



UNDERSTANDING THE POLITICAL ECONOMY OF THE EVOLUTION AND FUTURE OF SINGLE-PAYER PUBLIC HEALTH INSURANCE IN CANADA

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SUMMARY

Surprisingly little attention has been paid to how we pay for health care affects how much we spend on health care. In this paper, I discuss how non-contributory finance and effective subsidization of public health care spending with federal cost sharing crowded out demand for private insurance as voters opted for high levels of public health spending. From this perspective, the Romanow Report's call for increases in federal cash transfers to provinces for health care spending would result in an increase in provincial health spending and a diminution of the demand for private health insurance. It is not clear, however, that federal subsidization of health spending is either sustainable or socially desirable. Indeed, as Canada's population ages, the current financing of health care represents enormous unfunded liabilities for the provinces. To sustain current levels and growth rates of health spending without tying current revenues to that objective means asking the next generation of working Canadians to pay far more for their health care than do working Canadians today. Although the effect of population aging on health care expenditures is projected to be modest, it could trigger a serious political crisis for Canadian medicare as taxes rise.

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INTRODUCTION

Canada's choice in 1984 to make private health care purchases an exclusive (opting-out) alternative for service providers, rather than a supplement to publicly financed health care services provided in hospitals and/or by a physician, is unique among member countries of the Organisation for Economic Co-operation and Development (OECD).¹ To meet the conditions for full transfer payments from the federal government under the 1984 *Canada Health Act* (CHA), the provinces have regulated — and, in some cases, prohibited outright — private payment and private insurance for publicly insured services.² An implication of the fact that Canada's single-payer public health insurance systems are for the most part financed by the progressive tax systems of the federal and provincial governments is that resources are redistributed not only from healthier to less healthy Canadians but also from higher- to lower-income Canadians. Understanding the evolution of Canada's single-payer system of health care finance, therefore, requires an appreciation of the implications for voters of income redistribution as well as the restrictions placed on their access to privately financed health services.

At the outset, finance arrangements for health care in Canada were much different from what we have today. Yet, in studies of the evolution of public budget constraints on health care over the past half-century, surprisingly little attention has been paid to how we pay for health care affects how much we spend on health care. Thus, the broad purpose of this paper is to look at the shift from contributory to non-contributory health care finance, cost sharing between the federal and provincial governments, and the softening of public health insurance budget constraints through borrowing in order to understand the role these fiscal changes have played in the evolution of health care spending and to determine whether the status quo of health care financing in Canada is sustainable.

The policy debate is also confused by vague notions of the appropriate level of health spending. For example, the final report of the Commission on the Future of Health Care in Canada (the Romanow Report) suggests that “Canadians want necessary hospital and physician services to be fully funded through our taxes” (Romanow 2002, 31). It is not obvious, however, what it means to fully fund necessary hospital and physician services. Whose level of services is to be fully funded? If everyone's care were fully funded — that is, if the highest demand were met — then most people would be overinsured in the sense that more funding would be provided than they would want or need. What would be the cost of meeting this level of demand and would it be palatable to the majority of voters? Or is the idea a notional one that *average* demand should be fully funded, in which case the health care services of many Canadians would be less than fully funded, which would create demand for supplementary revenue channels such as private insurance?

In this paper, I discuss how non-contributory finance and effective subsidization of public health care spending with federal cost sharing crowded out demand for private insurance as voters opted for high levels of public health spending. From this perspective, the Romanow

¹ Since 1975, the public share of health care finance in Canada has been around the OECD average of 74%, but in other OECD countries private payment allows individuals to supplement the quantity and quality of publicly provided health care. Canada reserves private payment for non-medicare categories of health care expenditures such as long-term care, drugs, and non-physician-provided services. See Gouveia (1997).

² For a discussion of Canada's varied health care systems — each province and territory administers its own system according to conditions defined by the CHA — see Boychuk (2008a).

Report's call for increases in *federal cash transfers* to provinces for health care spending would result in an increase in provincial health spending and a diminution of the demand for private health insurance. It is not clear, however, that federal subsidization of health spending is either sustainable or socially desirable. Indeed, as Canada's population ages, the current financing of health care represents enormous unfunded liabilities for the provinces (Robson 2001, 2007). To sustain current levels and growth rates of health spending without tying current revenues to that objective means asking the next generation of working Canadians to pay far more for their health care than do working Canadians today. Although the effect of population aging on health care expenditures is projected to be modest, it could trigger a serious political crisis for Canadian medicare as taxes rise.

Finally, the sustainability of Canadian medicare is not the right focus for the debate, in the sense that there is no call to eliminate universal public health care finance. Rather, the more appropriate sustainability question concerns the CHA's precluding a mixed private/public financing arrangement for health services in the light of both restraints on public health spending, as governments bring it more in line with current revenues, and rising demand for supplementary private health insurance.

THE EVOLUTION OF GOVERNMENT FINANCE OF HEALTH CARE IN CANADA

Canadian medicare is not an insurance system, and there is no clear link between health expenditures and the tax price for paying for them. Since the passage of the 1957 *Hospital Insurance and Diagnostic Services Act* (HIDS) and the 1966 *Medical Care Act*, the federal and provincial governments have relied increasingly on non-contributory finance to pay for health care services provided by physicians and hospitals. Payments, for the most part, are from general government revenues, as opposed to a contributory scheme such as the Canada Pension Plan, where expenditures are financed with tax revenues generated specifically for that purpose.³

The earliest Canadian scheme to finance health care costs was Saskatchewan's 1947 Hospital Services Plan, under which premiums were levied specifically to pay for hospital costs on a contributory basis.⁴ The plan did not preclude private payments through co-insurance or user fees for publicly financed services. Then, in 1957, the Diefenbaker government brought in the HIDS, which Boychuk (2008b, 113-114) argues had characteristics that led to the development of current health care financing arrangements, although their iconic features more correctly were an unintended consequence of the political forces that led to public health insurance supported by federal "50/50" cost sharing.

³ Ontario, British Columbia, and Alberta make use of health care "premiums" but these revenues cover only a portion of total health care costs in those provinces. The premiums are not reflective of risk characteristics of individuals, their use of health care services, or their income, so that, in effect, they are a kind of "poll tax," distinguished from other government revenues only in that their levy is notionally tied to paying for health care. As these premiums are not separated out from other government revenues once collected, however, they are not necessarily allocated to health care — in much the same way that gasoline taxes are not spent solely on expenditures sensitive to automobile use. See Boychuk (2008b) for discussion of the use of health care premiums in Canadian medicare.

⁴ See Gagan and Gagan (2002, 11-12, 92-96). Before the plan came into being, hospitals were obligated to provide care to the indigent, the costs of which were covered by a combination of municipal government grants to hospitals, charitable donations, and fees charged to paying patients. With the rising cost of medical care due to rising fees charged by hospitals, the number of paying patients declined and hospital finance became a challenge, made worse by the dire economic conditions of the 1930s.

Constitutionally, health care is a provincial responsibility, a fact that influenced how health care came to be publicly financed. Since a national health insurance scheme administered by the federal government seemed impractical, the expedient solution was to have federal payment in support of provincially administered health insurance. According to Gagan and Gagan (2002, 94-95), the provinces, fearing that a national health insurance would be a “federal tax grab,” called in the 1950s for health insurance to be a provincial initiative funded “primarily through generous transfer payments from the federal government.” Under the 1957 HIDS and the 1966 *Medical Care Act*, the federal government agreed to share the costs of provincial hospital programs and physicians’ services so long as the programs satisfied conditions of comprehensiveness, universality, portability, and public administration (see Banting and Boadway 2004, 8-9). This agreement to share the costs helped to persuade higher-income provinces Alberta, British Columbia, and Ontario to join the federal plan even though their governments previously had expressed a commitment to the principle of private insurance for most of the population and to limiting the role of public programs to covering hard-to-insure groups such as the elderly and the poor.⁵

Boychuk (2008b, 113-114) argues that the goals of public health insurance in Canada were not rooted in egalitarian ideals but instead reflected a desire to keep direct public control over public funds. To this end, the federal government established conditions for sharing hospital costs with the provinces that precluded using federal funds to subsidize insurance provision through private plans. Politically, Ottawa wanted its funds to be seen as a benefit to all Canadians, so it would not provide cost sharing to provinces that did not have universal coverage, which discouraged provinces from reserving public insurance for the poor and the aged. Ottawa also discouraged the use of premiums and co-insurance by matching provincial government expenditures on hospitals but not expenditures financed by payments by patients. Consequently, by the 1980s, most provinces had moved away from health insurance premiums.

Critics of the 50/50 cost-sharing arrangement argued that it created the incentive for provinces to expand the generosity of their programs, and expressed concerns about the federal government’s ability to control its own budget with an open-ended commitment to pay half of provincial health care expenditures (see Banting and Boadway 2004, 11). With the Established Programs Financing (EPF) arrangement of 1977, transfers for hospital and medical services, along with post-secondary financing, were combined into a single block grant. The EPF transfer was an equal per capita payment to each province that was paid both as cash and as a transfer of tax points⁶ Over time, the tax-point portion of the transfer has increased and the cash portion decreased.⁷

⁵ See Taylor (1978, 340-341); and Boychuk (2008b, 127-130). In other words, in the absence of federal cost sharing, the higher-income provinces would have preferred a health care system similar to the one the United States developed in the 1960s. Indeed, Alberta premier Ernest Manning would have preferred to continue that province’s voluntary, privately operated medical services plan, whereby only Albertans with incomes above a defined threshold paid premiums. He explained, however, that opting out of the federal program was not an option: “The province’s only option is to take the [federal] program in its entirety or refuse it in its entirety. But if it refuses, it can only refuse to accept the benefits. It cannot refuse to pay its share of the costs because the extra federal taxes that will be levied to pay the federal share of a national Medicare plan will be levied on all Canadians....The only so-called option is the right to refuse any part of the benefits. I think you will agree that this is hardly an option at all” (quoted in Brennan 2008, 150-152).

⁶ Tax points are tax transfers whereby the federal government reduces its tax effort to make room for the provinces and territories to raise their own tax revenues. With the 1977 EPF, the federal government agreed to give up 13.5 percentage points of personal income tax and 1 percentage point of corporate income tax to the provinces and territories. The reduction in federal government revenues collected in the provinces and territories is offset by an increase in provincial and territorial tax revenues of the same amount. See the Department of Finance’s explanation online at <http://www.fin.gc.ca/transfers/taxpoint/taxpoint-eng.asp>.

Monique Bégin, the federal minister who tabled Bill C-3 (the CHA) in December 1983, explains that the act was intended to stem the erosion of medicare that arose as a result of changes in how health care was financed with EPF in 1977 (Bégin 2002). Following the changes under EPF, the provinces cut health care budgets and extra billing by doctors and user fees became more prevalent. For the federal government — whose role was to enforce the conditions and regulations about universality, comprehensiveness, portability, and public administration defined under the HIDS and the *Medical Care Act* — the challenge was that EPF had no enforcement mechanism. With the 50/50 cost-share cash transfer, Ottawa could refuse to reimburse its half of health care costs for provinces that violated the conditions of the medicare acts. With EPF, however, it chose a major tax-points transfer associated with an “automatic” monthly lump-sum global payment for health (and post-secondary education) sent to each provincial treasurer, which meant that Ottawa no longer had any means by which to enforce federal medicare conditions. The CHA then introduced a fifth condition — that of accessibility — indirectly to ban physician extra billing and user fees for medicare services. With that change, the federal government now could levy a one dollar penalty on a province’s block fund for every dollar of extra charges to patients, whatever the source of those charges.⁸

The significance of the use of tax points through EPF to permit provinces to finance health care is that, unlike the cost-sharing (all cash payment) arrangement, it notionally ties health care expenditures to the provincial tax price of health insurance. If provinces want to have more money for health care when the federal government reduces the cash transfer, they must raise provincial taxes to do so. Boychuk (2008b, 136) observes that the shift to EPF stabilized federal government expenditures but exposed the provinces to the risk of cost increases greater than GDP growth, albeit giving them more flexibility to allocate health care expenditures.

The link between income taxes and health care expenditures became even less clear with the 1995 Canada Health and Social Transfer (CHST), under which, due to its debt and deficit situation, the federal government combined EPF and the transfer for social welfare into a single block transfer. Although 43% of the CHST transfer was intended for provincial health expenditures, the transfers were fungible across categories of expenditure. Federal cash transfers to the provinces were cut by 20% between fiscal years 1995/96 and 1997/98 (Evans 2003, 13-14).

⁷ Banting and Boadway calculate that federal government transfers for health care as a share of provincial government health care expenditures trended down from 41.3% in 1975 to roughly 30% in 2000, while the cash portion fell from 41.3% in 1975 to under 15% in 2000 (2004, table 4, 17).

⁸ See Boychuk (2008a) for a detailed discussion of regulation under the CHA.

After 2000, the federal government made several commitments for spending on health care in the provinces to support priority areas such as health care renewal, primary health care reform, home care, medical equipment, and catastrophic drug costs.⁹ In 2003, Ottawa committed to spending \$36.8 billion through increased CHST transfers (\$14 billion), the new targeted transfers, the Health Reform Transfer (\$16 billion), support for the purchase of medical equipment (\$1.5 billion), and direct federal spending on health. Following a federal commitment to improve the transparency and accountability of its support for health and other social programs, in 2004 the CHST was apportioned into two transfers, the Canada Health Transfer (CHT) and the Canada Social Transfer (CST). Based on existing CHST legislated amounts for these programs, 62% of transfers were allocated to the CHT and 38% to the CST. Under the CHT, Ottawa provides legislated cash transfer amounts — which grew by an average annual rate of 10.2% per year over the five years up to fiscal year 2007/08 — and a tax transfer component that grows with the economy.

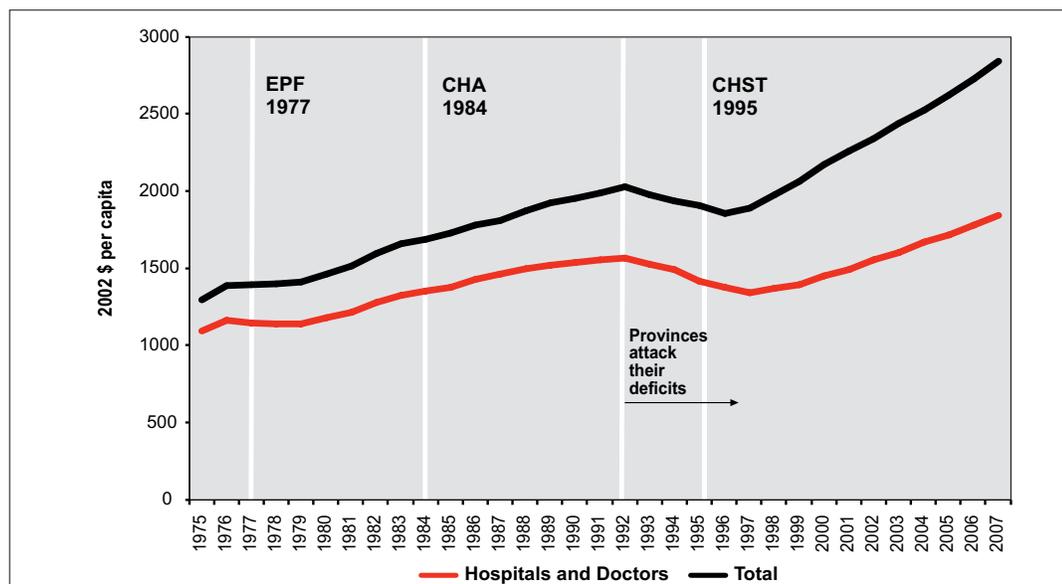
Although the CHT makes it clearer than did EPF and the CHST how much the federal government transfers for health and restores some of the importance of cash transfers for health, it maintains the link between provincial taxation effort and provincial health spending, and federal health transfers are still more fungible across government programs than under 50/50 cost sharing.

Government borrowing has been another important element of the fiscal arrangements for paying for medicare since 1975 (see Figure 1). Until that year, neither the provinces in aggregate nor the federal government had net borrowing. Between 1976 and 1981, however, the federal government borrowed and ran growing deficits. In contrast, the provinces maintained relatively balanced books until 1981, after which they ran relatively small deficits. In the 1980s, provincial governments opted to borrow to offset reduced cash transfers from the federal government. Indeed, after 1988, provincial borrowing grew rapidly, and budget balances were not restored until after 1996. Not until after 1992, however — by which time the provinces were addressing their deficits — were changes in health spending obvious (see Chung and Kneebone 2004). Until then, Canadians had not necessarily faced a tax price for health care that reflected the full resource cost of their health care systems; when, after 1992, they did, spending on health care fell.

⁹ For a chronology of these changes, see Health Canada's overview of the evolution of federal transfers online at <http://www.hc-sc.gc.ca/hcs-sss/medi-assur/cha-lcs/transfer-eng.php>. See also Department of Finance, "A History of the Health and Social Transfers," online at <http://www.fin.gc.ca/fedprov/his-eng.asp>. The latter notes:

2004 September: First Ministers signed the 10-Year Plan to Strengthen Health Care. In support of the Plan, the Government of Canada committed \$41.3 billion in additional funding to provinces and territories for health, including \$35.3 billion in increases to the [Canada Health Transfer] through a base adjustment and an annual 6% escalator, \$5.5 billion in Wait Times Reduction funding, and \$500 million in support of medical equipment. 2003 February In support of the February 2003 First Ministers' Accord on Health Care Renewal, Budget confirmed: (1) a two-year extension to 2007-08 of the five-year legislative framework put in place in September 2000 with an additional \$1.8 billion; (2) a \$2.5 billion CHST supplement, giving provinces the flexibility to draw down funds as they require up to the end of 2005-06; and (3) the restructuring of the CHST to create a separate Canada Health Transfer and a Canada Social Transfer effective April 1, 2004, in order to increase transparency and accountability.

FIGURE 1: Per capita Public Health Spending and Spending on Hospitals and Physicians, Canada, 1975-2007



SOURCES: Canadian Institute for Health Information; Statistics Canada, CANSIM II database.

Medicare, it should be recalled, was introduced through 50/50 sharing of health care costs between the federal government and provinces. As Romanow (2002, 46) notes,

[h]istorically, the federal government encouraged the adoption of publicly administered single-payer insurance systems in the provinces through the use of the federal spending power. The success and longevity of medicare is in part due to the federal government's ongoing social program transfers, equalization payments, and its willingness to use its political capital to promote and defend the system.

If federal taxes were levied solely on personal incomes and collected with equivalent incidence in all the provinces, it would be hard to see the importance of Romanow's emphasis on federal transfers on spending and health, and the taxpayer would have no reason to distinguish between paying a federal tax to fund provincial health care expenditures or a provincial tax to do so. But federal governments tax corporations and, with progressive income taxation, high-income earners pay a large share of total federal taxes; moreover, large corporations and high-income individuals are disproportionately concentrated in a few provinces. Consequently, residents of some provinces might prefer a federal taxation effort along with cash transfers to the provinces to their own province's raising the necessary taxes to finance health spending.¹⁰

¹⁰ Federal equalization payments that are intended to allow provinces to provide services on roughly equal terms further weaken the direct link between provincial tax prices of health and the level of health spending. Alberta, British Columbia, Ontario, and sometimes Saskatchewan are the only provinces that pay out on net through equalization (see Mansell and Schlenker 1995; Courchene 2004). Borrowing by the federal and provincial governments could also be interpreted as a subsidy for health care spending so long as Ricardian equivalence does not hold — that is, so long as taxpayers do not interpret borrowing today as necessarily leading to a tax increase tomorrow. In the Canadian context, for federal borrowing, Ricardian equivalence might not hold for voters in a given province for reasons similar to those described above. For provincial borrowing, the option to migrate out of a borrowing province means that voters might prefer to borrow today and migrate tomorrow to avoid the tax. The aging baby-boom borrowers might not expect to be tomorrow's taxpayers once they have retired.

In summary, with the introduction of government health insurance in the 1950s and 1960s, there was little political pressure or demand for private insurance for publicly financed health care services. Under federal-provincial government cost sharing, taxpayers did not pay the full resource cost of health care through their provincial income tax systems. The significance of the use of tax points through EPF, the CHST, and the CHT to allow the provinces to finance health care, however, is that, unlike cost sharing, it creates a clearer link in the minds of voters and politicians between health care expenditures and the tax price of health insurance — at least, it reduces the size of the subsidy of the health care services individuals obtain.

A MEDIAN VOTER MODEL OF PUBLIC HEALTH CARE FINANCE

What effect would a subsidized tax price and deficit financing have on government health spending and on the demand for supplementary insurance? To answer this question, one needs some understanding of how much governments choose to spend on health care and, consequently, how much tax revenue they need to collect to pay for that spending. If one considers public health care finance — that is, public health insurance — to be simply a pooling insurance contract, it has two features that differ from private health insurance. First, while the prices and levels of insurance benefits of private contracts can differ according to individuals' income and risk of needing health care services, public health insurance provides a single level of coverage for everyone. Second, the price of that single level of coverage through the tax system varies according to individual income and health care needs. One-size-fits-all public coverage means, however, that some individuals will find the level of public health insurance more generous than they need, while others will find it insufficient to meet their needs and/or wants and, if offered the opportunity, might choose to purchase additional insurance coverage through a private insurer. How much coverage they might want would depend on the price of supplemental private insurance and on the level of public coverage.

In the context of public health care finance, how the single level of coverage is determined is an important issue. If sufficient tax is collected to meet expected health care expenditures, then this balanced-budget constraint defines the tax price of a dollar of public health care spending. An individual then would choose a level of public health care spending based on the tax price of that spending. If one believes that governments set tax and spending policies so as to get elected, then there will be a pivotal voter whose choice of public health care spending and the consequent taxes to pay for it will result in a government's achieving the necessary political support to remain in power.¹¹

Under public health care financing, the tax price of the spending redistributes income from high-income individuals to lower-income individuals and from individuals with a low risk of requiring health care services to individuals with a high risk of doing so. For an individual to support a positive level of government health care spending, then the tax price of public spending would have to be lower than the private insurance price the individual would

¹¹ If a government requires the political support of at least 50 percent of voters, then the pivotal voter would be the median voter in the population. In the case of a government that is influenced primarily by wealthy members of society, the pivotal voter would be a wealthy individual. For examples of economic models of public health care spending, see Gouveia (1997); Kifmann (2005); and Emery (2010a).

otherwise face in the private insurance market (see Emery 2010b). Public health care spending can offer price advantages as a result of lower administration costs and through subsidies arising from federal/provincial cost sharing and government borrowing in lieu of having voters face the full tax price of their spending. Beyond that, low-income and high-risk individuals benefit from the redistribution of income that arises from the tax price; for low-risk and high-income individuals, however, the income redistribution away from them means that public health care finance is a net disadvantage compared with private insurance.

Because of the presence of subsidized tax prices for health spending and lower insurance costs due to lower administration costs, individuals who support government health care spending at all would support a higher level of public health insurance coverage than they would have purchased through a private contract. Once the government selects the level of public health insurance coverage based on the preferences of the pivotal voter, many individuals find the level of public health insurance coverage far more generous than they would have chosen, while others could find the level deficient and consequently seek supplementary private insurance. As one would expect, increasing the subsidy increases public health expenditures and crowds out the demand for supplementary private insurance. Conversely, reducing the size of the subsidy reduces public health care spending and could increase the demand by high-income individuals for supplementary insurance.

This simple intuition explains why, from the introduction of the medicare acts in 1957 and 1966 to the 1990s, there was little political pressure or demand for private insurance for publicly financed health care services. When public health insurance was introduced through the 1950s and 1960s with federal-provincial cost sharing, taxpayers would not have paid for the full resource cost of their health care system through their provincial income tax system. Banting and Boadway (2004, table 4) calculate that federal government transfers for health care as a share of provincial government health care expenditures trended down from 41.3% in 1975 to roughly 30% in 2000, while the cash portion was down to less than 15% in 2000 from 41.3% in 1975. The timing of these changes in federal government cost sharing along with provincial government borrowing helps to explain why Canada's single-payer health care system came under increasing strain after the early 1990s. What is harder to pin down is the exact nature of the political and fiscal crisis. Was medicare, or the single-payer feature of medicare, at risk? To answer this question, one needs to know whether the pivotal voter might have been a wealthy or a middle-income Canadian.

Evans (2003,19; 2004) alleges that the strain on resourcing the public health care system arose because governments became more sensitive to the policy preferences of wealthy Canadians and, presumably, corporations.¹² Consequently, according to this view, the pivotal voter is wealthy, and the preclusion of private payment for medicare services is necessary to keep wealthy Canadians committed to supporting the public health care system.

¹² Evans (2004, 187) further argues that the real motive underlying proposals for more private financing is simply to allow those with high incomes to obtain first-class care without having to pay taxes to help support a similar standard of care for everyone else. In his view, the prohibition on private payment and private insurance for medicare services ensures that high-income Canadians pay the necessary taxes to support medicare.

If the subsidy for public health care spending were large enough, the wealthy pivotal voter would choose a level of public health insurance that was higher than the individual would have purchased privately. It follows as well that the level of public health spending would exceed both what lower-income, higher-risk voters would have chosen and what they would have purchased privately. Reducing the subsidy, however, would reduce public health spending until it was low enough that the wealthy pivotal voter would choose a purely private health insurance system, and the political shift in support of public health insurance would be abrupt. In other words, if the pivotal voter were wealthy, the political crisis of the 1990s would have put the future of medicare at risk. Clearly, in Evans's scenario, in the absence of a subsidy, a prohibition on private insurance would be needed to ensure the support of the wealthy for health care financing through taxation, otherwise they would use their political power to choose private coverage. If this were the case, however, it is not clear why the wealthy would not simply eliminate the prohibition on private insurance in the first place.

The alternative to Evans's scenario is that the pivotal voter is a middle-income Canadian. For this voter to support public health care financing, he or she would have to face a tax price that was lower than the cost of a private contract. The more generous the tax price, as a result of either subsidization or redistribution through taxation, the higher the level of public health care spending the middle-income voter would choose. In the absence of a subsidy, a lower-income pivotal voter likely would choose a level of spending that left some of the demands of higher-income voters unmet. In this case, subsidizing the tax price would increase the level of health care spending so as to crowd out the private insurance demands of higher-income individuals. In contrast to a wealthy pivotal voter, a middle-income pivotal voter who faced a rising tax price for health spending as the subsidization of provincial health spending declined would not necessarily fail to support the financing of public health care. As the level of public health care spending fell, demand for private supplementary insurance by high-income individuals gradually would emerge. In this scenario, the political crisis in the 1990s concerned the single-payer feature of medicare, but not medicare itself.

Note in this case that a prohibition on private insurance would reduce the welfare of high-income individuals without affecting the level of public health care spending. In other words, the demand for private insurance would be a symptom of underlying changes in the determination of public health care spending, rather than the cause of changes in public health care spending. In the language of the majority of the Supreme Court of Canada in the 2005 *Chaoulli* decision, the prohibition would be arbitrary in the sense that it would impose harm on frustrated demanders without any commensurate benefit for others in society (see Yeo, Emery, and Kary 2009).

The policy literature on the issue of private payment for medicare services in Canada supports the proposition that the pivotal voter is not wealthy and that the likely size of the market for private insurance is small (see Evans 2004; Emery and Gerrits 2006). Polling suggests that a majority of Canadians is not dissatisfied with the public system and that only a minority believes that private payment and private insurance would be good way to add revenues to the health care system.¹³ Perhaps most telling, the political debate over health care in Canada has not been about changing the universal and comprehensive features of public health care finance, but about the prohibition on private payment that discourages mixed health care finance. A wealthy pivotal voter would have created the former situation but not the latter.

Considering that the pivotal voter is not wealthy, it is not surprising that there was little opposition to the passage of the 1984 CHA, with its preclusion of private payment and private insurance, nor that challenges arose to the CHA after 1995 as the pivotal voter faced a rising tax price for health care spending once provincial governments determined they could not continue to run deficits. The CHA passed when public spending levels were high due to the subsidized tax price, which would have limited demand for private insurance. Once federal cost sharing began to fall and health spending became tied more closely to the tax price, however, the level of public spending fell, causing the emergence of unmet demand on the part of higher income Canadians.

Ironically, the perspective of the pivotal voter suggests that the rising share of total income of high-income Canadians after the 1990s (see Saez and Veall 2005) might have been responsible for the return of high growth in public health care spending and diminished pressure to change the 1984 CHA preclusion of private health insurance for medicare services. Overall, the federal tax system became more progressive over the 1990s: between 1990 and 2002, the 10% of Canadians with the highest incomes paid more than one-half of federal income tax and the growth of the amount this high-income group paid increased at the same rate as its income. In contrast, the 50% of taxfilers with the lowest incomes paid less federal tax in 2002 than in 1990, despite rising income over the same period (Martineau 2005; see also Dyck 2003). With increasing inequality of income distribution, a lower tax price for the health care of middle-income Canadians would have led to an expansion of public health spending and, consequently, to a diminution of demand for supplementary private insurance.

¹³ See *Health Care in Canada Surveys*, annual 1999-2007, online at http://www.hcic-sssc.ca/index_e.asp. The 2007 survey asked, "If more money was needed to improve the health care system, which of the following options would you most strongly support?" Only 13% of respondents supported "Having the public purchase supplemental, private health insurance to cover a portion of the cost of health care, either directly themselves or through their Employer"; 19% believed that the system would be improved by "Increasing taxes and directing it to the health care system"; while 29% preferred to see funding diverted from other government services to health care. See also Boychuk (2008a). Ruggieri, Van Wart, and Howard (1995) use income data for 1986 and voter participation rates for 1984 to infer Canadian voters' preferences for various policy options for balancing the federal budget, and find that the coalition favouring expenditure cuts and opposing tax increases is made up largely of households with above-median income and in their peak earnings years, and with an above-average propensity to vote. With a potential electoral majority against tax increases in the 1980s, the policy choice was between cuts in government services and cuts in transfers. Since the former presented less opposition, it would have been expected to be the policy of choice, at least in the first round.

Between 1980 and 2030, the share of Canada's population age 65 and older is forecast to increase from around 12% to 25%. Many observers project, however, that population aging will increase health care expenditures only by an apparently modest 1% per year between now and 2050, which suggests that such demographic change will not be a serious problem for the financial sustainability of medicare (see, for example, Evans et al. 2001; Hogan and Hogan 2004). Still, the modest fiscal impact of population aging might result in a serious political crisis for medicare. If the incomes of middle-income Canadians remain relatively unchanged but the average risk of illness or the need for health care increases as the population ages, then the tax price of public health care spending will rise. The demand by higher-income Canadians for private insurance will increase as the public system becomes less able to meet their demand for health care services, but this would not be the source of the political crisis. Rather, for government, the real problem is that, as the share of the population that is high risk reaches 25%, the tax price of public health care spending for middle-income, healthy Canadians could become too high. Causing them to prefer the elimination of public financing of health care. Moreover, there is no soft landing in this model, as the switch from the healthy, moderate-income pivotal voter preferring to rely solely on publicly financed health care to preferring only private insurance would be immediate once the tipping point was reached.¹⁴

The population aging example also provides a different explanation for the alleged cost inflation of mixed public/private health care finance systems compared with a single-payer arrangement such as Canada's. In a comparison of OECD countries, Tuohy, Flood, and Stabile (2004) find that the cost of public insurance is higher in a mixed finance system than in a single-payer system, which has been interpreted as evidence of the negative influence of parallel private insurance coverage on the public system. An alternative view is that, in OECD countries with aging populations, public health care spending will decline because of the rising tax price of that spending, and demand for supplementary private coverage will rise. This would result in a correlation between the cost of public insurance and the structure of financing the insurance, but the structure of finance would be a result, rather than the cause, of the cost difference.

CONCLUSION

The infusion of the health care system with revenues from non-income tax bases is a key explanation for the political popularity of public health insurance and for the lack of political pressure to allow supplementary private insurance coverage. It is interesting that the key recommendation to come from the Romanow Commission was to increase both the federal share and the level of health care spending.¹⁵ In the short run, this policy would help to sustain,

¹⁴ Unless, of course, population aging also were to induce higher incomes; see Bohn (1999) and Emery and Rongve (1999).

¹⁵ As the report notes (2002, xvii),

[t]o be sure, the system needs more money. In the early 1990s, the federal share of funding for the system declined sharply. While recent years have seen a substantial federal reinvestment into health care, the federal government contributes less than it previously did, and less than it should. I am therefore recommending the establishment of a minimum threshold for federal funding, as well as a new funding arrangement that provides for greater stability and predictability — contingent on this replenishment supporting the transformative changes outlined in this report.

if not increase, the overall level of public health care spending so long as Canadians did not recognize the current and future tax obligations arising from a return to the older model of health care finance. In terms of maintaining national support for the principles of the 1984 *Canada Health Act*, the Romanow Commission's recommendation would be effective due to the redistribution of after-tax incomes across provincial populations that would result. Moreover, to the extent that the "have" provinces redistribute public revenue to the "have-not" provinces, the recommendation would garner support among the latter — but would that support be sufficient to offset opposition in the "have" provinces?¹⁶

More fundamentally, is it socially desirable to sustain single-payer medicare by subsidizing its tax price and obfuscating the link between spending levels on health care and the tax cost of that spending? Much has been made of the social solidarity expressed through the single-payer health care system and the preclusion of parallel private payment and insurance.¹⁷ If the system were fully financed on a pure pay-as-you-go arrangement, with no subsidy or borrowing to augment spending levels, then it could be socially desirable, but only in the absence of an aging population — with population aging, a pay-as-you-go system would fail to price the future liabilities of the population, resulting in a greater financial burden on future generations. Indeed, Canadians have not paid the full resource costs of their chosen health care spending levels, leaving future generations to pay for today's health care services. In other words, the Romanow Commission's proposal would maintain temporary solidarity among Canadians but at the expense of intergenerational inequities. Robson (2007) identifies an enormous unfunded liability of Canadian health care under the status quo that will require higher taxes or lower spending levels in future — in short, future Canadians will pay more and/or get less from medicare than do today's Canadians.

Canada's public health insurance system is alleged to be in the midst of a political crisis, and opposition to the system supposedly is coming from high-income Canadians who would prefer not to pay the taxes that are redistributed to lower-income Canadians through the health insurance arrangement and who would rather be able to purchase private health insurance. In this view, the *Canada Health Act's* prohibition of supplementary private insurance is deemed essential to maintain higher-income Canadians' commitment to the redistributive function of the current health insurance system and to ensure that adequate public funding is available for it. Allowing the rich to purchase private insurance, it is argued, would reduce their "voice" in encouraging more resources for the public health care system.

¹⁶ After dramatic reductions in non-renewable resource revenues and the elimination of its health care premiums, and facing looming tax increases and/or expenditure cuts, Alberta recently requested \$700 million annually in additional funding for health care from the federal government. Ottawa rejected this request even though, under a ten-year federal-provincial 2004 agreement, Alberta receives about \$200 less per resident in health transfer funding than do most other provinces because of the strength of its tax revenues. MP Ted Menzies, parliamentary secretary to federal finance minister Jim Flaherty, commented: "The day or the minute that Alberta becomes a have-not province, pray to God they don't, then we have to readdress Alberta's health transfer" (quoted in Renata D'Aliesio and Jason Fekete, "Feds deny Alberta's health cash appeal: Ottawa will give province \$222M for infrastructure," *Calgary Herald*, 7 July 2009, pp. A1, A7).

¹⁷ The Romanow Commission (2002, 31) asserts that "our tax-funded, universal health care system provides a kind of 'double solidarity.' It provides equity of funding between the 'haves' and the 'havenots' in our society and it also provides equity between the healthy and the sick." For evidence on the progressivity of Canadian health care finance, see Dyck (2003, 18-19); Evans (2003, 17); and McGrail (2007). Glied (2008) challenges this perception, however, by arguing that the "haves" have higher health care costs along with their higher taxes since they make more use of specialist services and diagnostic services.

There is, however, an alternative perspective, one in which the complaints of higher-income Canadians have little impact on the public health insurance system. Most Canadians prefer public health insurance and have no demand for supplementary private health insurance, since the level of coverage in the public system more than fully insures them due to the redistribution that occurs from high-income to lower-income individuals. If the amount of redistribution or the level of tax premium subsidization were to fall, however, lower-income Canadians would choose to have a less generous public health care system. And if the level of public health insurance coverage were to fall, the desire of higher-income Canadians to purchase supplementary private insurance would increase, since the public system would cover less of their total insurance demand.

The important point to recognize is that, under the status quo, allowing the private insurance market to develop would have no impact on the level of public health insurance coverage, since that coverage is not determined by higher-income Canadians. Thus, there is little justification for the continued prohibition of supplementary private insurance coverage. It likely does nothing to improve the financial or political sustainability of Canada's public health insurance arrangement, but it does reduce the well-being of higher-income Canadians.

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