below a specified amount could be tax exempt.

Alternatively, health care benefits may be viewed as part of the individual's income and thus subject to tax. The billable health benefits, with a taxable ceiling, could be added to the taxable income and this amount subject to the marginal tax rate at that income level. Other than adding the taxable health benefits to the taxable income, no extra calculations for tax payable are necessary. This approach would view public program benefits similarly to other incomes (just as Canada Pension Plan benefits are added to income). In principle, contributions could be eligible for the medical expense credit. High-income earners, already paying greater income tax, which is partly used to finance the health care system (e.g., Ontario's "fair share" tax), may view this approach as excessive taxation.

Table 1 illustrates how the proposal might work, providing estimates of individual taxes and potential revenues; the assumption for these calculations is that the population under age 18 years and low-income earners would be exempt (determined by family income eligible for the GST credit). On the basis of 1994 tax statistics, about 44% of Canadian adults, including 55% of Canadian seniors, would be exempt from the proposed health benefits tax.[33] The maximum amount of taxable benefits could be initially set at the average per-capita publicly funded health care spending of $2000 in 1994.

Table 1 shows the average and maximum tax payable for people in different age and income groups and provides the estimated potential revenue from taxing health benefits at individual marginal tax rates. The estimated tax payable is the "average" for people who received health benefits pertaining to a certain age group and subject to a given marginal income tax rate. For example, for a person under 65 who received health benefits of $1201 and has a taxable income of up to $29 590 but is not entitled to the GST credit, the health benefits tax would be about $316 annually. No one in this income group would have to pay more than $527, as indicated for people above 65. The total tax revenue in the case presented would be about $5.6 billion, about 11% of the total 1994 public health care expenditure.

## Discussion

The threat to the viability of Canada's publicly funded

health care system is significant. Many critics believe that quality has already been adversely affected.[34–36] Our proposal for the taxation of health benefits would help fund the health care system and enhance its efficiency.

The taxable benefit concept confirms the principles of the Canada Health Act and can be combined with cost-effective principles and quality management methods. With the taxation process structured as we have outlined, those most financially vulnerable to added costs would be exempt or protected against an adverse financial impact. Those with chronically high health care costs would pay more, as they would with private insurance premiums, but ceilings could be structured to assure a non-punitive effect. Public policy could determine that especially high-risk groups (e.g., children and low-income groups) would not be disadvantaged by this structure.

One concern that might be raised is that the tax would be viewed as being imposed on the "sick." However, in principle, any co-insurance system, which includes a deductible for claims, would result in individuals paying for a portion of the costs incurred due to illness. Under our proposal, expenditures of low-income people and extraordinary health care costs would be fully covered by the government.

It could be argued that there might be some reduction in health care support required from general taxation by partially replacing it with this user-based system, thereby shifting some financial liability from the general public to those who use the system. But one should consider that general revenues support the infrastructure of the system that is required by all, and the taxable benefit system is directly related to individual utilization.

Our taxable benefit proposal confers a number of distinct advantages:

- The consumer would become more aware of health care costs without facing expenditures up front, which would deter the disadvantaged from obtaining necessary health care services because of cash flow problems.[26,27,37,38] A taxable benefit affects only selected payers of income tax.
- There might be a greater awareness of costs leading to greater participation of patients in the decision-making process. For example, a choice between comparable drugs with different costs would allow the patient to consider personal cost. Reference-based pricing in British Columbia and an incentive system in the United Kingdom are examples of how patient and professional choices can affect prescribing in a publicly funded system.[39,40] In contrast, private insurance-based coverage often promotes utilization because, once premiums are paid, patients often feel entitled to everything that is covered unless there is some element of co-insurance. Premiums are therefore adjusted to the costs of the insured group, which results in an upward cost spiral or coverage restrictions.[19,20,22,41]
- More components of health care could be covered. There would be no intrinsic economic reason to exclude drugs, home care, dental care or other desirable care components because of cost. The National Forum on Health has recommended the development of national pharmacare and home care programs.[42] In principle, these programs could be partially paid for with the increased revenues from the taxable benefit system.

## Conclusion

The taxable benefit proposal, as an alternative to in-

**Table 1: Estimated average tax payable and potential tax revenue (marginal rate case) in a health benefits tax system**

| | Taxable income | | | |
|---|---|---|---|---|
| Variable | < $29 590 | $29 590–$59 180 | ≥ $59 180 | |
| **No. of taxpayers,* millions** | | | | |
| 18–64 yr | 5.7 | 4.0 | 1.4 | |
| ≥ 65 yr | 1.0 | 0.4 | 0.2 | |
| **Marginal tax rate,[32] %** | | | | |
| Federal | 17.0 | 26.0 | 29.0 | |
| Provincial | 55.0 | 55.0 | 55.0 | |
| Combined | 26.4 | 40.3 | 45.0 | |
| **Tax payable on health benefits** | | | | Simple average |
| 18–64 yr | 316 | 484 | 540 | 447 |
| ≥ 65 yr | 527 | 806 | 899 | 744 |
| **Potential tax revenue, $millions** | | | | Aggregate |
| 18–64 yr | | | | 4503 |
| ≥ 65 yr | 1803 | 1952 | 748 | 1051 |
| Total | 548 | 349 | 154 | 5554 |
| **Financing ratio†** | | | | 10.7% |

*Potential taxpayers are over 18 and do not receive a GST credit. Figures are from information provided by Revenue Canada, Statistics Division.
†Percentage of total public health care expenditure in 1994.

creased privatization of health care, preserves the professionally sound and ethically laudable principles of the Canada Health Act. Our health care system could continue to be one in which equity of access, universality and the ethical principles of distributive justice are maintained. This model should support the principles of accountability, cost-effectiveness and proper economic parameters along with clinical outcome indicators, without compromising the universality of Canada's health care system. If proven workable, it could become a model that health care systems in other jurisdictions could emulate.

## References


1. Gray C. Physician fury mounts in Ontario as MDs seethe over cuts, prepare to take on government. *CMAJ* 1996;155:751-3.
2. Sullivan P. Future of health care dominates meeting as CMA urges governments to fix "system in crisis." *CMAJ* 1996;155:744-5.
3. Canada's threatened healthcare system [editorial]. *Lancet* 1995;345:333-5.
4. Harper T. Code Blue. *Toronto Star* 1997 Sept 13;Sect B1, B4.
5. Coutts J. Doctors to debate privatized medicare. *Globe and Mail* [Toronto] 1996 July 16;Sect A6.
6. Dirnfeld V. The benefits of privatization. *CMAJ* 1996;155:407-10.
7. Bliss M. Marketplace rules should extend to health care. *Toronto Star* 1996 Jan 12;Sect A21.
8. Sky K. Should specialists support Canada's single-payer system? *Ann R Coll Physician Surg Can* 1997;30:12-3.
9. Gunton RW. It's time to re-introduce a private componenet to the funding of health care. *Ann R Coll Physician Surg Can* 1997;30:9-11.
10. Gordon M, Berger PB. The alluring myth of private medicine. *CMAJ* 1996;155:404-6.
11. Gordon M, Sternberg SA, Turner T. Should specialists support Canada's single-payer system? *Ann R Coll Physician Surg Can* 1996;29:398-400.
12. Light DW. Betrayal by the surgeons. *Lancet* 1996;347:812-3.
13. Currie D. BUPA subscription? That will do nicely [editorial]. *BMJ* 1996; 313:431.
14. Coutts J. Private care no cure, British say. *Globe and Mail* [Toronto] 1997 June 24;Sect A1, A10.
15. Cordner S, Ettershank K. Australians continue to flee private schemes. *Lancet* 1997;350:650.
16. Peabody JW, Bickel SR, Lawson JS. The Australian health care system: Are the incentives down under right side up? *JAMA* 1996;276:1944-50.
17. Johnston CI, Standford M. Swapping health care systems: Whose grass is really greener? *JAMA* 1996;276:1986-7.
18. Woolhandler S, Himmelstein DU. Extreme risk — the new corporate proposition for physicians. *N Engl J Med* 1995;333:1706-7.
19. Bodenheimer T, Grumbach K. The reconfiguration of US medicine. *JAMA* 1995;274:85-90.
20. Bodenheimer T. The HMO backlash — Rightous or reactionary? *N Engl J Med* 1996;335:1601-4.
21. Kassirer JP. Managed care and the morality of the marketplace. *N Engl J Med* 1995;333:50-2.
22. Smith BM. Trends in health care coverage and financing and their implications for policy. *N Engl J Med* 1997;337:1000-3.
23. Braithwaite SS. The courtship of the paying patient. *J Clin Ethics* 1993;4:124-33.
24. Buchanan A. Privatization and just health care. *Bioethics* 1995;9:220-39.
25. Østbye T, Hunskaar S. User fees for health services: Norwegian perspective in copayments. *Can Fam Physician* 1996;42:2109-13.
26. Soumerai SB, McLaughlin TJ, Ross-Degnan D, Casteris CS, Bollini P. Effects of limiting Medicaid drug-reimbursement benefits on the use of psychotropic agents and acute mental health services by patients with schizophrenia. *N Engl J Med* 1994;331:650-5.
27. Moorhouse A. User fees: Fair cost containment or a tax on the sick? *Can Nurse* 1993;89:21-4.
28. Hux JE, Fielding DA. *The Ontario Drug Benefit Program copayment: its impact on access for Ontario seniors and charges to the program*. North York (ON): Institute for Clinical Evaluative Sciences; 1997.
29. Goodman WD. Why not share the cost of health care? *MacLean's* 1997;May 19:5.
30. Gordon M, Turner T. Healing medicare: some options to save the single-payer system. *Ann R Coll Physician Surg Can* 1997;30:275-8.
31. Macintosh RM. Information technology for health care in Ontario. [Backgrounder report] Toronto: C.D. Howe Institute; 1995 Jan 12. Available www.cdhowe.org/eng/pub/pub-2/publindm.html
32. Canadian Tax Foundation. *Finances of the nation*. Toronto: The Foundation; 1995.
33. *Statistics on individuals, 1994*. Ottawa: Revenue Canada; 1996.
34. Buske L. Where is the money going? *CMAJ* 1997;157:492.
35. Coutts J. Health-care funding moves from public to private sector. *Globe and Mail* [Toronto] 1997 Aug 12;Sect A6.
36. Rafuse J. Private-sector share of health spending hits record level. *CMAJ* 1996;155:749-50.
37. Chubon SJ, Schultz RM, Lingle EW, Coster-Schulz MA. Too many medications, too little money: How do patients cope? *Public Health Nurs* 1994; 11:412-5.
38. Selby JV. Cost sharing in the emergency department — Is it safe? Is it needed? *N Engl J Med* 1997;336:1750-1.
39. McLaughlin PR. Reference based pricing for provincial drug benefit programs. *Can J Cardiol* 1996;12:16,25-6.
40. Bateman DN, Campbell M, Donaldson LJ, Roberts SJ, Smith JM. A prescribing incentive scheme for non-fundholding general practices: an observational study. *BMJ* 1996;313:535-8.
41. Vincenzino JV. Trends in medical care costs — revisited. *Stat Bull Metrop Insur Co* 1997;July-Sept:10-6.
42. *Canada health action: building on the legacy — volume I*. The final report of the National Forum on Health; Feb 1997. Available wwwnfh.hc-sc.gc.ca/publicat/list-e.htm


***Reprint requests to:*** *Dr. Michael Gordon, Baycrest Centre for Geriatric Care, 3560 Bathurst St., North York ON M6A 2E1*