

# MEDICAL REFORM GROUP

## Paying for Health Care in Canada

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## 1. Executive Summary<sup>1</sup>

One can look at issues of health care funding from the point of view of total health care expenditures and maximal societal benefit or from the perspective of the Canadian government within the current Canadian political culture. Taking the former perspective, Canada spends a lower percentage of its GDP on health care than some European countries, and a lower percentage of its GDP on publicly funded care than most. Canadians place a very high value on health care and its health benefits, and increases in overall national wealth will allow increases in non-health public and private expenditures despite further increases in the proportion of GDP devoted to health care. These considerations suggest that substantial increases in public expenditure for health care are both feasible and sustainable.

Regarding the relative merits of public versus private funding of health care, strong evidence suggests a number of benefits of public funding. These include advantages of equity (a strong value for Canadians endorsed by the Canadian Medical Association); efficiency (including huge administrative savings); cost control of overall expenditures; quality of care and superior health outcomes; and competitive economic advantages. Relative merits of private funding are restricted to issues of autonomy and benefits to selected populations (insurers, entrepreneurial physicians, for-profit health care providers, and the wealthy). These considerations further support the merits of maintaining public funding of physician and hospital services, and expanding public funding in areas such as prescription drugs and home care.

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Canadian governments, despite a record of over 15 years in which public expenditure on health care as a percentage of GDP has risen very little, face the challenge of a public eager for universal high quality health care but reluctant to face the tax increases that would ensure this goal.

The evidence, in the context of the current Canadian political environment, suggests the CMA should aggressively promote public and professional education and policy initiatives in the following areas: i) The advisability and sustainability of publicly funded health care, and the desirability of expansion of publicly funded care ii) the efficiency and equity advantages of general tax revenue as a source of public funding, with the possible consideration of eliminating health care subsidies, raising targeted taxes directed at unhealthy behaviors, levying taxes earmarked for health care spending, and creating a single not-for-profit social insurer in each province iii) the efficiencies in Canadian health care that could come from more rational prescribing, more scrupulous use of diagnostic tests, the nation-wide systematic implementation of innovative health care delivery strategies, and initiatives in areas of public health and the social determinants of health.

## **2. Health Care and the Challenge for Governments**

Health care financing remains a contentious topic in all industrialized countries.

Concerns arise from three interrelated observations. First, health care spending is increasing over time and doing so at a faster rate than inflation and, in most countries, faster than growth in the gross domestic product (GDP). Second, public spending accounts for a majority of health care spending. Third, non-health-care government spending has generally decreased and many governments have decreased their revenue base through tax cuts.

These conditions leave governments under pressure to reduce public expenditures on health care. Voters, however, demonstrate very strong support for publicly funded health care; cuts to health care spending are therefore unpopular and politically difficult. An ideal solution would control public health care spending while maintaining health care delivery at current or better standards and improving the health of citizens. Such a solution, however, has proved illusive.

Confronting this challenging situation requires addressing a number of questions. What is Canada currently spending on health care? What is the appropriate amount of money to spend? What is the distribution of spending amongst public and private sources, and how does this compare to other high income countries? How much of health care spending should be publicly financed? What are the causes of increased spending in health care? Can cost pressures be controlled?

Physicians have a unique perspective to offer in such discussions. Clinicians understand the pressures to use new technologies for diagnosis and treatment. Public

health physicians appreciate the influence of social determinants of health and the importance of a comprehensive approach that maintains investments in multiple sectors. Health services researchers study issues such as access to care, health economics, and resource allocation. This report aims to integrate these disciplines to develop a comprehensive overview of possible approaches to funding health care in Canada. In particular, we critically examine market-based reforms that continue to be advanced as a solution for health care funding problems.

### **3. The Magnitude of Canadian Health Care Costs**

When all the numbers are tallied, estimates suggest that Canadian health care costs will have exceeded \$183 billion in 2009.<sup>1</sup> This number is large, but the important question is whether it is too high. There are several ways to try to answer this question:

- A common metric is to evaluate the proportion of the GDP (the total market value of all goods and services produced by a country) spent on health across countries. Using this indicator, Canada spent about 10.1% of its GDP in 2007, considerably less than the United States (16.0%) but more than the OECD average of 8.9%.<sup>2</sup> The projected numbers for 2008 and 2009 are 10.8% and 11.9%, respectively.<sup>2</sup> These numbers reflect both an increase in spending (the numerator) and a decrease in the GDP (the denominator) due to the economic recession.
- Trends over time may be more important for predicting future costs than single values. The average increase in total health care spending in Canada, adjusted for inflation, grew by 4.7% per year from 1996 to 2007 after very slow growth

(0.9% per year) from 1991 to 1996.<sup>1</sup> Growth (adjusted for inflation) is projected to be 5.4% in 2008 and 3.3% in 2009.<sup>1</sup>

- Another useful measure is to compare the increase in health spending over time to the increase in GDP. The ratio of health spending to total GDP reflects both the growth in health spending as well as the growth in GDP. As in every other industrialized country, Canadian health care spending has, on average, grown faster than the GDP. Between 1992 and 1997 Canada experienced an extraordinary reduction in the percent of GDP devoted to health care (from 10% to 9%) but the long-term trends have reasserted themselves since 1998.<sup>1</sup>

Thus, Canada is experiencing the same phenomenon as other industrial nations – despite a 5-year period in the 1990s of bucking the trend, health care spending in Canada is growing and is doing so at a rate faster than economic growth.

#### **4. Health Care Costs are Sustainable for our Society**

Observing an increase in health care spending is insufficient reason to be alarmed. Spending growth, both absolute and relative to the GDP, in areas such as information technology, transportation and recreational travel has been appropriately celebrated as a sign of economic development and improved population well-being.

As the economy grows, there is more money to spend on all services. Health care spending is a problem if it limits the ability to spend on other goods and services.

Economic forecasts indicate that even if health care grows moderately faster than GDP, health care spending will not crowd-out non-health-care spending.<sup>3</sup> Given that

Canadians place a very high value on access to high quality health care, moderate increases in the proportion of GDP devoted to health care in the face of growing income to spend on other areas appear both sustainable and reasonable.

The United States, with a health care system that is both woefully inefficient and disastrously inequitable, is no model for Canadian health care. The U.S. situation is, however, informative when considering the value that residents of an industrialized society place on health care and the amount of health care spending such a society can bear. Americans spend enormous amounts on health care - over 17% of their GDP, far more than any other country. Yet, whenever possible, they choose to do so rather than go without the benefits of health care. Further, the U.S. remains the world's richest country despite this level of health care spending. Once again, we are not suggesting the U.S. as a model; rather, the U.S. example suggests that, with appropriate organization and attention to quality and efficiency (as we will discuss), Canada still has considerable room to maneuver when it comes to health care spending.

Other cross-national comparisons are relevant to this issue. Most European countries spend a similar proportion of their GDP on health care as does Canada and some (including France and Germany) spend more.<sup>2</sup> Furthermore, these countries typically fund a higher proportion of their health care through taxes than does Canada. It is thus possible, where the political culture permits, for governments to spend considerably more on health care than does Canada, and still have funds available for social programs and other government expenditures.

Until now, we have considered total health care spending from a societal perspective and considered American and European political cultures. The Canadian government's perspective, introduced in our opening paragraphs, may be quite different. Thus, we next focus on what Canadian governments spend on health care.

## **5. Canadian Government Health Spending**

Since the mid-1990s, the public sector has paid for 70% of health care spending.<sup>1</sup> The proportion was over 70% before the 1990s, as it is today in most industrialized (Organization for Economic Co-operation and Development or OECD) countries.

- From 1993 to 2008, provincial and territorial government spending for health as a proportion of total program expenditures increased from 33 to 39%.<sup>1</sup> This increase was driven by both tax cuts and associated reductions in non-health-care spending relative to the GDP.<sup>1</sup>
- In 2006, Canada's tax revenue was equivalent to 33.3% of its GDP; this is higher than the United States (28%) but lower than the European average (38.0%) and the OECD average (35.9%).<sup>2</sup> Since 2006 tax cuts have moved Canada closer to the U.S. in tax revenue as a percentage of GDP.

Thus, governments in Canada have decreased or stabilized spending on many non-health sectors and reduced tax rates at the same time as they have continued to increase spending on health.

## 6. Options for Governments

Many governments and health care analysts focus on public health care spending, and frequently on the proportion of provincial budgets allocated to health, when discussing costs. There are three general policy options that could address this increase:

- Decrease overall health care spending. This option makes sense if there are inefficiencies in the health care system or other savings that can be found. Since Canada spends a relatively high proportion of its GDP on health compared to other industrialized countries without much better health outcomes, it might be possible to find such savings. A key question is whether such savings can be realized without worsening health indicators.
- Decrease public funding of health care. A second option is to increase the amount of health care spending provided by the private sector. Some governments favour this approach since it “offloads” spending from provincial budgets to direct expenditures by the public, either through private insurance or out-of-pocket payments. From a pure cost perspective, the limitation of this approach is that it is likely to increase overall health care costs, since – as the American experience vividly illustrates - private financing of health care is more expensive than public financing. Such an approach also raises serious concerns, as we will revisit below, regarding health outcomes, efficiency and equity.
- Increase provincial budgets. Increases in provincial budgets, with relatively greater increases in non-health areas, would decrease the proportion of

provincial budgets spent on health. Although this might offer only an apparent control of health care costs (as the recent increases have been only an apparent loss of control), such an approach might be justifiable since sectors such as education, transportation, and social welfare have been subject to substantial funding reductions. Provincial spending could increase if the economy improves (yielding higher corporate and personal income taxes at stable tax rates), if tax rates increase, if governments are willing to tolerate higher debt-to-GDP ratios, or some combination of these options.

## **7. What is Responsible for Increased Health Care Spending?**

Determining whether health care spending can be controlled requires an understanding of the drivers of increased expenditures. The most important factor is the increased use of health services (including drugs, technologies, diagnostic imaging, personnel, etc.).<sup>4</sup> This increase (shared across the entire population, and not focused particularly on the elderly) accounts for 48% of the increase from 1998 to 2007. Inflation accounted for 27%, population growth for 14%, and aging for 11%.<sup>4</sup>

Many technologies have had important effects in improving health. Advances in pharmacotherapy have decreased mortality and morbidity for many malignancies, chronic renal failure, organ transplantation, chronic heart disease, eye disease, respiratory illness and a host of other conditions. Surgical advances, particularly joint replacements, have alleviated suffering. Medical devices, including intracardiac devices, have increased longevity, as have the advent of expensive cardiac and intensive care units.

Most of these advances have increased aggregate spending even as they increase health. Some new cancer medications yield substantial improvements in mortality. Others, however, have high marginal costs with modest health benefits. Some of the increased spending may not yield any health benefits. Prescription medications, a major driver of increased costs, represent one of the fastest growing areas of health expenditures. Drug expenditures increased by 136% from 1998 to 2007.<sup>5</sup> Although appropriate prescribing yields unquestionable health benefits, evidence suggests substantial over-prescribing.<sup>6, 7</sup> Furthermore, many expensive medications are prescribed unnecessarily when cheaper medications would suffice.<sup>8</sup>

Factors that contribute to increased health care spending include:

- Medical care is prone to the “technological imperative” – because new technologies *can* increase health they are often adopted, even without a full accounting of potential harms or costs.<sup>9-11</sup>
- Similarly, popular expectations for health technologies may be increasing as individuals are aware of, and request, new interventions. Widespread access to a large body of health information of variable quality - particularly on the internet - can increase demand for both indicated effective services and ineffective or even harmful interventions.
- Health care professionals are highly trained and well compensated, and over the last decade growth in compensation has generally exceeded economic growth.<sup>1</sup> In the last decade, there has been marked growth in the number of several classes of health care professionals whose services are largely paid for privately,

including chiropractors, dental hygienists, social workers, and occupational therapists.<sup>5</sup>

- The aging of the population has drawn prominent blame as a factor underlying health care costs. Aging alone is unlikely to account for a substantial proportion of the costs.<sup>12</sup> Indeed, evidence indicates that increased use and costs of services across the entire population – and not increased illness among the elderly or increased number of people living to an advanced age – are the most important factors underlying cost increases.<sup>4</sup>

### *7.1 What can be done to Control Health Spending?*

Canadian governments have addressed many of these issues in the last two decades through a variety of measures. For example, hospital spending is substantially more efficient than it was a decade ago. Many hospitals were closed in the 1990s to achieve efficiencies in inpatient care. Inpatient surgeries have decreased by 16.5% while outpatient surgeries have increased by 30.6%. Overnight stays and length of stays have decreased substantially.<sup>5</sup>

Costs can also be addressed by limiting funding to efficient resources. The best example of this in Canada is the Common Drug Review conducted by the Canadian Agencies for Drugs and Technology in Health, which makes recommendations to all jurisdictions except Quebec about which drugs represent good value for health, integrating evidence about health with considerations of cost-effectiveness.

The drug review process is notable, however, for three limitations that apply more generally to efforts to control costs. First, there has historically been limited ability to determine the price of medications in Canada (although some jurisdictions have recently started negotiating on prices, these negotiations are not made public). Second, considerations of efficiency are only one factor in the decision-making process – jurisdictions might pay for inefficient resources to advance other social values such as fairness. Third, considering efficiency alone will not decrease costs. That is, a “cost-effective” drug is one that provides health gains at a reasonable cost, but few cost-effective drugs result in cost savings. Accordingly, paying for many cost-effective drugs will still result in an increase in aggregate costs. Considerations of overall budget spending and priorities in allocation are needed to control overall cost growth.

Other efficiencies are also possible but may be harder to achieve. For example, thousands of seniors are being prescribed inappropriate medication. Developing methods to improve such prescribing are, however, challenging.<sup>6,7</sup> There are also numerous examples of local initiatives that have made clinics or hospitals work more efficiently. For example, specific chronic disease management programs have been shown to reduce hospitalizations, thus reducing health care spending.<sup>13</sup> Nevertheless, it remains to be seen how generalizable such initiatives are and how expensive they are to implement on a large scale.

Health information technology presents another touted cost-saving advance. Advocates frequently assert that implementing information systems will reduce system redundancy and save money; such claims are appealing but remain unproven. Indeed, information

systems come with high implementation costs and, when not done properly, might create new inefficiencies in place of the ones that they alleviate.<sup>14-17</sup> Improving quality of care and introducing effective health information systems are endeavours worthy of study on their own merits, but it is not certain that they will be associated with cost savings and, if they are, how long it will take before costs fall.

## *7.2 Addressing Social Determinants*

Public health advocates often propose investing in “upstream” social determinants of health. Indeed, the association between some social determinants – particularly poverty – and health is very strong. If poverty were a disease, it would be among the deadliest conditions facing Canadians.<sup>18</sup> Similarly, addressing such determinants as discrimination based on ethnicity, gender, poor education, and other social factors could keep people healthy and avert downstream costs.<sup>19</sup>

Such an approach, however, faces some significant challenges. First, few interventions targeting social determinants of health have been rigorously evaluated. Investment in early childhood development programs for at-risk mothers is a notable exception.<sup>20</sup> Since social determinants work at multiple levels (individual, group, structural), intervening only at the individual level may prove ineffective if, for example, the problems are inherently structural. Second, even if interventions were effective, the cost savings would likely take years to recoup. In the short-term, government spending would increase (for example, for social housing or investing in education).

Addressing such social determinants is worthy for overall well-being and social justice independent of health. That is, poverty and discrimination – to cite but two examples –

are not primarily health problems; rather, they are social problems that need to be addressed with appropriate policies and funding across all sectors of government. Nevertheless, a commitment to addressing the social determinants of health and assessing long term improvements in population health and costs has been recognized as a priority by the World Health Organization.<sup>21</sup>

Population-based interventions can improve population health, and may therefore reduce health system demand. Anti-smoking policies have been shown to reduce myocardial infarctions hospital admission rates.<sup>22-25</sup> Other population-based strategies such as banning trans fats or labeling calories in restaurant foods can help promote improved population health.<sup>26</sup> Reducing population intake of sodium can be an effective preventive strategy for hypertension, a leading risk factor for heart failure and stroke.<sup>27</sup> Unfortunately, the impact of most candidate interventions to change behavior on health, and in particular on health care costs, remains uncertain.

## **8. Costs and Cost Reductions - Summary**

The greatest drivers of health care costs in the Canadian context are the increased use of health services by the entire population, and the increased expense of many new interventions. Further technological innovations, including new imaging procedures, devices, drugs, genetic testing and individualized medicine, are likely to provide incremental health benefits while further increasing health care spending. We can likely find some more efficient ways to deliver health care and we should actively seek such measures – but we remain skeptical that such measures can significantly decrease

spending. Similarly, there are many ethical reasons to invest in social determinants of health, but there is no assurance that such investments will return cost savings.

## **9. Market-based solutions**

### *9.1 User Fees*

As health care costs will continue to rise, many governments are tempted to turn to market-based solutions to reduce public spending on health care. One set of solutions involve user fees, which are currently being proposed in Quebec. Enthusiasts for user fees see them as both cost reducing and income generating - a somewhat contradictory stance, as has long been pointed out.<sup>28</sup>

The evidence has repeatedly shown that user fees decrease health care use but do so indiscriminately – decreasing both appropriate and inappropriate use.<sup>28-30</sup> User fees may be particularly harmful for low-income patients – in one experiment they were associated with increased mortality.<sup>29</sup> User fees are also costly to administer, reducing or even eliminating any cost-savings. A large body of evidence suggests that user fees often lead to a delay in seeking care. This delay not only leads to adverse health consequences - a serious ethical problem - but defeats the goal of costs savings, and often leads to an actual increase in costs.<sup>31-35</sup> User fees are therefore unlikely to achieve policy goals of costs savings, either with respect to total costs or government expenditures, and will result in adverse health outcomes for Canada's most vulnerable populations.

## 9.2 *Private Insurance - the Health Care Market*

Another option touted as cost saving - not for overall expenditures but for the government - is duplicate insurance for services that are already covered under provincial health care plans. Such insurance would facilitate preferential access for those who could afford it while denying the majority of the population access to these costlier services, thus potentially reducing government expenditures for both groups.

Before discussing private insurance solutions it is worth considering two issues: the health care market and health as a “commodity.” For many goods, a market-based economy allows consumers multiple choices at reasonable prices. The price of home computers has fallen while the quality has increased as multiple manufacturers compete with each other. Consumers might decide to fly in a coach seat, to fly first class, or not to fly at all. Some observers have indicated that they believe that the fundamental problem in Canadian health care is the lack of market-based competition. Both the health care market and health itself are, however, different than other markets in fundamental ways.

Health care economists have documented extensively how markets for health care fail to meet the requirements for a free and competitive market.<sup>36, 37</sup> One requirement is that consumers have sufficient information to make informed choices. In health care, patients are rarely in such positions; rather, they often follow the advice of physicians and other experts – leading to a situation of asymmetrical and incomplete information (to use the airplane analogy, if the doctor said to move to first class because it was better for health, most patients - unless the cost was prohibitive - would probably do so).

Another limitation of markets is that, in many settings, health care is delivered by only a few providers (consider large areas with a single hospital), a situation that economists term a “natural monopoly,” with no effective competition. Furthermore, there is limited competition on price of health care services – costs of prescribed drugs and physician fees, for example, are highly regulated in Canada. Finally, there is substantial limitation to the ability of the consumer to modify demand: people can’t decide not to buy health care this year because they got laid off – they can’t control when they need health care or how much of it they “buy”.

Some market proponents argue that limited markets (for example, for supplemental health insurance) in which insurance companies act as agents for patients (addressing the informational problems) will ameliorate some of the distortions from a pure market system while introducing competition. In the U.S., however, there is compelling evidence that allowing private insurers to compete did not have the intended consequences. Although the introduction of managed care slowed the increase in health care costs, the effect was transient.<sup>37</sup>

Furthermore, the U.S. private health insurance market, despite being the largest in the world, has substantial barriers to entry, including dealing with regulations, significant costs associated with identifying health providers, and required economies of scale to build networks that can spread risks. The result is a health care market in which there are few competitors, prices have increased, and antitrust legislation is being considered.<sup>38</sup> Perhaps the best corollary in the Canadian health care environment is that of companies that sell private drug insurance. Such competition has had limited or

no effect on the price of prescribed drugs. The evidence has led health care analysts to conclude the political factors, rather than plausible economic benefits, motivate market-driven solutions.<sup>39</sup>

### *9.3 Health as a Commodity*

Market-based solutions also fail to recognize that health is different than other goods. In Canada, as in many countries, good health has come to be recognized as a right that the state owes its citizens. The Nobel prize winning economist Amartya Sen argues that health – and a few other goods – are different because without health, it is impossible for humans to reach their full capabilities and attain their full freedoms, which are their fundamental rights.<sup>40</sup> There is a strong tradition in Canada for such an approach – indeed, it underlies the principles of Canadian Medicare.

Alongside valuing health, Canadians also place importance in other social values related to the distribution of health – issues such as equity, fairness, and solidarity. These concerns indicate that we do not only want there to be a right to health, we also want our health care system to be based on principles of social justice and to work to reflect those principles in action. In this regard, the interpretation of the goals of the Canadian health care system as ensuring universal access to care regardless of ability to pay is too narrow. Canadians want health care based on need and want a society in which unjust disparities in health are addressed. This requires a strong and robust health care system with strong commitment to its values by elected governments.

In summary, Canadians care not just about costs but also about equity and justice. We value solidarity (caring for each other) and providing insurance for our selves and our

neighbours to avoid adding economic burdens on top of illness. It is for these reasons that Medicare continues to have such strong support and that physician and hospital services are overwhelmingly paid for in the public sector (although some services, such as drugs, dental care, and others are largely paid for privately). Given these values, any proposed health care reform should be judged in terms of equity, autonomy, efficiency, cost control, effectiveness, wait lists, overall economic well-being and physicians' work. For each of these aspects, we consider both the current situation, in which there is a sole public insurer for physician and hospital services, and a market-based alternative, in which the public insurer continues to exist alongside private insurance.

## **10. Public versus Private Finance**

### *10.1 Equity*

Public insurance is clearly the preferred alternative to achieve optimal equity. The introduction of Medicare into Canada has increased access to health care across socioeconomic strata. Health care is demonstrably more equitable in Canada than in primarily private systems such as the United States.<sup>41</sup> Indeed, where public insurance does not exist in many parts of Canada – notably for prescription drugs and dental care – significant inequities persist.<sup>42</sup>

### *10.2 Autonomy*

Currently, Canadians are restricted in their ability to “buy” access to hospital care or physician services. Although some private health care facilities exist, they are either

highly specialized or largely operate as supplements to the public health care system rather than as duplicate private insurance. The Supreme Court of Canada, in the Chaoulli decision, ruled that the restrictions on private insurance in Quebec violated the rights of Quebec residents to life and security of person; 3 of 7 judges also ruled that the law violated the autonomy provisions of the Canadian Charter of Rights and Freedoms. By allowing those who can afford it an additional option, the private insurance option would increase autonomy for some Canadians.

### *10.3 Efficiency*

For many reasons, public health insurance is considerably more efficient than private insurance – that is, it achieves better health outcomes for the same or lesser cost. First, private insurance is associated with hugely increased administrative costs relative to public insurance.<sup>43</sup> Second, public health insurance is better at treating individuals early in the course of disease and averting downstream costs. As we have noted previously, there is compelling evidence that costs increase when individuals do not get necessary care when they need it and instead delay care until they are sicker<sup>31-35</sup>. Third, since the health care market is so severely distorted, competition is often wasteful, with resulting duplication of services and redundancies.<sup>44</sup> Finally, public insurance can achieve economies of scale that private insurance cannot, given their constrained markets.<sup>45</sup> Consequently, public insurers often can achieve lower costs for health care worker remuneration, drugs cost, and imaging costs. The one health care system among high income countries that relies most heavily on private insurance - the U.S. - costs far more than any other, and still (even after the latest health reform initiatives) fails to insure a large proportion of the population.

#### *10.4 Cost Control*

With requisite political will, a public insurance system can control costs effectively in ways that private insurers cannot. Governments across Canada in the 1990s made decisions to control health care costs. The result was that over a 15-year period there was very little growth in health care spending measured as a proportion of GDP. Although many of these decisions were painful and remain controversial, the important lesson is that such decisions are possible. Most other countries with largely publicly financed systems (the exception is Finland) didn't make the same commitment and their health care costs as a proportion of GDP continued to climb over this period. As a result, Canada went from being the country with the second-highest health care expenditure per GDP to being about a third of the way down the list.<sup>2</sup>

The United States, like Canada, made a commitment to cost reduction, but the absence of a single payer structure resulted in a miserable failure of their initiatives. Private insurance companies in the United States have found it exceedingly difficult to compete on price; both the cost of the services and the private insurance premiums have increased dramatically in recent years.<sup>4647</sup>

#### *10.5 Effectiveness*

Attributing health outcomes to health care financing is problematic for two reasons. First, cross-national comparisons depend on many factors aside from public spending. The United States, for example, has worse outcomes in many health indicators but also invests much less than other countries in determinants of health other than health care. Second, aside from the United States, the proportion of publicly financed care among

high income countries spans a limited range (Canada is at the lower end, with 70% public financing; European countries are largely between 70 and 80%, with some as high as 85%).<sup>2</sup>

Perhaps the best indicators of effectiveness of private versus public finance focus on outcomes clearly attributable to health care and make comparisons between the United States versus countries with much greater public finance. In such comparisons, despite spending far more on health care than other high income countries, the U.S. does no better, and in many cases not as well.<sup>48, 49</sup>

#### *10.6 Wait lists*

Evidence regarding the impact of financing alternative on wait lists also relies largely on relatively weak before-after and cross-national comparisons. Nevertheless, the evidence that is available provides no support for the contention that an expansion of private insurance will reduce wait lists. Probably the best evidence comes from Australia which 30 years ago had a system very similar to the current Canadian system. Since that time Australia has made a gradual, and more recently a massive, expansion in government-supported private insurance. This expansion has failed to decrease waiting lists, and has arguably led to their increase.<sup>50, 51</sup> Countries with duplicate private insurance for hospital services, such as New Zealand and England, appear to have longer waiting times for public services than in Canada.

A comparison from within Canada provides additional consistent evidence. Public patients of Manitoba eye surgeons who worked in both private and public systems had

substantially longer waiting times (26 weeks) than those who worked solely in the public system.<sup>52</sup>

These results are, on theoretical grounds, expected. To return to the plane analogy, setting up a duplicate private system is akin to expanding the first class section on the plane at the expense of regular seating. The few who can pay for a first class seat might get it more quickly; the many who need a regular seat will have to wait even longer.

The analogy is apt since there are many constraints, such as the number of physicians and other health professionals that make it highly unlikely that parallel insurance would expand the size of the market for providing health care (we're not buying a bigger plane). Therefore, instead of shortening the line in the public system by removing patients (as is often the case presented), the line is simply re-ordered so those with the ability to pay move to the front in the private system. Parallel private insurance is also likely to strain the public system by selecting the healthiest patients, leaving the public system with more complex, costlier patients.

### *10.7 Overall Economic Impact*

Canadian Medicare is good for business. By pooling both risk and payments across all members of Canadian society, Canada has avoided employer-based health insurance for physician and hospital services. This has been a significant economic advantage for businesses operating in Canada; in contrast, businesses in the United States spend large amounts on employer-based health insurance. As one would anticipate, U.S. health insurance premiums have risen in parallel with rising health care expenditures.

Employer health benefit costs accounted for 3.8% of total GDP in the United States in 2008.<sup>53</sup> Workers bear the majority of this burden as their real wages have fallen as benefits have risen, but employers also face upward costs and administrative burdens. Thus, neither employers nor workers are better off with employer-based health insurance in the U.S.

### *10.8 Physicians' Work*

Some physicians believe that it would be easier for them to work in a system in which a parallel private system operates alongside the public system. For most physicians, this is unlikely to be true. Although patients with private insurance might get facilitated access to some health services, the large majority of patients – those in the public system – are likely to face longer waiting lists as resources are drawn from the public system. The administrative challenges of working with multiple payers – largely unknown to Canadian physicians but a common complaint in multi-payer systems – would become a reality (these would apply not just to those working in the system but also to those referring patients). Finally, physicians have a large degree of autonomy in the publicly funded system – much more than their U.S. colleagues have in dealing with many private insurers where their bargaining power as a group is diminished, payers must pre-authorize services (and frequently refuse on the basis of cost), and physician records are audited by managers looking for reasons not to pay the full amount that was billed.

### *10.9 Public versus Private Finance: The Bottom Line*

For most Canadians, a sole public health insurance system without a parallel duplicate private system will be the clear choice. Not only will Canadians pay less for health care, but the system will provide superior health equity, efficiency, and effectiveness. Both employers and workers will likely be better off without employer-based health insurance. The only winners in a system with duplicative private insurance are the insurers themselves, physicians who can provide a significant proportion of their services to privately insured patients, and the wealthy.<sup>39</sup>

For governments facing the dilemma presented in our introduction, private financing may be tempting despite its disadvantages. Private insurance for duplicate services would offload some of the cost of paying for public health insurance. This could be a sufficient attraction despite the consequences of increasing overall health care costs, increase administrative costs and consequent decreased efficiency, increased waiting times for services in which the private and public systems compete, decreased health equity, and – if private insurance is employer based – higher costs for Canadian-based companies and lower wages for their workers. The clearly preferable alternative is to avoid the negative consequences of private payment by finding ways to pay for health care within the public system. We will now explore the available alternatives.

## **11. Public Options for Increasing Revenues for Health Care**

Polls indicate that Canadians are strongly support the public health care system and have little interest in a more private health care.<sup>54</sup> As the economy recovers, governments should look at smart social investments. Expansion of public health care

funding should be widely debated, particularly in the form of a national Pharmacare program suggested by the Romanow Report. We need a national debate about the appropriate rate of public expenditure in Canada. We spend less of our GDP publicly than most comparison countries and have lower taxes.

A variety of public options should be considered in order to accommodate increases in costs for physician and hospital services and raise the funds necessary for Pharmacare, home care, and other extensions of Medicare. Each of the potential sources of revenue should be evaluated in terms of whether it is fair (i.e., an option should be considered to be unfair if the costs are disproportionately borne by those with relatively low incomes), whether its administrative costs will be overly burdensome and whether it is political feasible. Several such options are displayed below in Table 1.

<b>Mechanism for raising funds</b>	<b>Fairness</b>	<b>Administrative costs</b>	<b>Political feasibility</b>
Increasing personal income taxes	Fair	Low	Low
Elimination of the private health insurance subsidy	Fair	Low	Medium
Earmarked taxes for health care	Depends on specifics	Medium	Medium
Prefunding model using payroll tax deductions	Depends on specifics	Medium	Medium
Earmarked Taxes on sugary foods and beverages	Controversial	Medium	Medium
Social health insurance	Dependent on specifics	High	Medium

### *11.1 Increasing income tax rates*

Increasing income tax rates as a strategy for funding health care has enormous advantages in terms of both fairness (because taxes are progressive) and administrative efficiency and simplicity. There is, however, currently little or no desire among Canadian politicians to raise income tax rates, even to fund social programs that most Canadians feel are worthwhile.

### *11.2 Elimination of the private health insurance subsidy*

Governments should seriously consider elimination of the private health insurance subsidy. Because the subsidy is proportional to the highest income tax rate paid by an individual, those with the highest incomes benefit the most. Eliminating the subsidy would be associated with minimal or no administrative costs. Even though most economists agree the subsidy is inefficient and unfair, proposals to eliminate it will likely be opposed not only by the insurance industry but also by those with private health insurance and the associations and unions that represent them.

### *11.3 Taxes directed to health care*

Earmarked taxes for health care are appealing because the public generally indicates an increased willingness to pay higher taxes for better health care. Earmarked taxes should be developed thoughtfully however, since they can be highly unfair. For example, the British Columbia Medical Services Plan premiums represents 2.3% of pre-tax income for someone with an income of \$30,000 per year but less than 0.1% of income for someone with an income of \$700,000 per year. In contrast, a graduated

earmarked tax varying between 0.5 and 2.0% of income would likely raise sufficient funds to bring prescription medications within Medicare.

One form of an earmarked tax is prefunding. In such a model, workers would contribute to a fund that would be invested and used to pay for health care in the future. The fund would be collective rather than individual, to ensure risk pooling. Mark Stabile and Jacqueline Greenblatt recently proposed developing such a mechanism to pay for prescription drugs.<sup>55</sup>

Prefunding has several advantages, including transparency and improved intergenerational equity. The Canada Pension Plan provides an example of how prefunding can work for a social program. However, prefunding for health would be challenging to implement. It is also not clear how accurately health care costs in any one sector (e.g., prescription drugs) can be predicted several decades into the future.

#### *11.4 "Sin" taxes*

Historically, increasing taxes on activities - particularly smoking and alcohol - that are detrimental to health, has proved politically palatable. For tobacco and alcohol, governments have exhausted this possibility, which in the case of tobacco resulted in a lucrative black market. Given current perceptions, however, taxes on sugary foods and beverages, or other goods and services with a negative impact on human health, may be feasible and have not been adequately explored. Although likely to be controversial, in time these taxes may become as accepted as cigarette excise taxes. Whether these taxes are fair or not is a controversial issue; although they are paid for

disproportionately by those with lower incomes, the same individuals also benefit from reduced consumption due to higher prices

### *11.5 Social Insurance*

Some see social insurance, which has worked reasonably well in Europe for decades, as a way to raise revenues and potentially to spur competition. Social insurance in Europe has, however, proven more expensive than tax-based funding (the administrative costs of collecting social insurance can be substantial), and lowers overall labor force participation. It is also limited relative to tax revenue in being restricted to formal earnings.<sup>56, 57</sup>

Despite these disadvantages, in a political environment in which the population is unimpressed with the equity and efficiency merits of general tax revenue increases, governments might reasonably consider social insurance. Practical barriers may, however, prove formidable. Social insurance in Europe developed over decades, and the non-profit insurers that pay for health care in many European countries do not exist in Canada. The administrative costs and political feasibility of establishing competing non-profit insurers may be prohibitive.

On the other hand, a single social insurer for each province, administered at arms length, is similar to the model that Alberta is exploring with its development of Alberta Health Services, an agency charged with delivering hospital care and many other health services throughout the province. Provincial governments might reasonably explore the possibility of establishing a single social insurer for their province.

## 12. Conclusion

The Canadian Medical Association has a unique voice in the debate over health care spending. That voice can also be extremely powerful as a tool for public education. A contentious and emotional debate regarding health care funding is about to emerge. The CMA should be ready with a clear and cogent message. The evidence presented in this submission can provide the basis for that message which should include the following elements.

1. CMA documents in development affirm that access should not be constrained by ability to pay. These documents should be central to CMA public positions. Advocating for a system in which Canadians with higher incomes can purchase seats at the front of the health care plane would violate both the letter and the spirit of the fundamental philosophic positions that the CMA is wisely adopting.
2. Relative to public funding, market-based solutions increase costs, reduce quality, and increase health inequities. In addition to violating the values captured in CMA principles, private funding options represent a bad deal for Canadians.
3. Public rhetoric is overwhelmingly and almost hysterically raising cries regarding out-of-control, unsustainable health care costs. The CMA should point out how misleading such rhetoric is. In comparison with other high income countries Canada has done a remarkably good job of controlling health care expenditures over the last 15 years. Health care advances bring important health benefits that Canadians value highly. Health care spending will not consume the entire benefits of a growing economy and will therefore continue to allow increases in

spending on other public and private priorities. European countries manage higher total per capita GDP expenditures on health care greater than Canada's, with higher percentages of expenditure funded by taxes. Keeping physician and hospital services publicly funded, and expanding public funding in areas such as prescription drugs and home care is both feasible and sustainable. If the CMA took on aggressive advocacy of a national Pharmacare program and made it a key objective, it could bring new life to a key initiative that remains stalled.

4. Funding predictable increases in health care expenditures would be done most efficiently and fairly by increasing existing tax rates. In the face of continued government and public resistance to tax increases, governments should eliminate health care subsidies, and explore possibilities of raising targeted taxes directed at unhealthy behaviors, levying taxes earmarked for health care spending, and creating a single not-for-profit social insurer in each province.
5. The CMA should educate Canadians that more health care is not necessarily better. The CMA is ideally positioned to advocate for efficiencies in Canadian health care that could come from more rational prescribing, more scrupulous use of diagnostic tests, the nation-wide systematic implementation of innovative strategies (such as systematic joint replacement systems of care, or community integrated specialty services), and initiatives in areas of public health and the social determinants of health.

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