Getting to the Roots:
Health Care Financing and the
Inegalitarian Agenda in Canada

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Health Care Financing and the Inegalitarian Agenda in Canada

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Conrad Black, in a vigorous editorial written after the last federal election, heaped scorn on Canada and all things Canadian. A central focus for his contempt was the fact that Canadian governments engage in “… the process of taking money from people who have earned it and redistributing it to people who haven’t.” Reserving judgement on the word “earn”, this is quite accurate. All modern governments play, to a greater or lesser degree, the role of Robin Hood. Taxation is, on average, roughly geared to income, and the money thus raised provides both direct transfers to those with lower incomes, and support for public programs such as education and health care. Governments thus mitigate the (increasing) economic inequality that is generated in market systems. Mr. Black is explicit in his strongly held preference for a more inegalitarian distribution in Canada; few of those who agree with him have been so open.

One of the public programs that redistributes significant economic benefits from the long to the short end of the income distribution is, of course, Medicare. The services of physicians and hospitals, costing in 2001 an estimated $46.1bn. or 4.2% of national income, are provided to users more or less on the basis of relative need, and financed more or less according to ability to pay. The healthy and wealthy thus pay for more than they use, and the unhealthy and unhealthy use more than they pay for. Not surprisingly Medicare also attracts Mr. Black’s contempt; not only do the wealthy pay a larger share of the total cost, but they do not receive the superior access to higher quality care that they would enjoy in a system with more private funding.

Interestingly, the percentage of national income passing through the Medicare programs is exactly the same as it was in 1975, a quarter century ago. This stability contrasts sharply with the pattern for prescription drugs; expenditures on these have risen from 0.44% to 1.13% of national income over the same period. This is consistent with the general observation that sole source funding leads to better cost control, an observation which was one of the reasons why the National Forum on Health recommended a national Pharmacare program.

The “unsustainability” of universal public programs is itself unsustainable on the evidence. But the contrast between the long-run stability of expenditure patterns in Medicare, and the widespread, almost universal, rhetoric of unsustainability in the public media and from provincial governments, is a phenomenon which itself demands explanation. The rising share of provincial government budgets devoted to health care, over the last five years, is real, but is traceable not to escalating Medicare outlays, but to reductions in non-health operating expenditures – and drugs. Overall, provincial governments have been restoring their fiscal balance after the dual impact of the last major recession, and the CHST cut in transfer payments.

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That process is now completed. The rhetoric of future unsustainability, however, persists and seems to be driven rather by the desire to undermine and discredit the universal public programs themselves, as obstacles to a general shrinkage of governments. Smaller governments have less capacity to redistribute resources, whether in cash or through social programs, a fact clearly recognized by Lord Black when he began to use his newspapers to try to convince Canadians that they were over-taxed. On the other hand the rhetoric of fiscal unsustainability of the public programs seems to be combined with a powerful message that the health care system is in fact seriously underfunded – again curious on the evidence that the Canadian health care system is the most expensive in the world except for the grossly inflated and inefficient system in the United States. Put these two propositions together, and the conclusion is obvious – more private funding is needed. Let people pay for their own care – if they can – and do not require them to pay for that of others.

If one’s objective is greater inequality, there are two ways of making the financing of health care less egalitarian. One can shift the balance of financing sources to reduce the relative share of tax finance, or one can change the tax system so as to reduce the strength of the linkage between income and tax liability. A considerable variety of financing proposals, old and new, have been put forward to increase the share of private financing, through user charges or private insurance; without exception these would reduce the financial burden on those with higher incomes and move it toward the lower end of the spectrum. They would also, of course, transfer money from the sick to the healthy. But the egalitarian objective can be attained equally well, and so far with much less political opposition, by modifying the tax structure itself. This has already been done overtly in Alberta and British Columbia, and is the central point in any consideration of alternative sources for additional federal funds for health care.

Taxes are described as *progressive* if an individual’s tax liability rises more than proportionately as income rises, such that higher income individuals not only pay more, but pay a larger share of their incomes. Conversely *regressive* taxation results in lower income people paying a larger share of their incomes in tax. The same concepts can be applied to private financing sources; user charges are highly regressive, and not just because poorer people tend, on average, to be sicker. Even if health status were not correlated with income, private outlays would make up a much larger share of the incomes of lower income people. Private insurance, likewise, is regressive because competitive insurance markets force insurers to charge premiums based on risk, and not on income.

Public financing sources can be more or less progressive depending upon the mix of tax sources used, and there is considerable difference among developed countries in the progressivity or regressivity of their overall tax systems. Income taxes tend to be either proportional or somewhat progressive; consumption taxes – depending upon the tax base – are more or less regressive. Thus proposals to increase the share of consumption taxes in the overall tax mix serve to transfer more of the tax burden down the income spectrum and to provide more relief to the wealthy. [In principle it is possible to design consumption taxes that would be proportional to income or even progressive. But in practice this does not happen. Greater regressivity is, after all, the whole point.] But the most regressive
taxes in common use are poll taxes or head taxes, requiring each person to pay the same amount regardless of income level. The proportion of income paid through such poll taxes thus falls dramatically as income rises; it is not difficult to see that the share of income paid by someone with an income of $300,000 a year is one-tenth that of the person at $30,000. In Canada, these poll taxes are called health insurance premiums.

The label is misleading, inviting confusion with private insurance premiums. But health insurance “premiums” are compulsory, not voluntary, and are not set on the basis of individual risk status. They feed into general public revenue, and whether or not they are described as earmarked “for health care”, the revenue they raise bears no direct relationship to program outlays. Shortfalls/ surpluses of revenue over program expenditure are absorbed into/made up from general public revenue. And finally, although not widely known, eligibility for coverage does not depend, in those provinces with such premiums, on having paid the premium. The Canada Health Act requires participating provinces to cover 100% of their eligible populations; it does not say “unless their premiums are in arrears”. “Health care premiums” are simply taxes, and are treated as such by national and public accountants.

It follows that the choice between income and poll taxes as revenue sources is simply a tax policy choice as to who should pay, and how much. Poll taxes place the greatest burden on the lowest incomes. In practice, of course, both B.C. and Alberta provide premium relief for the very lowest incomes, but the decision to cut income taxes and raise health care premiums is a very deliberate political choice to transfer money – quite directly, from those with moderate to those with high incomes. Governments are elected to make political choices, and all policies will inevitably favour one group over another. The present governments in B.C. and Alberta have made their choices clear.

To get some idea of the magnitudes involved, the attached set of figures shows the results of a unique study carried out in Manitoba by Cam Mustard and his colleagues, and reported in 1998 at a conference of the Centre for the Study of Living Standards. The study is unique because it was based on a linkage, at the individual level (and under extremely rigorous privacy controls) of individual-level utilization of publicly insured health care services—physicians, hospitals, and long-term care—with individual-level incomes from the long form of the census. The study is based on an anonymous representative sample of Manitobans, expanded to the total population. Individuals are grouped into income deciles, with approximately 100,000 people represented by each decile, with a small group (about 18,000) of the permanently institutionalized analysed separately.

Figure 1 shows the distribution of total public expenditure, in 1994, by income decile of beneficiary. As one would anticipate, average use was markedly higher among those in the lower income deciles, and fell with rising income until the middle of the distribution, after

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which it leveled out. The variation in use within each decile would, of course, be considerable; this was not reported. What is perhaps surprising is the very large amount of total cost accounted for by the permanently institutionalized.

Figure 2 shows the estimated distribution in 1994 of federal and provincial tax liability – income and consumption taxes – for the same groups of people. (These amounts are averages by income class and estimated from a federal government tax model, rather than aggregated from individual data.) The heavy weighting at the high end reflects that fact that incomes are, in fact, very unequally distributed – average market incomes in the top decile were $120,000 per family, twelve times the level in the second decile. This top group received 25% of total market income. The overall impact of taxation is progressive rather than proportional so that after-tax incomes are somewhat less unequal than before-tax, but the top decile still received about 20% of consumable income. The total tax liability across the whole population is set to equal the total outlays for health programs, so that the second figure represents the distribution of tax burden specifically to finance public health care.

The third figure simply subtracts the second from the first, showing the net benefit or burden by income class. It represents the total cost of services used by the members of each income decile, less the total amount of taxation contributed from that decile. Thus, in 1994, the top decile of Manitobans contributed $374.3mn. more than they used, and the bottom decile used $169.2 mn. more than they contributed. The permanently institutionalized population, having very little income, paid very little tax, indeed one could say that the top ten percent of the income distribution paid for the institutionalized population.

These numbers represent the absolute dollar amounts transferred by the tax-funded public health programs between the different income classes. Any shift of financing mechanisms from taxation to private insurance or self-payment would shrink these bars toward the x-axis; a hypothetical “purely private” financing system would shrink them all to zero.

To give an idea of the significance of these transfers, Figure 4 expresses them as a proportion of total consumable income, that is total incomes after taxes paid to and financial transfers received from federal and provincial governments. In effect these proportions represent the amounts by which consumable incomes would change in each decile, on average, if all expenditures were privately financed and taxes reduced in proportion. The amounts at the ends of the income distribution are quite large; “full privatization” of financing would raise the consumable incomes of the top decile by an average of 14.4%, and lower those of the bottom decile by 22.2%. [The corresponding dollar amounts, for Manitoba in 1994, would be an average annual net gain for persons in the top decile of $3539, and a net loss in the bottom decile of $1599. But the scenario is implausible, as it implies an annual net loss of $19,207 for each of the permanently institutionalized population, more than three times their average annual income. (They cannot be fitted on this graph; their percentage loss would be over 300%).]
This framework then permits one to show the effects of substituting a poll tax, such as a flat health insurance premium, for the income tax. Figures 5 and 6 show the redistributive effects, within this data set, of a 20% cut in income taxes (both federal and provincial) with the revenue loss made up from a poll tax that exempts the bottom decile of the population and the permanently institutionalized population. People in the exempt groups would have gained a few dollars a year from the tax cut, but the really big winners are at the top end of the scale – because so much of the income goes to that end. Families in the top decile would gain, on average, over $4000 a year from this hypothetical change in tax mix. The next decile do much less well, gaining just over $1000, while the lower 80% of the population come out either more or less equal, or substantially behind. Within the top decile itself, of course, the net gains build up rapidly for the families with the very highest incomes, as the category is open-ended upwards. Roughly, families with incomes of $250,000 would gain over $11,000 a year while those at the half-million mark would be close to $25,000 ahead. Poll taxes rest very lightly on the wealthy.

As a percentage of consumable income (prior to the hypothetical change) these sums amount to a gain of over 5% for the top ten percent of the population, and a loss of nearly six percent for those in the second-to-lowest, and substantial losses across the lower half of the income distribution. The percent change in the top decile is less dramatic than the dollar gain, because the incomes are so much higher at that end. But the pattern is the same, shifting the tax mix by substitution a poll tax – “health insurance premium” – for part of the income tax transfers a substantial amount of consumable income to the highest income group, at the expense of almost everyone else.

Increased health insurance premiums, at federal or provincial level, combined with proportionate reductions in the income tax, are thus quite a powerful device for moving us towards Conrad Black’s objective of a less redistributive society, in which those who receive the largest share of income from the market are able to keep more of it for themselves instead of having it taxed away to support others. But one could reinforce this process by financing the cut in income taxes, not through a poll tax, but through a user charge for insured services, set so as to bring in enough revenue to match the loss. Figures 7 and 8 show the redistributitional effect of a 20% cut in total income taxes, made up by an across-the-board coinsurance charge for the Medicare insured services in Manitoba in 1994, again exempting the permanently institutionalized and the lowest income decile.

The redistributitional effect is similar to that of the poll tax, but accentuated because the lower income deciles use more health care per capita. Since average per capita use of care is roughly equal across the deciles in the top half of the population, the additional financial gains in this group, relative to the poll tax scenario, are roughly equal. But the additional losses in the bottom half of the population rise steeply as income falls; families in the second-lowest decile lose almost twice as much under the coinsurance scenario as under the poll tax.

This would suggest that high coinsurance rates can be an even more powerful mechanism than health insurance premiums for promoting greater inequality. But the appearance may be deceiving. The poll tax, or health insurance premium, increase would have imposed a
tax of $681.54 per year on the non-excluded population, or $56.89 a month – steep, but not crushing. The coinsurance policy would have required users of health care to pay over half of the costs generate on their behalf – 55.62%, in the scenario. Relative to the poll tax, this almost doubles the share of consumable income that would be transferred from the lowest two non-excluded deciles. But the effects on income distribution within deciles – not addressed in the Mustard et al. study – would be much more extreme. It is not clear that the Canadian public is yet ready to accept this degree of “taxation of the sick.”

It is well-known and extensively documented that a relatively small proportion of the population use a very high proportion of health care services, both in any one time period and over longer times. A recent study in B.C., now being written up for publication, shows that the five percent of the adult population with the highest use of physicians’ services (measured in dollars of billings) not only accounted for 33.7% of total billings, but made up 43.5% of hospital admissions and used 69.3% of inpatient days. These people were generally quite ill, typically with major and multiple problems. They were on average older – almost half were over 60 – came from poorer neighbourhoods, and had a death rate nearly eight times that of the general population. For most of them, there seems no realistic prospect of their paying over half of the costs that they generate, even if such an extraordinarily skewed distribution of financial burden were acceptable to the general population. Accordingly the introduction or increase of health insurance premiums seems a much more promising and acceptable way of promoting the inegalitarian objective so clearly laid out by Conrad Black.

The data from the Mustard et al. study are regrettably rather elderly; more recent changes to both federal and provincial income tax rates have probably served to reduce the redistributinal effects of the tax funding of Medicare. As noted above, the Alberta and B.C. governments have already recognized the redistributive potential of changing the tax mix by cutting tax rates and raising health insurance premiums. The regressive pattern effects can, of course, be accentuated by providing greater reductions for higher income taxpayers; the figures included here are based on an assumed equal proportionate reduction across the whole population. That is why the lowest-income groups actually show a small income gain from the changes in funding mix – a useful feature for covering up the real impact of the change, if that is thought necessary.

For the longer run, however, these potential consumable-income transfers still fall far short of the objectives of Lord Black and those he speaks for. He sees the best hope for Canada as “…a friendly American takeover bid, which most Canadians, despite their nationalist posturings, might find irresistible.” Absorption into the United States would offer a truly spectacular increase in both inequality of income, and inequality of access to such benefits as health care and education. While American incomes are higher, on average, than those in Canada, it turns out that the bottom 25% of Canadians are absolutely better off than their American counterparts – not just in relative terms. This group of Canadians could thus

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3 Reid, R.J. et al. “Conspicuous Consumption: Characterizing High Users of Physician Services in One Canadian Province” (in process, 2002)
4 Black, Ibid.
expect an absolute decline in their income levels under Lord Black’s preferred outcome.\(^5\) On the other hand the upper ten percent of Americans enjoy incomes 25% larger than their Canadian counterparts – who have to support, among other things, a more egalitarian (though much less expensive) health care system. (Other studies have indicated that the division by deciles is still too coarse to capture the largest differences, and that it is the growing proportion of income accruing to the top one percent of the US population that is really remarkable.)

As for the American health care system, it is well known to be the most inequitable in the developed world, and by far the most expensive in the world. What is less well known is that it is in fact largely funded from public sources – nearly 60% of health total expenditure – but the distribution of this public financing burden is also the most inequitable in the developed world. Inequality is, in fact, quite compatible with public financing; the trick is to ensure that higher income people have greater access to the benefits financed by the public sector. American ingenuity has shown how this can be done.

It seems unlikely, and Black concede as much, that Canadians are yet ready to accept absorption into the United States despite the benefits that it might offer for upper-income Canadians. For that matter, it is unclear why the US should offer a “friendly takeover” since it can probably reap most or all of the benefits of full control of the Canadian economy without having to provide political representation. The process of Americanization, is proceeding steadily enough – as witness the tenor of the current debates over health care, which would have been unimaginable twenty or even ten years ago. The data showing that Canada remains a much less inequalitarian society than the US are, after all, five years old now; the fiscal changes since, and the health policies under active discussion, could contribute substantially to increase inequality here as well. To use an old policy analysts’ metaphor, “the frog is being boiled”. Why startle it with any dramatic act?

Lord Black’s outburst was probably triggered by intense frustration at the slow progress of change. But he should be patient; his agenda is clearly making progress, if not as fast as he might like. Those who share that agenda, and who are working towards its achievement, have been much more strategic in alternately revealing and concealing their objectives. Those who do not, and are not, might however be grateful to Lord Black for his editorial. As Sir Francis Bacon said, “We are much indebted to Macchiavel, and others, who write of what men do, and not of what they ought to do.”

Figure 1: Expenditures on Publicly Financed Health Care, by Income Decile, Manitoba, 1994

Figure 2: Tax Contribution to Health Care, by Income Decile, Manitoba, 1994

Figure 3: Net Transfer to/from Income Decile, Public Financing of Health Care, Manitoba, 1994
Figure 4: Net Transfer by Income Decile, as Share of Consumable Income, Manitoba, 1994
Figure 5: Net Transfer by Income Decile, in $ per Family, from 20% cut in Income Tax and Off-setting Poll Tax (INS and Dec. 1 exempt), Manitoba, 1994
Figure 6: Net Transfer by Income Decile, as Percent of Consumable Income, from 20% cut in Income Tax and Off-setting Poll Tax (INS and Dec. 1 exempt), Manitoba, 1994
Figure 7: Net Transfer by Income Decile, in $ per Family, from 20% cut in Income Tax and Off-setting Coinsurance (INS and Dec. 1 exempt), Manitoba, 1994
Figure 8: Net Transfer by Income Decile, as Percent of Consumable Income, from 20% cut in Income Tax and Off-setting Coinsurance (INS and Dec. 1 exempt), Manitoba, 1994