# Health care system needs new revenue streams, expert argues

When medical experts gather to discuss health care transformation, there is often much talk of improving efficiency and quality of care. Few would argue that those aren't important topics, but according to Mark Stabile, director of the School of Public Policy and Governance at the University of Toronto in Ontario, there needs to be far more discussion on another subject: how to increase revenues.

"Do we have the revenues in place right now to fund the costs our system is taking on right now?" Stabile asked delegates to the Canadian Medical Association's 144th annual general meeting in St. John's, Newfoundland and Labrador, during an education session on Aug. 21. "The answer, clearly, is no."

Though improving efficiency can save money, it is not enough, said Stabile. To cover its costs, the Canadian health care system will need more revenues generated through such actions as diversifying sources of income and restructuring the role played by private insurance.

Of course, Canada is hardly the only developed nation with a health care system that is increasingly devouring more resources. In many countries — France, Japan, Germany, the United States and the United Kingdom, to name but a few — the rate of growth of health expenditures has long been outpacing the growth of their gross national products.

"We are not alone," said Stabile. "The bad news is that most of these countries have been far more courageous in tackling health care reform reform than we have."

If Canada were to become more bold in adopting revenue-generating reforms, those changes would likely fall into one of four "buckets": tax increases, cost-sharing with patients, private financing and diversification of public financing Stabile said.

Roger Collier

**European nations and others have been "far more courageous in tackling health care reform" than Canada, Mark Stabile (left), director of the School of Public Policy and Governance at the University of Toronto in Ontario, told CMA President Dr. Jeffrey Turnbull (right) and others during an Aug. 21 special educational session of the association's annual general meeting.**

The tax burden on the average Canadian has decreased slightly in recent years, noted Stabile, so there is room to increase taxes. However, politicians tend to steer clear of this route. "The political reality is that most [politicians] are campaigning on not raising taxes," he said. "Many are campaigning on undoing tax increases."

It has been suggested that increases in so-called "sin taxes" on cigarettes, alcohol and junk food would be an effective means of offsetting the rising costs of health care. That might be true, but going down the path of penalizing people for behaviours that put them at risk can be a tricky tactic, CMA President Dr. Jeffrey Turnbull told the session. "What about not wearing a bicycle helmet? What about a poor diet and obesity? When do we start to realize that these are societal issues?"

In a cost-sharing model, patients would help generate revenue through user fees. A visit to a doctor, for instance, would leave your wallet lighter by $25 or so. The good thing about this model, said Stabile, is that it makes people more aware of the services they use, and increased awareness is always a good thing.

But cost-sharing systems are usually only palatable to the public when certain groups of people are exempt — two groups in particular: low-income and the chronically ill. The former can't afford to pay fees and the latter are in hospitals so often that per-visit fees would be an unreasonable burden. From a revenue-generating standpoint, this is a major problem.

"Once you combine low-income Canadians and really sick Canadians, you get most of the people who use the health care system," Stabile said. "Once you exempt the really sick and the low-income, you have taken a huge chunk out of the revenue from user fees."

Many countries have attempted to cut public costs by allowing various forms or degrees of private health insurance. Germany, for example, allows

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people to obtain "substitutive" private insurance, which covers people who aren't covered under the public system, either because they opted out or are excluded. And Denmark allows "complementary" private insurance to cover services not covered publicly.

But countries that permit the purchase of "supplementary" private insurance to promote faster access to services and enhanced patient choice — thereby creating the much-debated "two-tier" system — only hurt the public health care system, said Stabile. "The empirical evidence of the effect of a two-tier system on the public system tends to lead in one direction, and that direction is negative," he said. "This does not end up saving the public sector money."

It appears that the best option to generate revenue is to diversify how resources are generated for the public system, Stabile said. That could be done by following a social insurance framework, in which mandatory contributions are gathered from employed citizens and their employers based on salary levels.

Whatever the option chosen, more people should be discussing revenue generation, Stabile added. "The discussion, then, since we are going to be spending more, needs to include the best way to pay for all this. My view of the evidence supports diversification of public financing in the short term over private financing." — Roger Collier, *CMAJ*

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