**Think Like a Canadian Economist**

**Episode 7. Health Care Finance.**

**VIDEO SCRIPT:**

Many people view Canadian Medicare as central to the Canadian identity as hockey, Tim Horton’s Coffee, and complaining about the weather. However, we often give less attention to how we pay for health care and why.

Lets start with what we mean by Canadian Medicare. Many of us may think we have a national health care system. We actually have a set of 13 different health care systems: one in each of the 10 provinces, and one in each of the three territories. All 13 operate roughly the same, but only because of a national piece of legislation called the Canada Health Act.

A provincial or territorial health insurance plan should conform to the five pillars of the Canada Health Act - Comprehensiveness, Universality, Portability, Accessibility, and Public Administration. To receive transfers from the federal government, provinces and territories must ensure their health insurance plans meet the requirements of the Canada Health Act

This require~~s~~ provincial or territorial health insurance plans to provide universal coverage for medically necessary hospital and physician services. The implication is the overall operation of the province’s health care system is mainly a provincial responsibility. However, paying for health care is the responsibility of provinces, territories and the federal government.

In 2014, Canadians spent roughly 10 percent of GDP on health care. While higher than the OECD average of 9%, Canada spends less then 9 other OECD countries. What is more interesting (at least to Economists) is how we pay for health care.

Basically, we have two sources: public sources (such as public insurance) or private sources (such as private insurance or out-of-pocket payments). Roughly 70% of all health care is paid by public sources, while the remaining 30% is paid by private sources.

The provinces and territories run the public insurance system, typically allocating 40% of their budget to health care. This mainly pays for hospital services, prescription drugs (inside of the hospital), and physician services for eligible residents.

Private sources pay for everything else, such as prescription drugs (outside of the hospital), dental services, vision care, and over the counter drugs. Approximately 60% of prescription drugs (outside of the hospital) and dental care are paid for by private insurance. However, services like vision care are mainly paid for out-of-pocket. Over the counter drugs are almost exclusively paid out-of-pocket.

Both public and private sources provide insurance for health care costs we might experience.

The basic idea of health insurance is to cover medical bills in the event you get sick. As individual Canadians, we don’t know when or if we will get sick. However, for a group of Canadians on the same insurance plan, the insurance provider knows (with near certainty) how many in the group will get sick and the total cost of their medical bills. Having insurance, so individual Canadians don’t have to worry about medical bills, generally makes people happier.

Insurance companies charge individuals an insurance premium to be part of the group, the idea being all members of the group pay the same insurance premium and the insurance premium reflects how many in the group will get sick and the total cost of their medical bills.

However, for the basic idea of insurance to work both you and the insurance company need to have enough information about how likely you are to become sick and what your medical bill will be if you become sick. If you know more than the insurance company, it may not be surprising private health insurance markets are likely to fail.

Specifically, the market failure of “adverse selection” occurs when you know how likely you are to become sick, and your insurance company doesn’t. If you are healthy, you are less likely to purchase health insurance. If you are sick, you are more likely to purchase health insurance. If an insurance company charges the same price to everyone (whether they are healthy or sick), healthy people will view insurance as a “bad deal” and will not buy insurance. Which leaves only sick people purchasing insurance, resulting in higher insurance premiums.

The solution? The solution to adverse selection is simple - people can’t choose to be part of the group covered by provincial / territorial public insurance. The universalpublic insurance systems in Canada mean healthy individuals cannot opt out. The elimination of adverse selection is an important economic rationale for Canadian Medicare.

However, the health care products and services outside of Canadian Medicare (such as prescription drugs (outside of the hospital), dental services, vision care, and over the counter drugs) mainly rely on private sources of finance. Private insurance is mainly provided as an employment benefit. Which means people without employment benefits (such as the unemployed and the self-employed) must rely on out-of-pocket payments.

**References:**

Canadian Institute for Health Information (2014). National Health Expenditure Trends, 1975 to 2014. <http://www.cihi.ca/CIHI-ext-portal/internet/en/documentfull/spending+and+health+workforce/spending/nhex_product_2014>

OECD (2015), Health spending (indicator). doi: 10.1787/8643de7e-en (Accessed on 31 August 2015)