

**It is our pleasure to make this article from Inroads 12 available to you free of charge.**

Please consider a subscription (or a small donation) to help us to continue to provide timely, thought-provoking articles in print – and often on-line – to readers across Canada and beyond.



On the last page, you will find information about subscribing. You can print it out or just send us an email or give us a call. Or you can subscribe on-line.

[www.inroadsjournal.ca](http://www.inroadsjournal.ca)

Check out our website to find out more about Inroads 12, and our back issues.

*Thanks.*

A WORD ABOUT PRINTING THIS ARTICLE: These pages are intended to print on legal (8.5 x 14 inch) paper, two pages per sheet, in a horizontal landscape. Pages can also be printed onto letter sized paper, vertically, at a reduced size.



# What future for health care?

**T**HOSE OF US WHO ARE FROM SASKATCHEWAN CONSIDER TOMMY Douglas our patron saint – with good reason. In public meetings, he called for higher wheat prices and the brotherhood of man in rhetoric that bested William Jennings Bryan. He gave comfort to the poor. He damned the owners of the CPR and the banks, and all the other vested interests who scurried along Bay Street, St. James Street and other insalubrious neighbourhoods in the East. Interspersed in the social gospel message were

In a spirit of ecumenism, we should acknowledge the role of some non-NDPers in all this. As Prime Minister, John Diefenbaker appointed Judge Emmett Hall to chair the

royal commission that recommended pan-Canadian adoption of Saskatchewan's medicare plan. By the time Hall reported, Lester Pearson

was Prime Minister. He instituted cost-sharing with the provinces that induced all of them to implement variants of the Saskatchewan plan.

was Prime Minister. He instituted cost-sharing with the provinces that induced all of them to implement variants of the Saskatchewan plan. In 2002, medicare has become almost as politically controversial as when the Saskatchewan government introduced it 40 years ago. Some on the Left consider medicare the keystone of the Canadian identity, and fear that any market-oriented change will destroy the program and potentially the country. Some on the Right think that the program's inefficiencies explain much of the productivity gap between Canada and the United States, and that the program needs drastic pruning. Canadians – on both Left and Right – should relax. Conservatives need to keep in mind a few basic facts.

flashes of Scottish humour. And he ran a good government too. In late 1959, Douglas had won four successive provincial elections, and was facing a fifth. Like Jean Chrétien, he wanted to retire on a legacy. In a fireside radio chat, he promised that if reelected in 1960 he would introduce universal medicare. After winning the election, just as the medicare debate was becoming intense, he resigned as Premier and agreed to lead the newly formed federal NDP. Hence, much of the credit for successful implementation of medicare falls to his lieutenants: to Woodrow Lloyd who succeeded him as Premier, to Allan Blakeney who served as Minister of Health during the first crucial years, to Sam Wolfe who was the first chair of the Medical Care Insurance Commission and to many others.

In a spirit of ecumenism, we should acknowledge the role of some non-NDPers in all this. As Prime Minister, John Diefenbaker appointed Judge Emmett Hall to chair the royal commission that recommended pan-Canadian adoption of Saskatchewan's medicare plan. By the time Hall reported, Lester Pearson

In 2002, medicare has become almost as politically controversial as when the Saskatchewan government introduced it 40 years ago. Some on the Left consider medicare the keystone of the Canadian identity, and fear that any market-oriented change will destroy the program and potentially the country. Some on the Right think that the program's inefficiencies explain much of the productivity gap between Canada and the United States, and that the program needs drastic pruning. Canadians – on both Left and Right – should relax.

Conservatives need to keep in mind a few basic facts.

If the Americans' combination of employment-based health insurance and state coverage for the old and poor were efficient, at least some other industrial countries would be copying them. None are, because the U.S. system is too expensive and leaves too many uninsured. Per capita public-plus-private health care spending in Canada is also high, well above the median among OECD countries, but it is a great deal lower than the comparable U.S. statistic. Furthermore, in terms of life expectancy, people enjoy (slightly) better health outcomes in Canada than in the United States or in the typical OECD country.

Left-wing Canadians also need to keep in mind a few basic facts.

Medicare is a complex program that needs ongoing attention to managerial detail. Relative to Canada, European countries – including those with social democratic regimes such as Sweden – have made many more experiments with market-oriented reforms such as “internal markets” and patient copayments. The Europeans have done this without jeopardizing universal health coverage.

Tommy Douglas and his colleagues got many things right, but there are morally complex health problems they did not address. Here I cite two. On average, half of health costs accrue in the last year of life. At great expense, advances in medical technology can preserve lives of limited quality for several years. Governments cannot pay for all feasible geriatric health care. If not all, how much should they pay? How much should patients and their families pay?

Another morally difficult problem is Aboriginal health, one of the blots in our system. Improved Aboriginal access to health

facilities has lowered the Aboriginal/non-Aboriginal life expectancy gap, but much of the remaining gap is probably due to public accommodation of very low employment rates and very high welfare use among Aboriginals, and hence an epidemic of “new” diseases related to poor diet and a sedentary lifestyle. What should we do about this state of affairs?

In its report this fall, Senator Kirby's committee has recommended that Ottawa introduce a dedicated health tax to raise more money for health care. Before deciding whether the committee is right or wrong, read Finn Poschmann and Grant Reuber's survey of alternate mechanisms through which governments could potentially raise additional revenues and experiment with some efficiency-enhancing copayment mechanisms.

By the time most Inroads readers turn to this section, the Romanow Commission will have released its report as well. As Roy Romanow has repeatedly said, health care is a service unlike most things we buy and sell. The health system includes a complex network of public agencies (provincial and federal line health ministries), not-for-profit private institutions (including most hospitals), small for-profit firms run by health professionals (most ambulatory care physician practices) and large private corporations (such as pharmaceutical companies). Each of these organizational forms has strengths and weaknesses. Raisa Deber undertakes a careful dissection of the health system and makes recommendations as to which organizations fit where, and why.

Finally, in my article I examine the “blot” that is Aboriginal health.

— John Richards

# Patient incentives

## Why we need them, and how they can work

by Finn Poschmann and Grant L. Reuber

**P**AST EFFORTS TO IMPROVE CANADA'S HEALTH CARE SYSTEM HAVE focused either on more money or on incremental administrative reforms. While helpful, these efforts have failed to deal adequately with the steady rise in health costs that soon will present the provinces with more profound fiscal difficulties than any they have faced to date.<sup>1</sup>

One major problem is the continuing lack of financial incentives to restrain the demand for health services, improve their efficiency or reduce the costs of providing them. No matter how much money is allocated or what administrative reforms are made within the realm of the politically possible, without stronger financial incentives for people to use services more carefully the health care system will inevitably be short of the money required to provide the level of service the public demands.

At this late stage in medicare's develop-

ment, the introduction of appropriate financial incentives will be difficult both technically and politically under the Canada Health Act. Nor will the introduction of incentives be a silver bullet that resolves all problems in the industry. But we believe incentives, properly designed and implemented, can serve the interests of Canadian health care consumers by stabilizing the financial condition of the system and improving its performance.

The issue is not just whether new incentives can restrain the growth in costs to a

more acceptable level, but whether they might also help to narrow the gap between our level of spending and our performance – including, obviously, prompt provision of needed health services. Using Organization for Economic Cooperation and Development (OECD) definitions, Canadian health spending was US\$2,312 per capita in 1998. This placed us in the high-spending category among OECD countries (fifth after the United States, Switzerland, Germany and Norway). At the same time, Canada ranked

**The issue is not just whether new incentives can restrain the growth in costs to a more acceptable level, but whether they might also help to narrow the gap between our level of spending and our performance.**

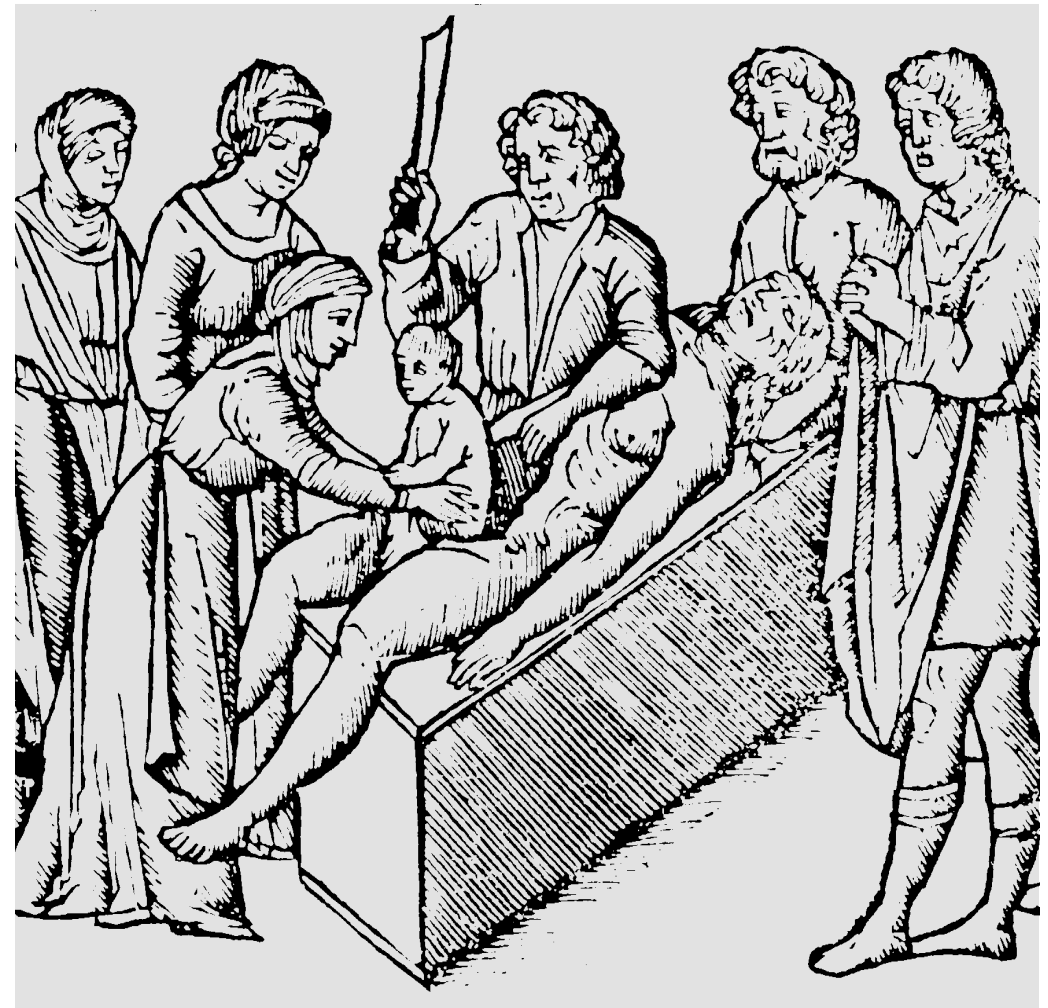
only 30th in overall performance efficiency as judged by a weighted index measuring health outputs and finance method.<sup>2</sup>

We focus on incentives bearing directly on public demand for health care services paid for by governments. Many observers argue that patient demand for health services is highly insensitive to direct financial incentives.<sup>3</sup> Or, arguing in the alternative, they say that to the extent they work at all, these incentives postpone the use of health services, and that making up for the delays ultimately costs the health care system more.

Finn Poschmann is Senior Policy Analyst at the C.D. Howe Institute and a member of the Inroads editorial board. Grant Reuber is a former federal deputy minister of finance, past president, chief operating officer and deputy chairman of the Bank of Montreal, and currently a director of Sussex Circle, a public policy consulting company. This article draws on a recent C.D. Howe Institute *Commentary* by the same authors.

The conventional premise is that the doctor is gatekeeper for the system, and the patient a passive participant. But the weight of accumulated evidence suggests that this basic picture may be wrong. While doctors and other professionals do have considerable influence on individuals' use of the system, patients themselves are sensitive to financial incentives. Moreover, being rational, patients may act more quickly, rather than delay treatment, if doing so is likely to save them money. Support for this contention is bolstered by the recent proliferation of consumer-oriented private medical insurance plans in the United States with the feature that participants who cost-effectively manage their health care usage receive monetary rewards at year-end.<sup>4</sup>

Patient incentives would also have an indirect effect on the suppliers of health services. More meaningful management information and a clearer image of consumer preferences would provide a much stronger basis than now exists for steering supplier behaviour and structural change. Single-payer, fee-for-service systems typically lack incentives encouraging providers to find least-cost effective treatment patterns. Conversely, capitation systems, like representative managed-care health organizations, can sometimes fail to encourage health professionals to allocate enough resources to a particular patient's care. Bringing to the table patients' financial interests as well as their health interests will encourage them to work with providers who arrange healthy, cost-effective care and treatment regimes.



### **What we have in mind, and some alternatives**

The core of our proposal is a credit against provincial tax otherwise payable. Other models for introducing price mechanisms to the public health care market have also been proposed. In addition to our own tax credit model, we will look at a proposal to tax health care benefits and a generic Medical Savings Account (MSA) system, and then see how the three proposals compare with

regard to their impact on management efficiency, income distribution and provincial budgets, their ease of administration and their consistency with the Canada Health Act.

#### **A credit against taxes payable**

The tax credit we propose could be, for the sake of illustration, \$1,000 per person on average, with adjustments for age and family status.<sup>5</sup> The value of the credit would be reduced by the sum of all eligible health care

costs incurred during the year, supported by “T4-H” slips that report public health care system costs incurred by the taxpayer’s family. With the exception of a small “corridor” (discussed below), this mechanism does not require public health costs to be paid directly by individuals; expenses above the assigned credit would be covered, as at present, from general tax revenue.

This mechanism would decrease provincial tax payable for individuals whose demands on the health system were low; those with high needs would be left in the same tax and benefit position as otherwise. But

**Being rational, patients may act more quickly, rather than delay treatment, if doing so is likely to save them money.**

those with low system usage (below half of the mean, in dollar costs assessed) in fact represent more than half of the population. This means that a substantial share of the population would save modest amounts on their tax bills by carefully monitoring their health system usage. Those who pay no income tax – well over a third of the population aged 16 and over – would be unaffected.

The credit could be made similar in impact to a Medical Savings Account system. The \$1,000 per person credit is essentially a grant against which health care costs would be charged. Suppose now that each patient were required, after exhausting the \$1,000 credit, to pay a further amount of his or her health care costs up to \$200 out of pocket before all health costs were covered by the government as at present. The \$200 paid out of pocket would correspond to the corridor costs usually associated with MSA models. We suggest this very small

corridor to avoid causing serious financial hardship to patients, while retaining a meaningful hurdle from the range where patient incentives are relevant to the higher range where marginal incentives would cease to bear, thus avoiding serious disruption to provincial budgets.

What about taxpayers whose taxes payable are less than their allowed credit? They would be unable to take full advantage of the available credit, but they would stand the risk of being exposed to a corridor cost. There are numerous mechanisms that would avoid this problem by phasing in the corridor cost in a way that does not bear heavily on lower-income families. In our modelling (discussed later) we chose a simple mechanism that scaled the maximum assessed bill against provincial taxable income, so those with no tax liability would be unaffected by the new credit.

#### **Special tax on health care benefits**

In a recent C.D. Howe Institute paper,<sup>6</sup> Shay Aba, Wolfe Goodman and Jack Mintz (AGM) developed a proposal to levy an annual usage fee on health care services. Their levy would come to 40 per cent of the cost of services up to a maximum of 3 per cent of annual family income over \$10,000. Those with incomes below the \$10,000 threshold would receive fully paid health care services.

Under the AGM scheme, most health care costs would still be paid using general tax revenues. The scheme’s incentives arise from not having to pay the special tax if health services are not used; there are no other direct financial benefits to the patient. Health service providers would be required to provide receipts and T4-H forms for tax return purposes.

The authors estimate that their proposal would raise about \$6.8 billion, or 16 per cent of total public spending on physicians, hospitals and other health-care-related institutions. A further \$6 billion, or 13 per cent of total spending, would arise from reduced use of health services because of the impact of the incentives applying to patients. In total, then, it is estimated that the proposal would yield about \$13 billion – a 30 per cent benefit to the health care system. A little more than half of this would result from tax increases. These increases, the authors suggest, could be offset by governments making reductions in individuals’ income tax rates.

#### **Medical savings accounts (MSAs)**

A representative MSA system is based on four payment tiers. The first consists of individual accounts, established by the government in the form of direct grants to residents. In Singapore, where MSAs have been in use for some time, the grants are financed by a payroll tax levied on employers and employees – in other words, a tax on employment.<sup>7</sup> In some variants people are also allowed to put a portion of their income into their MSAs on a tax-deductible basis. The annual grant would be spent at the patient’s discretion on eligible health care services. Optional features include allowing money not spent to be taken out as cash, accumulated to pay future years’ health costs or rolled over into an RRSP.

The second tier of costs is covered by voluntary insurance to protect against catastrophic illness, including chronic care. The third tier of costs is covered privately. After the MSA is exhausted, patients would pay for themselves up to a predetermined level; everyone without catastrophic insurance –

except for the poor, who would be covered by public funding – would pay these so-called “corridor” costs. Above this, government would cover health costs; this public support is the fourth tier.<sup>8</sup> In the MSA model patients are free to make health care choices and are, in large part, financially responsible for those choices.

#### **Evaluating the proposals**

What are some of the criteria against which these proposals might be assessed? Here we examine several areas more or less related to design, consider the Canada Health Act implications and look at some financial projections.

#### **Impact on information**

Common to the systems we have outlined is the obligation on health care institutions and professionals to collect detailed information on the costs or prices of their services so they can issue T4-H forms to patients. Making more detailed information available would permit more efficient management.

Lack of satisfactory cost and price information has been a longstanding and widely acknowledged deficiency of the present system, and one remedied only in part by hospitals’ recently improved management information systems. Indeed, the impact on efficiency, reduced costs and increased sensitivity to the public’s health needs that may arise from the improved information emanating from any of these systems may be more important than the direct impact on the public’s demand for health care. And the modified demand by clients would introduce more competitive discipline to providers’ management choices.

On the information criterion, we do not see much basis for choosing among our tax credit scheme, the AGM proposal and an MSA system. All require cost and price information to be made available to the patient, care providers and health system managers – and all are superior to what we have today.

### **Impact on the distribution of income and fairness**

A credit against income taxes payable would have only a modest impact on income distribution. This is true even with the inclusion of a corridor cost. Those who pay no tax would be unaffected and, owing to the phase-in mechanism, the usual arithmetic of nonrefundable credits and overall health spending patterns, the tax cost of health care usage generally would be higher for those in high income tax brackets than for those in low.

The effect on income distribution of special taxes assessed directly against health care use (such as the AGM proposal) would depend on the tax schedule applied. If the same tax scale were applied to “taxable” health care benefits as is applied to other forms of income, the system would be income-tested. On the other hand, if a flat rate of 40 per cent were levied, as proposed by AGM, the tax would be proportional within the income range to which the tax was applied – although another aspect of the AGM proposal, the 3 per cent of income cap on the total payment, makes the full impact of the proposal mildly progressive.

The answer for MSAs is unclear and depends on the specifics of the system implemented. The amount deposited in the MSA is a tax-free grant. When financed by a progressive tax system, such a grant is of course

redistributive. That, however, leaves open the question of corridor costs. Since these would not be eligible for tax credits, their impact would be regressive unless these costs were shifted to employers or insurers.

Our tax-based proposal would affect only taxpayers. There would be no impact on incentives for those who do not pay tax, about a third of the population aged 16 and over. Under an MSA many more would be affected, assuming they could not shift the incidence of corridor costs. But that leaves open the issue of who pays the corridor costs if the patient is unable or unwilling to do so.

Figuring out which groups would pay more or less under each of the systems is, of course, important to assessing each proposal’s impact on patients’ marginal incentives to modify or temper their health system usage in response to the changes. The tax-based approach seems likely to have a larger incentive effect on taxpaying individuals than MSA systems. Between the tax-based systems, the incentive effect of the AGM proposal is likely to have a lower impact because of the 3 per cent of income cap on payments and because there is no direct financial reward to the patient.

### **Ease and cost of introducing changes and running the system**

Political considerations aside, our credit-based system seems cheap and easy to introduce and run as compared with setting up a special tax arrangement (as required by AGM) or a full-fledged MSA system.

The main cost, common to all proposals, would be the cost to health providers of supplying users with receipts and T4-H forms. But the initial cost would be small relative to the major ancillary benefits arising

from an improved management information system. The cost will vary across institutions, depending on the current state of cost data; the smaller the information gap remaining today, the smaller the cost required to close it.

### **Impact on the fiscal position of governments**

Since one reason for changing the system is to constrain the growth of net government spending on health care, the fiscal impact of any proposal is an important criterion. Tax-based systems can readily be adjusted, given time and experience, to make the impact on the budget neutral, positive or negative.

If the demand for health services is highly responsive to the incentives created, the impact on health care costs and their relative growth will be relatively large; the reverse is true if the demand response is small. In the latter case, however, the revenue gain from the payment of corridor costs would be substantially larger than if the elasticity of demand were high. Thus the risk to the fiscal position of the government would be smaller than otherwise expected. In our tax credit model, the availability of a large credit is contingent on taxpayers actually limiting their draw on the health system, thus protecting governments’ revenue position.

How an MSA system would affect the fiscal position of government depends on the details. It could easily be designed to be much more stringent than any of the tax-based systems reviewed here – for example, by removing a ceiling on corridor costs. Were we to install the same system as Singapore, it undoubtedly would benefit government budgets considerably. Of course, a much less stringent MSA system could also

be designed that probably would have beneficial consequences for the fiscal positions of governments but less than those resulting from Singapore’s system.

### **The Canada Health Act**

The Canada Health Act contains five basic principles: comprehensiveness, universality, accessibility, portability and public administration. To what extent are the options considered here consistent with the act? Since all the options are concerned with public financing mechanisms, all seem reconcilable with it. The most obviously consistent, in our view, is the tax credit proposal: there is no direct charge to the consumer, and the system is administered through the current tax system, is univer-

**All three proposals require cost and price information to be made available to the patient, care providers and health system managers – and all are superior to what we have today.**

sally applicable across a province and has no impact on the accessibility or comprehensiveness of the health care system.<sup>9</sup>

### **Some financial projections**

We prepared simulations for Ontario and Alberta, based on several models, to provide estimates indicating the direction and scale of the proposals’ impacts. We used the Alberta Ministry of Health and Wellness’ administrative dataset to attribute costs by detailed age group and by sex. We imputed those costs based on the distribution of 1999–2000 system usage within each age and sex group. The reason for this approach

was to capture the very wide range of health system usage within and across age and sex categories. In Alberta, for example, median health system usage ranges from one tenth to half of the age-specific mean, and this ratio varies widely across age groups.

We assigned age- and family-status-based standard credits, scaled so that the sum across the provincial population amounted to half the relevant public spending. The amounts for each province's simulations were tuned so that differing family types (such as those with and without young children or with and without elderly members)

### **Marginal reductions in demand can improve response time or improve quality of service even while cost reductions are achieved.**

received standard credits roughly commensurate with their imputed health care system usage. The sum of these credits, less estimated health usage, was multiplied by the provincial nonrefundable tax credit rate and used to reduce provincial tax payable.

Three assumptions were made about the response of demand to these tax changes: no response, a 10 per cent reduction in demand and a 15 per cent reduction in demand. We selected these degrees of price responsiveness because they are modest but plausible;<sup>10</sup> one obvious extension would be to let the assumed reductions in usage vary more under different pricing options. For these simulations, we assumed the degree of responsiveness to be normally (and fairly tightly) distributed around the central value.

Who would respond? If a family was in a position such that reducing demand by the assigned amount (by 10 or 15 per cent,

as the case may be, plus or minus a random deviation) would save money over the course of a year, the family was assumed to reduce demand by that assigned amount. But what of families where annual usage would stand well in excess of the credited amount? Some proportion of families, owing to chronic health conditions, would know at the beginning of the year that their consumption would be outside of the range where a 10 or 15 per cent reduction would save them net funds. Others would not know until late in the year where on the continuum they would fall. For simulation purposes, these groups were divided randomly in two, so that half are assumed to respond (again at the average response rate, plus or minus a random deviation) and half are assumed to make no change in their health care consumption habits.

We found that under all models considered, for both Ontario and Alberta, families on average would receive a small tax reduction. This is because the tax credit would be larger than imputed health system usage for a large proportion of taxpayers. Regardless of the particular model, the dollar impacts are small and roughly proportional to income.

Our simulations relied on an assumed reduction in health system usage only when taxpayers were in a position to benefit financially from cutting their usage. The provincial health systems would therefore see less than the postulated 10 or 15 per cent reduction in costs. In the Ontario case, for example, with a 15 per cent impact, the health system would enjoy savings of \$1.3 billion, or about 8 per cent of the relevant cost pool in 2001. The matching figure in Alberta would be a little over \$300 million.

These systemwide savings represent op-

portunities to reduce queue lengths and improve the quality of service delivery to patients. This follows from the reduced claims on health systems' capacity to respond to simultaneous and competing demands: marginal reductions in demand can improve response time or improve quality of service even while cost reductions are achieved.

Against these savings must be counted the costs of system setup and continuing operation. The investment in improving costing systems, upgrading database design and dealing with legacy software and hardware will be significant. That said, if there is a realistic prospect of saving a billion dollars or more annually, as our simulations indicate for Ontario, then even a very large one-time investment in systems is a paying proposition.

### **A practical patient-payment system**

What do we conclude from all this?

First, it is feasible to contemplate a practical patient-payment system, providing direct incentives to conserve health care resources and to manage the system better. We believe this could contribute significantly to reducing the propensity of health care costs paid for by governments to grow at unsustainable rates.

Second, we think that it is desirable to rely as much as possible on existing institutional arrangements such as the tax system, rather than to invent new ones with the risks and costs that such arrangements would entail.

Third, in judging the efficiency of various systems it is important to remember that revenue generation is not the foremost criterion – if that were the issue, the simplest

way to proceed would be to raise taxes. Nor are considerations of *one-time* cost reductions or financial injections. Rather, the focus ought to be on designing a system in which the growth in costs is sufficiently constrained by the introduction of incentives to conform reasonably closely with the priorities of the public and the financial willingness of governments, and ultimately the public, to pay.

And finally, any change in the present system must be acceptable to the public. Apart from those who object to any form of market incentives on ideological grounds, the main political resistance to changes such as proposed here, in our opinion, is likely to come from officials, health care unions and associations and the health service establishment. They are concerned not only about administrative problems and the costs of implementing major changes but also about giving greater influence and control to the consumers of health care services.

With these considerations in mind, our own preference is to introduce a credit against which health costs are charged for tax purposes, along with a modest corridor for private payment. The mechanism is easier to administer than many alternative approaches, yet it can be arranged to provide patients with meaningful and helpful incentives to participate in the fiscal aspects of their health care management. Introducing such a system, in our view, would make a significant contribution to improving the financial stability and performance of Canada's public health system.

Moreover, to the extent that such a system created stronger incentives bearing on consumers, and resulted in better and more meaningful management information and a clearer picture of consumer preferences,

it would provide a much stronger basis than now exists for designing supplier-related incentives and other structural changes in the system. ■

## Notes

<sup>1</sup> See William B.P. Robson, "Will the Baby Boomers Bust the Health Budget? Demographic Change and Health Care Financing Reform," *C.D. Howe Institute Commentary* 148 (Toronto: C.D. Howe Institute, 2001).

<sup>2</sup> Agay Tandon, Christopher J.L. Murray, Jeremy A. Lauer and David B. Evans, "Measuring Overall Health System Performance for 191 Countries," *GPE Discussion Paper Series* 30 (Geneva: World Health Organization, 2001).

<sup>3</sup> See, for example, M.L. Barer, R.G. Evans and G.L. Stoddart, *Controlling Health Care Costs by Direct Charges to Patients: Snare or Delusion?*, Ontario Economic Council Occasional Paper 10 (Toronto: Ontario Economic Council, 1979).

<sup>4</sup> The evidence is reviewed in Åke Blomqvist, "Canadian Health Care in a Global Context: Diagnoses and Prescriptions," *C.D. Howe Institute Benefactor's Lecture* (Toronto: C.D. Howe Institute, 2002). More on the consumer-driven/employer-financed health plans being developed in the United States is found in Michael Waldholz, "Consumer Choice May Mean Better, Cheaper Health Care," *Wall Street Journal*, August 4, 2002.

<sup>5</sup> It is customary to refer to tax credits in terms of the amount of income exempted from tax, given the relevant tax rate. In our proposal, the credit would be multiplied by the relevant province's nonrefundable tax credit rate – say 15 per cent – and the amount (\$150) netted against provincial tax payable.

<sup>6</sup> Shay Aba, Wolfe D. Goodman and Jack M. Mintz, "Funding Public Provision of Private Health: The Case for a Copayment Contribution through the Tax System," *C.D. Howe Institute Commentary* 163 (Toronto: C.D. Howe Institute, 2002).

<sup>7</sup> Payroll taxes may have a harmful effect on employment, unless they are perceived strictly as a fee for benefits. Another difficulty with this financing method is that it leaves out a substantial percentage of the population.

<sup>8</sup> The Singapore system is based on Medisave, providing first-tier financing, Medishield, a voluntary government insurance plan to deal with catastrophic costs, and Medifund, an endowed fund to provide a safety net for low-income citizens. Access to Medifund is assessed by a committee and is by no means automatic. In effect, this means there is no automatic ceiling on the costs borne by citizens unless the committee authorizes special government assistance.

<sup>9</sup> The spectre of a corridor payment might be seen as a distinct issue, but it does not seem offside with respect to the Canada Health Act. It would not be collected as an upfront user fee, and it would not of itself detract from the principle of equal access.

<sup>10</sup> Some comment on the elasticity of demand for health services is included in the AGM paper (p. 5) and especially in the references cited there. There is also useful evidence from recent consumer choice models of employer-sponsored health benefit plans in the United States, in which non-hospital costs drop sharply when patients derive financial benefits if their choices save money.

# Inroads

now twice yearly

---

**subscriptions • 2 years (4 issues) • \$48**  
(students \$36 • institutions \$60)

**Inroads**, Suite A, 3777 Kent Avenue,  
Montreal, Quebec H3S 1N4

subscription info: 514.731.2691  
or by email: [inroads@canada.com](mailto:inroads@canada.com)

On subscribe on-line at [www.inroadsjournal.ca](http://www.inroadsjournal.ca)

Prices include taxes.

Foreign orders in U.S. funds. as quoted above.

Visa and Mastercard accepted.