The Demand for Alternative Forms of Financing Universal Health Care in Canada: a Literature Review

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Résumé : (traduction)
Le discours entourant le manque de durabilité du financement des soins de santé universels au Canada a mené de nombreux intervenants à évaluer le système actuel afin d'envisager d'autres formes de financement. Plusieurs modèles de financement des soins de santé ont été avancés, notamment les comptes d'épargne-santé (CES), une hausse d'impôt et des politiques visant à contrôler les facteurs de coûts spécifiques tels que l'inflation des prix des services médicaux et hospitaliers. Cet article s'adresse aux professionnels de la santé, aux chercheurs et aux décideurs politiques, et demande que l'on se montre plus sensible quant à l'évaluation des initiatives de réforme de la santé publique relatives aux options de financement alternatives des soins de santé universels. Cette potentielle réforme publique doit être considérée afin d'améliorer le coût et la prestation des services de santé. Des méthodes privées tendent à influencer négativement, en fin de compte, sur les déterminants de la santé des individus et des populations. Des stratégies alternatives de financement sont examinées dans cet article avec l'évaluation de leurs avantages et de leurs limites, et des recommandations pour le système de soins de santé du Canada.

Mots-clés : la privatisation, la réforme des soins de santé, les modèles de financement alternatifs, le Canada, la durabilité, le financement de la santé.

Abstract:
The discourse surrounding the unsustainability of financing universal health care in Canada has led many stakeholders to evaluate the current system in order to consider alternative forms of funding. Several health care financing models have been suggested and include Medical Savings Accounts (MSAs), increased taxation and targeting policy to control specific cost drivers such as price inflation of physician and hospital services. This paper targets health care professionals, researchers and policy makers and calls for more awareness in evaluating public health reform initiatives for alternative measures of financing Universal Health Care. Public reform must be critically considered in order to improve the cost and delivery of health care services since private methods ultimately impede on individual and population determinants of health. Discussed here are alternative financing strategies with an evaluation of benefits, limitations, and future recommendations for Canada's health care system.

Keywords: privatization, health care reform, alternative funding, Canada, sustainability, financing health.

Introduction

In 2010, the total cost of the Canadian health care system was approximately CAN$ 193 billion, averaging CAN$ 5,663 per capita (CIHI, 2012). With regard to provincial budget spending in 2010, health care costs were highest in Quebec (45%) and Ontario (40%), with a national average of 38% (Palley, Pomey, Forest, 2011). This is a target of policy change at the provincial level because health care spending increasingly subordinates other budgetary needs; for example, it is suggested that if current trends continue, Ontario's cost of health care will amount for 80% of its budget by 2030. As a result, the remaining 20% of the budget would be insufficient to fund the current public education system costs (Toronto Dominion Bank, 2010).

For the past decade, the discourse of the sustainability of financing universal health care has led many politicians, economists, healthcare professionals, statisticians, and stakeholders to evaluate the current system to consider alternative forms of funding. Suggested interventions have included Medical Savings Accounts (MSAs), increased taxation as a hypothecated tax, and reform of the health care system through management of the drivers of physician services and health services costs. This paper targets health care professionals, researchers and policy makers, with a call for more awareness for evaluating public health reform initiatives to finance universal health care in order to improve the cost and delivery of health care services. Alternative financing strategies are discussed, with an evaluation of their benefits, limitations, and future recommendations for Canada's health care system.

Methodology

A literature review was performed using Scholars Portal Journals and PubMed online academic journal databases accessed through the University of Ottawa library. The keywords used for the search were "health care," "Canada," "financial crisis" and "alternative forms of funding." Articles published before 2001 were excluded because the information can be considered out-dated. One exception to the publication date exclusion criterion was the Canada Health Act legislation codified in 1985, which was included for use as a reference source. Articles were excluded if they were not published in English, did not involve an economic model or strategy, or did not evaluate the Canadian health care system. All academic articles selected were peer reviewed government or non-government organization publications. Quantitative and qualitative research articles were chosen. Online published books found through the University of Ottawa's general search forum were also used using key words "Financing health care in Canada," "health care reform." Additionally, government websites including Statistics Canada and Health Canada were used as resources for current information regarding the Canadian health care system.

Medical Savings Accounts (MSAs)

Medical Savings Accounts (MSAs) are a new financial model for funding the health care system. MSAs address key problems with user fees and out of pocket payment models (Deber, 2011). Several designs have been proposed for the implementation of these financial models. Fundamentally, MSAs are a yearly allowance that an individual or family is allotted from provincial and federal governments, which can be used to "purchase" health care services (Deber, 2011). MSAs provide a new health paradigm that allows consumers to control a portion of their health care spending rather than leaving it up to third-party insurers (Deber, 2011). Since these models are newly introduced onto the health care market, there are limitations when evaluating their effectiveness.

There are several benefits to this financial model. MSAs provide patients with more control over their use and delivery of medical services (Deber, 2011). It also allows for more organization and efficiency of the health care system by avoiding unnecessary usage and providing information and transparency to the actual cost of medical services (Deber, 2011). These effects can be explained by the economic theory underlying MSAs, which suggests that people will be more efficient purchasers if they must pay for items from a credit limit (Herrick, 2009). Economic incentives for individuals to be efficient consumers of healthcare include enhanced patient choice and empowerment, reduced government expenditures, improved system efficiency, and effectiveness including reduction of wait lists and enhancing innovation due to an increased cost consciousness (Herrick, 2009).

The MSA model assumes that the use and purchase of medical services is optional. Research shows that the highest medical expenditures are to address accidents, injuries or chronic health conditions (Deber, 2011). The MSA model would disproportionally cost those who use the health care system more because of these medical conditions. For example, in a case study involving MSAs, the use of some services did decrease when higher co-payments were introduced; however, this reduction also included necessary usage of the healthcare system, putting certain individuals at risk for serious lack of medical care (Herrick, 2009). This case study also showed that low-income persons had worse health outcomes compared to those with higher incomes (Herrick, 2009). This is because cost-sharing is associated with lower rates of adherence to medications and higher rates of adverse health outcomes, particularly among vulnerable populations including children, the elderly and those with chronic di-

seases (Herrick, 2009).

Opponents suggest many of the benefits of MSAs are unlikely to emerge because of the high disparity in health expenditures in the population. They suggest potential risks of adopting MSAs, including undermining insurance arrangements, transferring resources from the sick to the healthy, increasing total costs, subsidizing services of questionable value, and producing worse health outcomes (Deber, 2011).

Increased Taxation

Recent research has focused on using the tax system as a way of increasing revenue for the federal and provincial governments. An increase in taxation for healthcare is an alternative that can support equality, accessibility and universality while generating revenue (Rode & Rushton, 2002).

There are a number of possible ways taxes can be used to generate revenue. One form of taxation that has been suggested to help raise provincial revenue for health care services is a "dedicated" or "hypothecated" tax (Romanow, 2009), or a single tax dedicated solely to funding of medical services. The government would not be able to allocate money that is generated from the dedicated tax to other areas of spending (Romanow, 2009).

Research shows that Canadians support the idea of a dedicated tax, as it would improve accountability and transparency with the taxation they pay (Guy, 2002). This is beneficial as it promotes less resistance of taxation if the public knows where the money will be spent, especially if it is toward a health care system that ranks high in priority in social consciousness. The Fabian Society's Commission on Taxation and Citizenship in the United Kingdom conducted research on public attitudes toward taxation and noted that if the public was informed on the allocation of their taxation, resistance toward increased taxes decreased. Only 40% of those surveyed agreed to a 1% increase in personal income tax toward a general pool of government revenue whereas 80% agreed if the 1% increase in taxation was spent specifically toward the National Health Service (Le Grand, 2001). Relative to Canadian society, a tax increase specifically for health care in the form of a hypothecated tax is supported, as it appears equitable.

There are some limitations to a dedicated tax approach. Given the sheer size of the health care system, the tax increase would have to be large in order to raise the necessary funds (Romanow, 2009). However, a smaller tax increase could be used to finance a portion of medical services. Additionally, this policy may not be favourable to departments of finance as it can reduce their ability to control taxation compared with funding from a general pool of revenues (Romanow, 2009). Furthermore, the implementation of a new tax requires high start-up and administration costs with the need to create new jobs. Revenues from other provincial taxes will be needed to support this, which may cause the allocation of resources that the hypothecated tax was meant to deter.

Cost Driver Reform

An evaluation of the main drivers of public health care spending and how these drivers can be reformed to reduce spending and offer more efficient and quality care is another strategy to reduce health care spending. A study released from the Canadian Institute for Health Information (CIHI) examined health care spending from 1998 to 2008 found that total public spending on health care increased at an average rate of 7.4% per year (CIHI, 2011). This study showed that the principal cost driver was price inflation and that the increase was most notable with physician spending and hospital spending (CIHI, 2011).

Currently, the fastest growing health expenditure is physician spending, which has increased at an annual rate of 6.8% per year from 1998 to 2008 (CIHI, 2011). Physician fee schedules are attributable to more than half of this growth at 3.6% (CIHI, 2011). This increase in costs in the past decade can largely be attributed to the increase of average weekly wages for doctors which grew faster than the wages of other health service workers (CIHI, 2011). Cost control of physician remuneration must face policy reform in order to reduce spending and moderate the effects of price inflation. With respect to hospital costs, price inflation has also had a tremendous impact. As shown in the study, 60% of the total cost of a hospital's budget can be attributed to compensation for the hospital's work force (CIHI, 2011). Essentially, this puts health-sector price inflation substantially above the rate of general inflation. From 1998 to 2008, the Government of Canada undertook a plan of action to control and mediate general inflation growth to a target of 1-3% (CIHI, 2011). Although this decision is out of the realm of health care, the fact labour costs are a major contributor to health care inflation was highlighted through this process. A continuation in the increased rise of health care inflation compared to general inflation will place substantial pressures on the provincial and the federal governments for maintaining and reducing health care costs (CIHI, 2011). During a time of economic uncertainty and fragility, the costs of hospital services and the increase of physician remuneration should be a significant area for policy-makers to consider for further research and focus.

A policy reform that would affect both the remuneration of physician services and the increased hospital spen-

ding is expanding the scope of practice of primary care providers and other health and social service professionals. For example, broadening the scope of practice for nurse practitioners has shown to increase patient access to care in different primary care models (DiCenso, Bourgeault, Martin-Misener, Kaalalainen, Carter, Harbman, 2010). A study conducted at a primary care facility in British Columbia found that the addition of one nurse practitioner increased the facility's patient capacity from 1,200 to 1,800 patients (Dicenso et al., 2010). Increased costs may be associated with creating a mosaic primary health care model; however, the increased attention to health promotion and chronic disease management may result in highly reduced health care costs due to reduced downstream resource, physician, and hospital utilization. This could decrease physician spending in the hospital and could also compliment efficiency and delivery of health care aimed toward the determinants of health and prevention, which has been shown to considerably decrease health costs.

Conclusion and Future Recommendations

If current spending and cost trends continue, the health care budget in Canada will amount to the majority of provincial spending and subordinate other significant budgetary needs. Alternative funding strategies including MSAs, a hypothecated tax, and cost-driver control reforms were considered as potential models to reduce the increasing costs of the Canadian Health Care System. MSAs and increased taxation may not be the most effective financial models. MSAs may impose high financial pressure on low income individuals leading to inequities and ultimately poor health outcomes. Taxation is most supported by public opinion as it appears to be an equitable way to decrease the financial pressure for the cost of health care. Taxation alone may not have the ability to finance the vast health care budget but does allow for covering a portion of health care costs.

Controlling the main drivers of health care spending, such as price inflation at the physician and hospital level, has a high potential to reduce health care costs. Policy reform that expands the scope of practice for primary care and social services may be the most effective way to stabilize these cost drivers. This requires more research and political attention, as the ability to sustain the principals of universal health care, access, and equality must be seriously considered to ultimately improve the determinants of health across Canada.

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