HEALTHY, WEALTHY AND CUNNING? PROFIT AND LOSS FROM HEALTH CARE REFORM

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Biographical Note: Considered one of Canada's foremost health economists, Dr. Evans holds degrees from the University of Toronto and Harvard. He has served as Commissioner of the B.C. Royal Commission on Health Care and Costs; Member of the SNS International Panel Review of the Swedish Health Care System, Member of the LSE Health team reviewing the Greek Health Services; and Member of the National Forum on Health, chaired by the Prime Minister of Canada. He served as the Director of the Program in Population Health of CIAR, from 1987 to 1997.

Those of you who heard last week's lecture by Dr. Fraser Mustard, the President of the Canadian Institute for Advanced Research, will have some idea of the breadth and eclecticism of CIAR research programs. Tonight's address will likewise draw on, and I hope integrate, ideas and research findings from a number of different subject areas. In particular, the first part will be built around some very intriguing work by Professor Tad Homer-Dixon, who is a political scientist directing the Peace and Conflicts Studies program at the University of Toronto. Tad and his associates are interested in environmental change and violent conflict. You may wonder how an economist studying the reform of health care systems comes to be interested in an intellectual apparatus developed by a political scientist interested in violent conflict (or perhaps you may not!). But I hope to show you that there *is* a connection. I believe that Tad's work provides an intellectual basis from which to think about a number of the things that are going on in the current debates over the reform of health care, not just in Canada, but in many countries in the world. I will, however focus my remarks tonight on Canada.

The down side of the kind of eclectic, broad-based, multidisciplinary thinking that is characteristic of a program like ours in the Canadian Institute for Advanced Research is that it can be mightily entertaining, and extraordinarily shallow. That is the great danger with multidisciplinary research; it's a whole lot of fun, but it can very easily turn into a bull session. The test of the quality of ideas that emerge from such a process of cross-fertilization and synthesis is whether they make sense and seem to be helpful and useful to audiences with a number of different kinds of interests. Do they change and broaden the "frameworks of understanding" through which we try to comprehend the world around us? So in some ways this audience represents the testing environment for these ideas tonight. As we begin to probe them further, we shall see whether, when you try to push a bit deeper with them, you actually do find something useful emerging.

The first question, though, is: "Why does one need a broader framework of understanding at all?" Why do you need to go and look at international political science theory to think about health reform when you're supposed to be coming at the topic as an economist from Canada? And I guess the quick (and honest) answer is: "Boredom." That is by no means a complete answer, but it actually serves as a very good lead into more fundamental motivations. Let me illustrate.

In 1990-91 I served under Mr. Justice Peter Seaton as a member of the BC Royal Commission on Health Care and Costs. When our report, *Closer to Home*, was released in November, 1991, Jim Hume wrote a very instructive column ("Talk Politics") in the Victoria *Times Colonist.* He listed several statements characterizing the province's health care system and recommending specific reforms. But he then pointed out that these were not drawn from the Seaton Commission's report. They were from the federal Task Force on the Cost of Health Services of 1969, and from the provincial Foulkes Report (the Health Security Program Project) of 1973. But they could also have been the recommendations of the Seaton Commission, and in fact some of them were. "Only in a few areas do the three major health care reports of the past 22 years vary, and even when they do

the variations are slight." And that is an extremely important point — that those same sets of ideas keep coming back, and back, and back, over and over again. It is not, as has been said, that the only thing we learn from history is that we learn nothing from history. We learn quite a lot, but we seem to have great difficulty acting on what we learn.

On another level — even closer to home, so to speak — another commissioner, David Sinclair, brought in a clipping quoting the Dean of Medicine at UBC to the effect that hospital beds were being heavily over-utilized in Canada, and particularly in British Columbia. The Dean emphasized the importance of reducing the unnecessary use of in-patient care, and discussed ways to do so. But the clipping was not quoting Dean Hollenberg in 1990, it was a quote from Dean Jack McCreary and the date was 1965.

Yet again, consider the whole debate over "privatization" in our health care system — Should there be "two-tiered" care, with a preferred level for those willing to pay, or should we preserve the single tier? Should we open or keep closed the Canada Health Act? — all those issues. I think it is safe to say that, though the terminology changes, nothing new is being said, or has been said for at least thirty years. All of these arguments were brought forward in front of Mr. Justice Hall back in the early 1960s; many go back long before that time. They were all rehashed again during the run-up to the Canada Health Act in 1984. Yet despite more than a quarter-century of experience with Medicare – easily the most successful and popular public program in Canada, the same issues keep coming back to the table. How many times do we have to go through this same set of arguments? Why do we not seem to make intellectual progress in this area, despite the accumulation of experience?

Well one of my colleagues, Ted Marmor at Yale, has a very useful aphorism to the effect that "nothing that is regular is stupid." (I think he filched it from Hegel.) Ideas in particular may seem stupid, especially after they have been refuted a number of times by logic, experiment and field experience. But most of the time people are not all that stupid, at least not consistently so, especially on matters that are important to them. (They may look stupid, but they are

usually not as stupid as they look.) And so if a pattern keeps on recurring, there is probably a reason for it. If you don't understand it, if you can't explain it, if it looks stupid, that's probably because you just don't understand the dynamics behind it.

Moreover, this observation of recurring patterns of thought does not appear to be unique to health care, or to Canada, or to our century. I have found a lovely quote sourced to the *Edinburgh Review* of 1843. "In the pure and physical sciences each generation inherits the conquests made by its predecessors" — that's Newton and the shoulders of giants, you remember — "but in the Moral Sciences, particularly the Arts of Administration, the ground seems never to be incontestably won." In other words, you do have to keep going through the same arguments over again. They had noticed that back in Edinburgh in the 1840s, and that probably was far from the first time such thoughts had been expressed.

So if this is a phenomenon which is broader and more general than our particular circumstances, then we should be looking for broader and more general explanations. We should not be looking for the explanations solely in our own circumstances, although when we find useful insights, we certainly want to bring them back and see whether they help us in our own circumstances. And that is why I found myself trolling in the work of a scholar who was looking at the rate of erosion of topsoil in the highlands of the Philippines, and the conflicts between Bengali settlers and the local people in Assam, and water rights in the Middle East. I was looking for more general stories that might apply in other areas of conflict.

Professor Homer-Dixon's work goes back to some of the old "challenge-and-response" traditions in historiography. It takes off from the notion that human environments tend to degrade over time, that basically things get worse. It's very pessimistic in that respect. Resources run out, the game fails, the climate changes – and if none of those things happens then the Reverend Malthus comes along and increases the population until it presses against the available food supply. Famine and plague.

But we respond to that deterioration by the application of ingenuity of various sorts. Technical ingenuity is an important part

of the story — gadgetry, the engineers and the scientists, and their curious and handy predecessors, and not least the amateur and professional agronomists. But also very important, and usually less noticed, is *social* ingenuity — finding institutional adaptations, changes in our political system, changes in our economic arrangements that enable us to cope with the changes in our environments. Ingenuity of both forms permits us to continue to progress, even though the purely external world has a tendency to get worse.

The tension between human ingenuity as a positive force (most of the time), and the inherent tendency for things to get worse, on the other side, can be resolved – or perhaps projected — in two quite different ways in interpreting the evolution of human societies. One approach might be called Neo-Malthusian — as Homer-Dixon does — and the other I would label Naive Neo-classical Economic Optimism. That is a bit of a mouthful, but economists, despite the fact that everyone else thinks they are dismal, tend to think of themselves and the world around them in optimistic terms. It may be because they know what the alternatives are.

The Neo-Malthusians focus on population growth and the mining out, or the declining availability, of non-renewable resources. The "non-renewable" part is really important — once the resources are gone, there will never be any more, and what will we do then? You see this orientation expressed in the *Limits to Growth* literature that received considerable attention about twenty years ago, and it has stayed with us as a part of tree-hugger environmentalism. (My wife particularly likes the bumper sticker that says: "Hug a logger; you'll never go back to trees.") The implicit assumption is that no matter how much ingenuity we bring to bear, as a society or species, eventually the combination of population growth and declining resources will get ahead of us. There are fundamental limits to economic activity, and more generally to the (material) possibilities for humanity. Those limits will be binding soon, if not now, and there is no way out. That is why the viewpoint is Neo-Malthusian, and why economics – which was once built on a similar foundation – earned the title of the Dismal Science.

But intellectual fashions change. The optimistic neo-classi-

cal economist now implicitly assumes a continuous and unlimited supply of ingenuity (available at constant long-run marginal cost.). There will always be enough ingenuity to get around any limitations imposed by resource shortages, because demand (for ingenuity) calls forth its own supply through the magic of the market. The march of progress can continue indefinitely. So long as no one, such as misguided politicians, interferes with the price system and "free markets," they will, like the God of the eighteenth century Deists, assure that we will all live in the best of all possible worlds. (Actually the Neo-Malthusians might agree, except for them the best is none too good.)

Members of this school point to the fact that the real price of most resources does not seem to rise over time. If economic activity were really being constrained by a growing shortage of resources, we should find these increasingly scarce resources getting more costly over time. But we do not. There are occasional sudden run-ups, as in oil prices, but these are caused by special institutional factors, such as OPEC or a war, and in due course prices move back down again. ("Just you wait," say the Neo-Malthusians, grimly.)

So there are these two polar views, one of which essentially says that no amount of ingenuity will get us out of the long-run scarcity trap, and the other which says: "Don't worry about it." There's always going to be as much ingenuity as we need. The Invisible Hand will supply it, as it supplies all other good things, automatically, when left alone to do its beneficent work.

Homer-Dixon in effect goes up the middle of this argument in a way that harks back to H.G. Wells' comment that civilization is a race between education and disaster. Human progress, and indeed maintenance of present levels of capability and comfort, depend upon a race between ingenuity and deterioration, and the race has not been fixed in our favour – or against us. We might then be well advised to consider the institutions and circumstances that encourage, or discourage, the supply of ingenuity. International experience, past and present, gives us examples both of societies that have successfully generated the ingenuity necessary to cope with their changing environments and thrive, and also of societies that seem quite clearly to

be sliding backwards.

Secondly, however, he and his colleagues shift the focus from non-renewable resources to *renewable* resources. It would seem intuitively obvious that the former should be the objects of concern, because they are the resources that will (or will not, depending on your point of view above) "run out." Traditionally, this intuition has guided discussion. Renewable resources, after all, can be renewed. But just because a resource is *renewable*, does not mean that it *will* be renewed. Renewable resources are made available through really quite complex combinations of interactions within the physical environment and between that environment and human interventions. These interactions include both positive and negative feedback loops that are very incompletely understood. In simple terms, ill-informed, ill-judged or simply unaware human interventions can get you into bad trouble before you know it. The cod suddenly disappear. And you can have a lot of difficulty getting out of trouble again – they do not seem to be coming back. Previously renewable resources, now are not.

The non-renewable resources tend to be much simpler, conceptually. As you start to mine out available supplies of coal, the price of coal goes up and people think of substitutes for it. Or they become more ingenious at finding ways to mine previously unavailable reserves, at acceptable costs. The balance is between physically available supplies, and technical ingenuity, and there is a (conceptually) simple negative feedback loop that responds to increasing scarcity and tends to get you off the hook. Social institutions matter — a war or less dramatic dispute over property rights may suspend exploitation of a particular resource. But both it and the necessary technology remain available to be applied in more propitious times.

But renewable resources present much more complicated management problems, and the necessary responses — and this is the critical part of the story — tend to require social ingenuity as much as technical ingenuity. One has to design and create the appropriate institutions for managing the environment. The difficulty is only partially that of trying to figure out what to about the fisheries, for example. Professors Tony Scott and Peter Pearse here at

UBC, among others, have been telling us what should be done for years, and certainly I have no reason to believe that they're wrong. The problem, however, has been that the political environment, the balance of affected interests and their established patterns of interaction, have not permitted us to apply the knowledge that we already have. (This should remind you of Jim Hume's column about the report of the Seaton Commission, referred to above.) We are constrained in adapting to our changing environment more by the lack of social ingenuity than the lack of technical.

This perspective thus focuses attention on the kinds of social environments that will best induce the flows of ingenuity necessary to cope with deteriorating physical environments and maintain the progress of comfort and capability. Or won't. The flip side of this approach, and this is where the study of conflict and violence come in, is to consider what happens when societies do *not* cope well with adversity. In the face of challenge does your society mobilize to develop more ingenious responses, or does it fragment into smaller groups that fight among themselves over the resources that are still available? Are there lines of cleavage in your society — ethnic, religious, economic — that begin to open up when it is under pressure, and form natural battle lines? Do "narrowly based interest coalitions" form (or are they already in existence) that have more to gain by simply appropriating a larger share of the resources available, than by trying to figure out ways of expanding or extending them?

Such internal conflicts tend both to divert and to dry up the supply of ingenuity. It dries up, because in an unstable environment the incentives to "be ingenious" are weakened. The results of your efforts may be appropriated by someone else (stolen), destroyed, or simply ignored. Why bother? This applies to both technical and social ingenuity. There will still be a considerable demand for ingenuity, of course, but the highest pay-off comes from ingenuity devoted to internal conflict — violent, litigious, bureaucratic, political or commercial — rather than figuring out what to do with the common problem.

Again the distinction between non-renewable and renewable

resources becomes significant. People struggle, and may fight, over both forms of resource. But as an empirical generalization, Homer-Dixon and his colleagues observe that non-renewable resources tend to induce more explicit warfare among states. Struggles over renewable resources, when they become violent, tend to be low-level "communal" fighting between small groups of relatively close neighbours. The former tend to strengthen the formal state apparatus (unless total defeat discredits it) but the latter undermine its authority by weakening the monopoly on violence. Moreover as noted, non-renewable resources tend to survive conflict, being available to the victor, while the complex processes that sustain renewability may themselves be damaged by conflict such that nobody wins.

Thus the diversion and dispersion of ingenuity through fragmentation and internal conflict leads not only to failure to cope with the increasing challenges posed by the external environment, but to their becoming more severe. Nonetheless the calculations of those who initiate and sustain the process of internal conflict, and devote their ingenuity to it, are not necessarily wrong. General pain is quite consistent with partial gain, and quite large gain at that. In the "kleptocratic" society, warlords of various forms live very well indeed, with Swiss bank accounts for ultimate insurance.

Homer-Dixon's framework was developed as a way of trying to understand how communal conflict is generated within a state, as different from the more overt and dramatic conflicts among states. This process is linked to the need to develop, or the difficulty of developing, the appropriate social institutions for dealing with deterioration in the external environment. This has been a very cursory treatment of a very extensive and complex research program, but he has constructed a figure that encapsulates the outline of the story and makes explicit the key forces and interactions believed to be at work.

On the top of Figure 1 are the basic factors tending to lead towards deterioration of the environment: renewable resources availability going down, population growth going up. More unequal access to resources — a wider gap between rich and poor — also tends to create more severe social problems feeding into increased likelihood of conflict. Conflict in turn leads to increased scarcity of

renewable resources (damage to the environment), and possibly to migration or expulsion of people. Economic productivity declines, the state apparatus is weakened from both reduced economic resources and reduced legitimacy (inability to provide security by monopolizing violence). Governments have less room to manoeuvre — fewer policy choices available — and become vulnerable to *coups d'état.* Conflict feeds on itself as ethnic or religious divisions widen.

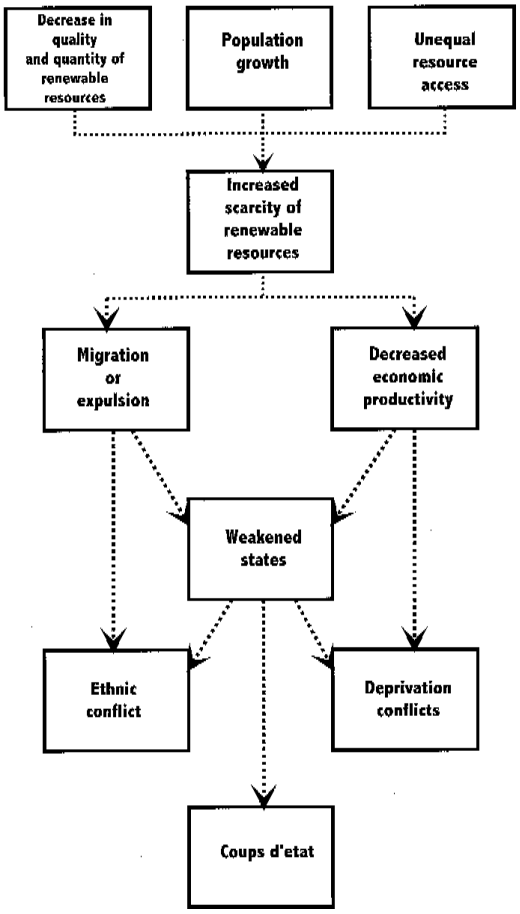


FIGURE 1: Some sources and consequences of renewable resource scarcity. Based on Homer-Dixon et al., *Scientific American*, Feb. 1993, pp. 38-45.

Well and good — or bad — you may say, for places such as Somalia, Bosnia, Rwanda or parts of west Africa. The international research program that Homer-Dixon directs has had teams studying a number of "hot spots' in the world, and fortunately West Point Grey is not among them. What on earth does this have to do with a modern developed society such as Canada? Well, certainly the forms and stakes of conflict are quite different.

Start with *coups d'état*. As far as I know, nobody is threatening to send tanks down to 700 Hamilton Street and take over the CBC. There have been, however, threats to the continued existence

of the CBC in the not too distant past. And given the nature of the commercial alternative, that might amount to much the same thing. When one man takes over nearly all the newspapers in a country, and is overt in his intention of using them for political purposes, does that not have elements of a coup? More generally, if we shift our focus from explicit violence to violent swings in political philosophy, personnel, or policies, is there that much difference between Mike Harris taking over from Bob Rae, and a *coup d'etat*?

Well, yes there is, because nobody gets shot, and that is a big difference. There are no tanks, and no bodies to speak of, which saves a lot of wear and tear on the personal as well as the social fabric. But in terms of the dramatic change in political focus, maybe not so much. What we have seen over the last couple of decades in Canada, the United States and Britain is this sort of more dramatic, more "violent" fluctuation in the political environment. Increased internal conflict, in mature democratic societies, is not expressed in actual fighting; the narrowly based interest coalitions do not raise private armies. (The United States may be a partial exception.)

But we *do* perceive our states to be much weaker now, burdened by debt, constrained by angry taxpayers, locked in by foreign investors. The public rhetoric, particularly in Canada, emphasizes this theme. Are we seeing increased conflict among ethnic groups, increasing pressure to control immigration, and "kick out the foreigners" and all that? Well, yes we are. The form and intensity of expression vary enormously from country to country – Canada is different from California, and there is some distinct ugliness developing in France and Germany.

Homer-Dixon's framework makes no pretence of universal applicability. But a set of tendencies can be observed, to different degrees in different countries, suggesting that similar forces may be at work. The fundamental notion of environmental deterioration leading to the opening up of lines of fracture within a society, and of increasing internal conflict diverting or dampening the supply of ingenuity needed for dealing with emerging problems, seems to have quite general applicability. The old advice has it that: "We would be well advised to hang together, because otherwise we shall certainly

hang separately." Well, more people seem to be prepared to take the risk of hanging separately.

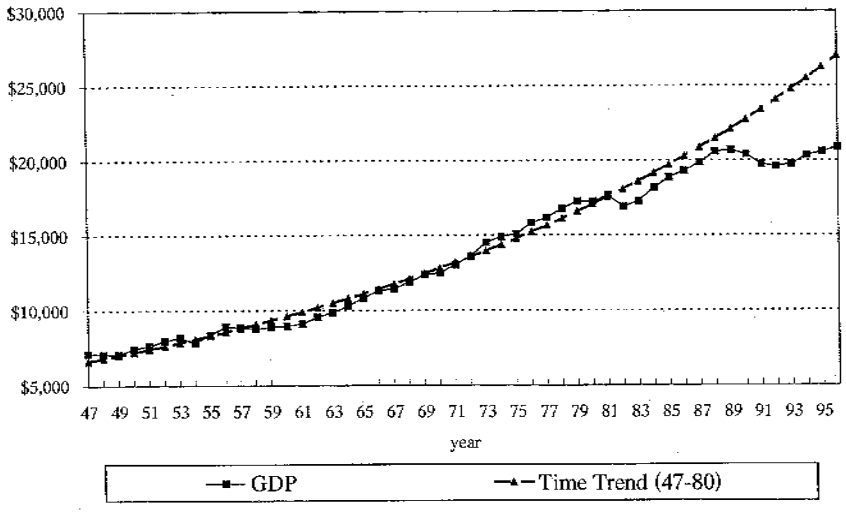
Let me then summarize the story so far. Human environments tend to deteriorate from a combination of declining resources and increasing population. But these challenges can be, with luck and good management, more than compensated for by human ingenuity. That human ingenuity must be applied both in the technical and in the social/institutional domains. But the process of mobilizing ingenuity can be interfered with or short-circuited by the opening up of lines of fracture within a society and increased conflict over shares of the resources available. Narrowly based interest coalitions emerge or are activated — small interest groups that expect to come out ahead, even though the overall situation may deteriorate, because they will eat someone else's lunch (the phrase "making out like bandits" comes to mind) and the whole process then leads to general decline. Prosperity and decline thus both seem to feed on themselves, virtuous/vicious circles or more neutrally, positive feedback loops.

This, then, is the story that I want to use as background to understanding the process of health care reform in Canada.

Let us begin with the deteriorating environment. Figure 2 shows the trend in "real" (i.e. adjusted for inflation) national income per capita in Canada (Gross Domestic Product or GDP) since the Second World War. The small boxes are the actual values; the curved line is simply a logarithmic trend that I have fitted to the data. That trend, however, was fitted only to the data from 1947 to 1980, and was then projected over the rest of the period. It thus shows what *would* have happened if the average growth rate over the thirty-four years prior to 1980 had continued down to the present. But it did not.

By comparing the actual experience after 1980 with a projection of the average experience prior to 1980, Figure 2 highlights the extent of the deterioration in our economic performance after that date. The recession of the early '80s dropped our real income per capita below the previous trend, and we never really recovered that lost ground. Then the wheels really came off the economy in the late

FIGURE 2: Canada Real GDP per Capita ($1986), 1947-1996

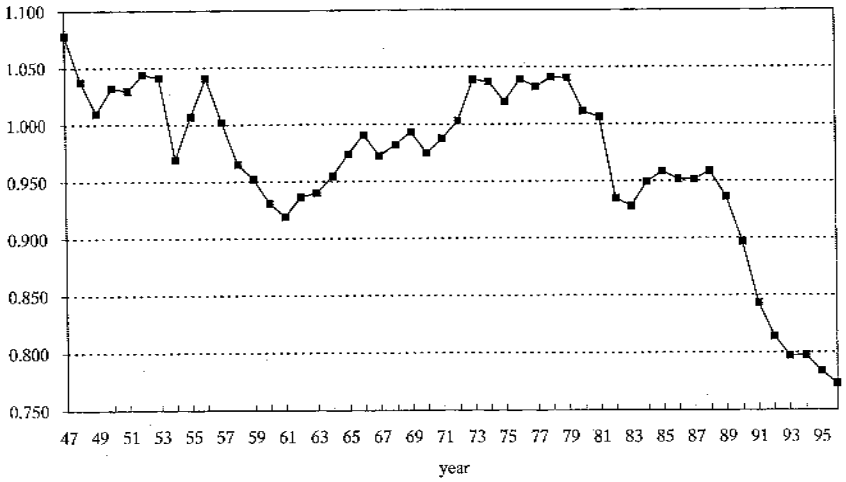


'80s. And despite a great deal of enthusiastic economic cheerleading, it is rather hard to find much of a recovery in these data. The stock market may have done extraordinarily well, but the most comprehensive measure of collective economic well-being, real income per head, has marched stolidly sideways.

That to me is a quite dramatic decline in the quality of our economic environment. It corresponds to the period of rising unemployment rates, rising payments for unemployment insurance, rising payments for welfare, rising public deficits and debts. All of those correlate, not precisely but quite closely, with the stagnation in the overall economy. It's really quite simple and straightforward. The recovery of the mid-1980s did not in fact return us to our previous growth path (averaged over previous booms and slumps); income per capita grew in parallel with but below the previous trend. Correspondingly we did not return to previous relatively low rates of unemployment or relatively low government deficits either.

Figure 3 recasts the same data to make the point a bit more dramatically, displaying the ratios of the actual values in each year

FIGURE 3: Canada Real GDP per Capita over Trend ($1986), 1947-1996



from Figure 2, divided by the value of the trend line in that year. As Figure 3 shows, prior to the 1980s the actual values of real income per capita moved in quite a narrow band around the trend value. But in 1982 the actual values dropped well below the previous trend line, and have never recovered.

The ratio did stabilize during the mid-1980s, but as Figure 3 shows, it stabilized at a level similar to that which, in the 1950s, was considered a severe recession. Yet in 1990 a commentator in the *Globe and Mail* enthused: "Canada has been blessed with seven extremely prosperous years" (Robert Sheppard, *The World in 1990,* prepared by the Toronto Globe and Mail Report on Business, Vol. 6 no.7, p. 32). In hindsight the enthusiasm is perhaps understandable, because things got a lot worse again at the end of the 1980s. The "recovery" of the mid-1990s is, from this perspective, another period in which we have stopped falling away from the former trend. But our standards have changed.

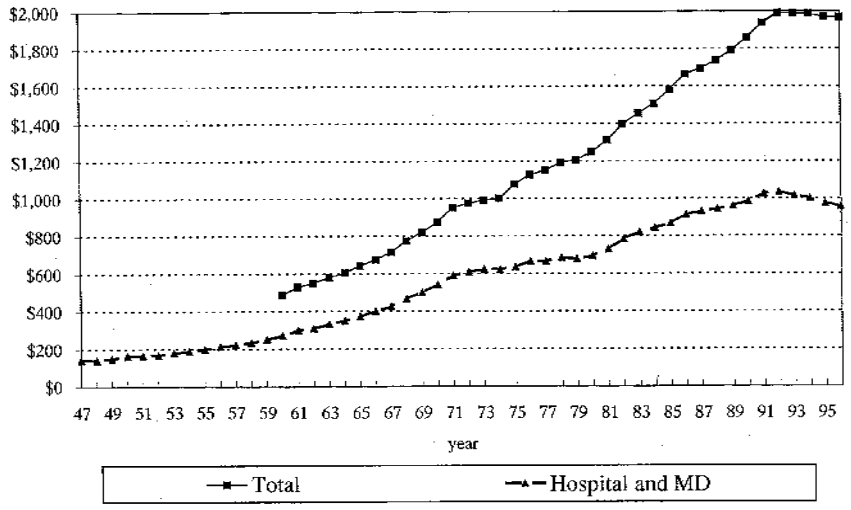
If one fits a trend line to real income per capita from 1960 to 1980, ignoring the earlier period, the contrast with the post-1982

period is even more extreme. The actual values cluster even more tightly around the trend, and the collapse in 1982 is even more pronounced – because growth in those two decades was more rapid and more consistent than before or afterward. But the post-1960 period is of particular relevance because that is when our health care system began to take on its present form. Universal hospital coverage dates from the late 1950s and the first of the universal medical care plans started in 1962 in Saskatchewan. The expectations as to the economic background for Medicare, implicit or explicit, were formed in an unusually favourable time.

The importance of standards and expectations is illustrated by the fact that even in the depths of the last recession, real incomes per capita were higher than at any time in the pre-1980 period — as shown in Figure 2. But Canadians *felt* much worse off economically (and a number of them were), and much less able to afford *inter alia* expensive public programs. Relative to previous growth paths, and to where people had expected to be, they were poorer. But what has all this got to do with health care?

Figure 4 shows expenditure patterns over the same period of

FIGURE 4: Canada Real Health Spending per Capita ($1986), 1947-1996



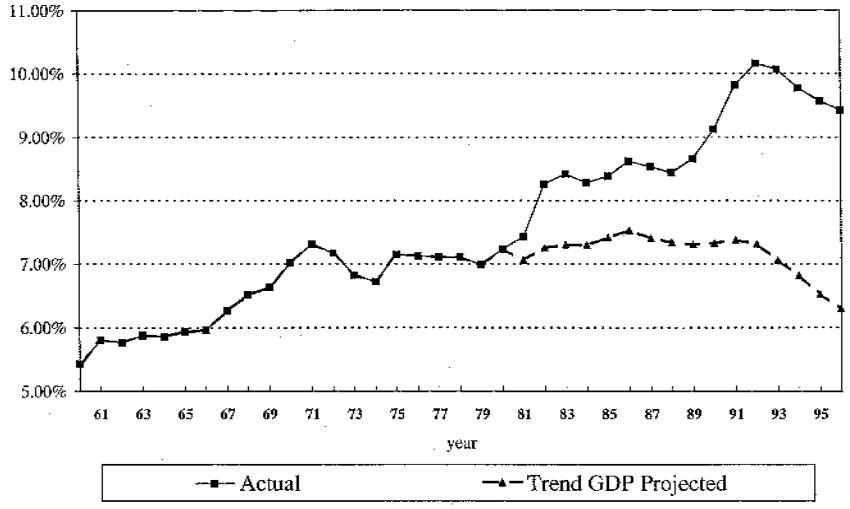
time in the health care system. As everyone knows, health care costs normally "explode" or "spiral," usually "spiralling out of control." Figure 4 shows nothing as interesting as that, but it does show steady increases from the immediate post-war until 1992, after which something quite different happens. Both this long term trend, and the marked change in pattern after 1992, are fundamental as background to any discussion of health care reform.

The data in Figure 4 are total expenditures on (what in Canada is defined as) health care, divided by the population, and also by the Consumer Price Index. [Data for Total Health Expenditures are not compiled prior to 1960.] They are thus, like those in Figure 2, real per capita values. But they are not adjusted for whatever was going on in the general economy at the same time. When the overall economy is growing, typically the people who work in the health care sector expect to participate in that growth and feel somewhat distressed and ill-used if they do not. Those expectations have an influence on overall costs, and particularly on perceptions, and claims, of underfunding and crisis.

As Figure 4 indicates, there are only two periods during which the escalation of health spending in Canada slowed down or stopped. One was the flat(tish) spot in the 1970s, and the other is right now, in the mid-1990s. Amid all the current rhetoric of cutbacks and system collapse, with the whole thing going to hell in a hand basket, it is important to note that the level of real resources per capita that Canadians were allocating to the health care system had been steadily increasing — prior to 1992 — for pretty much as far back as the data go. And yet it is never enough. In fact there have been claims of crisis, cutbacks, and underfunding for the last quarter century (roughly coincident with Medicare coverage for physicians' services). The money was continuing to grow, but never fast enough. Since 1992 total funding (per capita, adjusted for inflation) *has* stopped growing, but it has not in fact been cut to any significant degree.

But does that mean that people are making this whole crisis thing up? Well no, not really. Figure 5 shows the *share* of national income going to health care, rather than the dollar amounts as in Figure 4. The actual values are the black boxes, while the dotted line

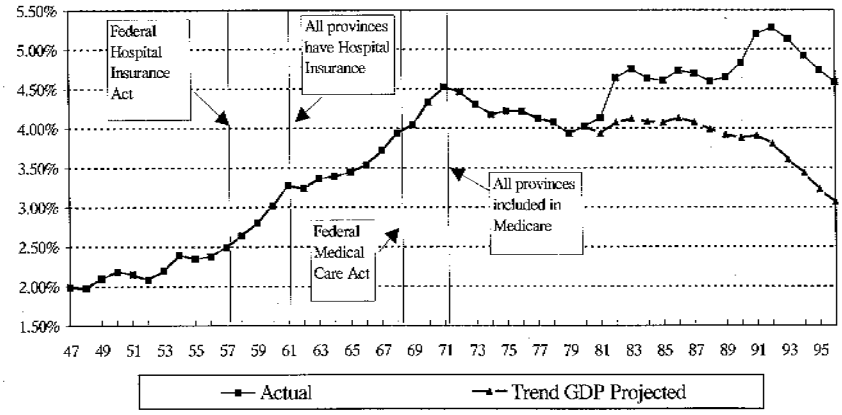
FIGURE 5: Canada Health Expenditure over GDP, 1960-1996



at the lower right represents a hypothetical alternative that "might have been." It is calculated by dividing actual expenditures, after 1980, by the projected trend in total income per capita shown in Figure 2. If the economy had continued to grow at its historic rates, and health care expenditures had nonetheless been what they actually were, down to the present (unquestionably a questionable assumption), the share of Canada's national income spent on health care would have evolved as shown on the lower, dotted line.

Figure 5 presents data only from 1960; Figure 6 shows spending on hospitals and doctors, for which earlier data *are* available. These categories are covered by the Medicare plans and are therefore the primary focus for public debate and policy. (They also account for the majority of the total.) They show the dramatic expansion during the pre-Medicare years and the equally dramatic flattening once universal coverage had been achieved. The impact of the cost restraints of the 1990s is also more pronounced for these components, because they are almost entirely financed from public sources.

FIGURE 6: Canada Hospital and M.D. Expenditure over GDP, 1947-1996



The differences between the pairs of lines in these two figures go far, I think, to explain the contrasting positions that have been presented in the arguments over health care reform, past and present. The reality is that the health care system substantially increased its share of national income after 1980. In effect health spending was protected during the recessions of the early and late 1980s, being not only maintained but continuing to grow, so that its share went up sharply as the denominator, overall income, went down. The relatively anaemic recovery of the mid-1980s did not bring that share back down again. As the fiscal crisis deepened, however, Canadian governments became unable — or unwilling — to maintain that protection and in 1992 the pattern changed.

But if one looks at Figures 5 and (especially) 6 from the perspective of the people in the health care system, a different story emerges. Viewed as a share of national income, the rate of cost escalation actually slowed dramatically — flattened — after 1970, and would have stayed flat in the 1980s if the economy had not collapsed. Providers of health care could see themselves as being quite restrained, in relative terms, and "living within the means" (taking a roughly constant share) of a prosperous and growing economy. They

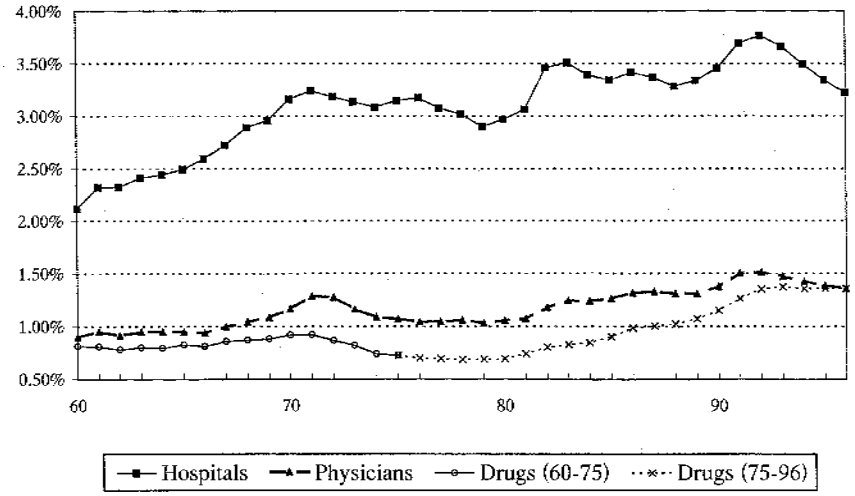
had formed their expectations of continuing expansion on this basis, and as Figures 5 and 6 show, relative to the economy that "might have been," health spending in Canada is now way down.

Mark Baltzan at the Canadian Medical Association expressed this view of the situation very nicely when he said that there was nothing wrong with the health care system, we just have to get a better economy. That is basically what Figure 5 says too, that health care looks pretty restrained – relative to the growth patterns of the past. And if that is what everybody in health care believes, those general beliefs become "facts." So those two lines can explain a considerable amount of cognitive dissonance, of failure to communicate. The people in the Ministries of Finance are dealing with the upper line and saying that is what is happening to the overall share (because it is), and the people in the health care system are saying "but we're being really restrained. You know, we're being much more careful than we used to be." Jack Armstrong at the Canadian Medical Association was quoted a week ago saying, "Our system is cut to the bone." Actually that "cut to the bone" rhetoric emerged in the mid-1970s. There was a flat spot then in the curve shown in Figure 2 — at a much lower level, and that is when I first heard the phrase. Anyway, the system is "cut to the bone" again — the bones are bigger now.

Coming back to the Homer-Dixon theme, these figures show the impact of deterioration in the overall economic environment translated through to the health care system. This is the opening up of a gap between what the people in health care had come to expect and thought was appropriate in terms of meeting expanding needs, and what was going on in the rest of the economy in terms of willingness or ability to pay. We *could* pay lots more, if we wanted to, by increasing taxes or user charges, or even deeper cuts in other public programs. But collectively, we seem to be saying we don't want to.

There's also a problem of expenditure shares that is illustrated in Figure 7. This figure shows the proportion of national income spent, year by year since 1960, on each of hospitals, physicians' services and drugs. Notice that the bottom line, expenditures on drugs, has been moving up quite steadily in recent years. These

FIGURE 7: Hospital, Physician and Drug Costs (as percent of GDP, Canada), 1960-1996



expenditures, predominantly on prescription drugs, have roughly doubled their share of total national income over the last fifteen years. Their growth has been unaffected by the restraints of the last five years, such that their share of total health spending has markedly increased. As Figure 7 shows, drugs now cost as much as physicians' services.

If you want to know why the province of B.C. is trying to set up a reference-based pricing system for Pharmacare, or why private employers in Toronto are getting interested in what are called "pharmaceutical benefits management companies" — i.e. private firms who will come and tell you how to slash your drug budget, or why Canadians are pretty unhappy with the extraordinary expansion, over the last decade, in the patent privileges enjoyed by the multinational drug industry — that's why, right there in Figure 7. Overall, health expenditures are being contained. But within the more or less constant total the pharmaceutical industry — a narrowly based interest coalition – are making out like bandits. Other sectors, such as hospitals, are correspondingly enjoying cuts.

So that's my story about a deteriorating economic environment for the Canadian health care system, that now has to be fitted into Homer-Dixon's story about the supply of ingenuity, human progress or decline, and what happens when the lines of fracture in a society open up under pressure.

But anyone following the argument so far might well say "Wait a minute! Homer-Dixon's story (as presented here) is all about opening up lines of fracture, of divisions within a society, of people engaged in more or less violent conflict with each other. All the data shown so far are aggregate numbers. The closest we have come to conflict is in the division of shares within overall health spending." And that is quite true. Nothing has been said about the distribution of services or resources among the members of Canadian society, only that the overall situation has become worse, both in the general economy and more recently in the health care system.

Research on the distribution of income and more generally of well-being in Canada has, however, become a very active field in recent years – and that is no coincidence either. The subject is very much a "moving target." The material here is drawn from the ongoing work of Michael Wolfson at Statistics Canada (also a Fellow of the Canadian Institute for Advanced Research). He first addressed the question of whether incomes in Canada were becoming more unequal over ten years ago, in a paper entitled "Stasis Amid Change" (a very Canadian title). Subsequent work has confirmed and extended its conclusions (likewise very Canadian): "Yes and no." But both the yes and the no are extremely important.

As backdrop to this question, there seems to be general agreement in both the academic literature and in the media more generally that incomes in both the United States and the United Kingdom *have* become much more unequal over the last two decades. There has been extensive media coverage, particularly in the United States, about the vanishing middle class, the increase in the income shares of the wealthy, and the increasing numbers of people in poverty. The middle band is allegedly disappearing – and it may well be so. But that is and is not happening in Canada.

In Canada, the distribution of *family* incomes (total, from all

sources) does not seem to have changed much for decades. The bottom 20% of families pick up about 4% of the total income, the top 20% pick up about 40%. There is quite a lot of inequality — not as much as in the United States or in the United Kingdom, but much more than in Scandinavia. The point is that it is not changing much. Whether you are against inequality or for it, the distribution of (family) incomes is not widening dramatically; in fact it's not widening at all.

But when one looks instead at individual incomes, earned out in the marketplace, one finds that these are becoming much more unequal over time. The *market* in Canada is changing so as to produce more and more inequality. So why is that not feeding through into overall family incomes? Because the system of taxes and transfers and the various other social programs in place in Canada are effectively offsetting the impact of a more and more inegalitarian market.

As the overall economic environment has deteriorated, developments in the private marketplace appear to be generating the same pressures towards more inequality in income as in the United States and the United Kingdom. But the difference is that in those countries public policies changed in the same direction, becoming less egalitarian and reinforcing the trends in the private marketplace. But in Canada, to quote Michael Wolfson: "The actions of government tax transfer policies have essentially offset the trends in market income inequality." Consequently the distribution among families of disposable income, i.e. the money you have available after you have paid your taxes and after you receive whatever benefits you get from government, has not become more unequal.

Now this buffering process should show up as a substantial increase in the share of total income coming from government transfer payments. And it does. According to Wolfson, transfer payments — i.e. things like old age pension, unemployment insurance, workers' compensation benefits, welfare — all money that people receive but do not work for directly — amounted to 6.6% of total incomes in 1967. By 1993 this percentage had more than doubled, to 14%.

These transfer payments are of greatest importance, as one would expect, to people with lower incomes. They make up about *two-thirds* of the income of people in the lowest 20% of the income distribution. (20% of persons, not incomes). People in the next 20% slice receive about 40% of their income from government transfers; for those in the top quintile, the top 20%, the figure is 3%. In other words, what you have is a social redistribution system that moves a considerable amount of money into the hands of lower income people, an amount that has been increasing over time, in proportion to total incomes. That expansion has offset the increasing inequality of market-generated incomes that appears to be associated with weaker general economic performance.

Now those trends are relevant to discussions of reform of health care delivery, and particularly finance, because the health care system as organized and financed in Canada *also* transfers substantial resources from higher to lower income people, in amounts that have been steadily increasing over time. Wolfson's data refer to the redistribution of money incomes through various forms of direct cash transfers. But Medicare provides what economists call "benefits in kind" in the form of "free" care that the user would otherwise have to pay for – or simply forego. These in-kind transfers are equally accessible to all on the basis of need rather than ability to pay; but people with lower incomes tend to use more care, and generate higher costs, because they are on average sicker. Health is correlated with wealth, as Fraser Mustard pointed out previously. But care is never "free;" in Canada it is paid for through taxation. And tax liability is also closely correlated with income. So on average, people with higher incomes pay more for health care (through taxes) and use less (because they are healthier). The amount of money involved is large – public funding for health care makes up about 70% of the total, or between 6% and 7% of total national income – and has been increasing over time as health expenditures have grown.

Now one can look at this process of redistribution from two quite different perspectives, each of which is reflected in a different approach to health care reform. On the one hand, one might say that these social programs are doing exactly what they were supposed to

do. They were intended and designed not merely as a "social safety net," but as mechanisms to moderate and buffer the inequalities that are generated by impersonal external forces such as private markets, or illness and injury. Since the strength of these "unequalizing" forces has been growing over time, the amount of redistribution necessary to mitigate their effects has also increased. The "work" being done by these equalizing programs is greater, because the system is working.

But suppose one turns that coin over. More and more money is being moved around by our social programs, both directly and in the form of services supplied to some and paid for by others. Specifically, more and more money is being moved from people with higher incomes to people with lower incomes, offsetting the changes in the economy that are tending to move money in the opposite direction. And this is happening at a time when the overall rate of income growth has become much slower. It follows that a successful *attack* on those programs, to reverse or divert that flow, has become increasingly profitable. In other words, if you happen to be at the payer end rather than the payee end there is a lot more money to be made/saved now by scaling back or wrecking ("reforming") our social systems. The prospects for overall growth, on the other hand, look much dimmer than in past decades.

These perspectives really are two sides of the same coin. One can look at the trends in our social programs from the point of view that more work is being done, through both money and in-kind transfers, in moving money from high to low income people and offsetting the increasing inequalities generated in the private economy. Or one can see these trends as increasing the potential gains from organizing "narrowly based interest coalitions" to reduce or remove the buffers, so as to benefit from the increased inequality that the private marketplace is providing. Both perspectives are reflected in the debates over social policy reform, which is why the proposals offered by different groups tend to be so inconsistent with each other. Behind the public rhetoric of (mostly) shared objectives, there is a tug-of-war going on over income shares – Homer-Dixon's internal fracture in response to external deterioration, but without guns.

Health care, and in-kind transfers generally, are however different from straight financial transfers in an important way. Lumping both together in general discussions of "social programs" obscures a key distinction that is crucial for understanding both the nature of the debates and the consequences of different policies. Public expenditures on health care are what is called in the trade "exhaustive expenditures," as distinct from pure income transfers. (There are others, such as education, but health care is the largest.)

Pure transfer programs — the ones described in Wolfson's analysis referred to above — are conceptually simple. They just move money around, taking money out of one person's pocket and putting it into another's. Governments tax one group and give the money to another. (More accurately they tax everyone, and give money back to most people, but some gain and some lose.) The money that is transferred is still spent in the private marketplace, by private individuals, in whatever way they see fit – but it is spent by *different* people. Contrary to most of the public rhetoric, governments are not in this way transferring resources from private to public purposes. Rather they are transferring resources from one set of private purposes to another. But for those who lose, the rhetoric of "Big Government" can be politically effective.

There is a little more to the story than this. There is the overhead cost associated with running these programs, which is an exhaustive expenditure – the "bloated bureaucracies." But these, on examination, turn out to be, like "welfare fraud," quantitatively pretty small potatoes. Such matters require serious attention, because the acceptability of such transfer programs by the general public depends upon confidence both in their administrative efficiency and in their moral integrity – and rightly so. But the claim that these factors play an important role in overall costs has no substance; it has been refuted time and again. Claims of "waste" and "fraud" continue to re-surface, because they are recruiting slogans for those who oppose the transfers *per se*.

On another conceptual level, it can be argued that transfer programs embody patterns of economic incentives that in various ways lower economic productivity and thus have an impact not only

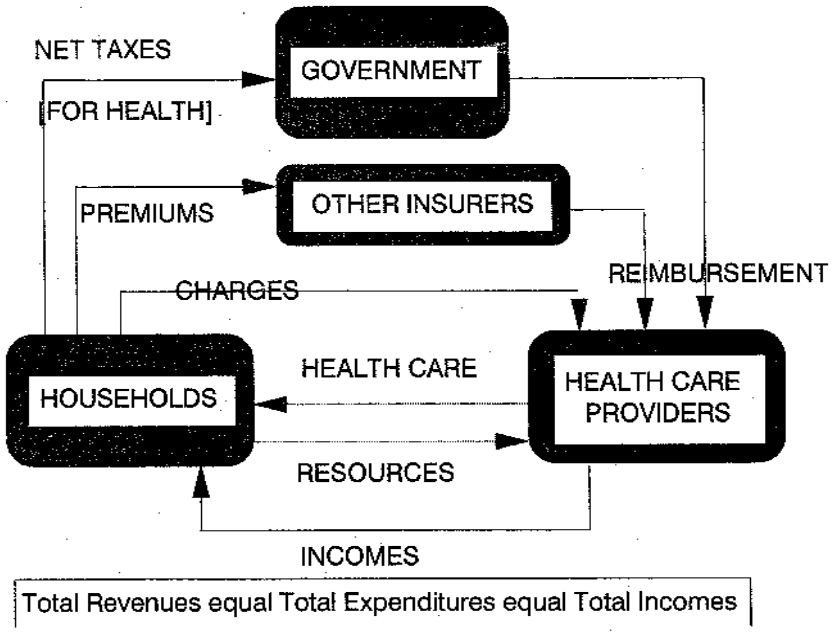
on the distribution of private output, but on its overall level. There are economists who can create the most extraordinary superstructures of cost associated with such programs, spun out of pure theory. But the costs thus identified turn out to emerge, not from the structure of economic theory *per se*, but from particular behavioural or technological assumptions imposed *a priori* by the analyst. They disappear if these are changed. Nor do comparisons of countries with different levels and forms of transfer systems show the differences in output that such theorizing would imply. But then economics is basically a form of religion carried on by other means anyway — to paraphrase von Clausewitz on war.

Back to the exhaustive programs. The effects of these are a bit more involved, because unlike pure transfers they actually use up resources, that are accordingly unavailable for other purposes. That is what economists mean by "exhaustive." Human time, skills and energy, physical resources, and services of capital are required, and used up, to produce health care. That in turn means that the owners of these "factors of production" in economic jargon must be paid for their use. Program expenditures are the incomes of the people involved, directly or indirectly, in delivering the services.

There are thus three groups involved — the payers, the recipients, and the suppliers — all with different economic interests. Pure monetary transfer programs have only payers and recipients; the third group involved in exhaustive programs generates a somewhat more complex set of relationships. These are shown in Figure 8. I have made a few simplifications that should be apparent to those familiar with national income accounting.

Figure 8 represents a health care system in terms of two different circular flows. The organizations that produce care — medical practices, hospitals, public clinics, the "firms" of economic theory — provide it to people, who are members of households. These same people own and supply to firms the resources with which care is produced. The dotted arrows represent the exhaustive use of resources; the households provide the services of the people who work in the health care sector, as well as the other factors of production that they own, and these are then combined and sent back as differ-

FIGURE 8: Alternative Ways of Paying for Health Care



ent forms of health care. Thus a "real" exchange of things, factor inputs for commodities, takes place between these two types of entities.

Corresponding to this physical exchange, however, is a set of financial flows. The members of households — people — are paid for their factor inputs by the organizations that have used them, and these payments constitute their incomes from the production of health care. These dollar amounts are shown as the solid arrow from provider organizations to households. But the return flow, of payments for the health services themselves, can go through three different channels. Revenues may be raised from households as taxes that are allocated into health care by governments, or as premiums paid to private insurers (where these exist), or as direct payments from persons to provider organizations. The funds flowing through all three channels then come to provider organizations as their rev-

enues, and are in turn paid back to households as incomes. And every stage in the cycle has to remain in balance – total revenues assembled from households through the various channels must equal total payments to providers (health expenditures) and total incomes earned by households from the provision of health care. If one of the arrows is left out, it means that money is collecting somewhere under somebody's bed or being spirited out into the Cayman Islands. [What it really means, if these three components are not equal, is that people are just not doing their sums right.]

This three-part identity among total expenditures on health care, total income for the people who work in the sector, and total revenues raised to pay for it, holds (cannot *not* hold) at the aggregate level, for a whole society and any health care system. Thus it cannot in itself tell us anything about the balance of gain and loss from different ways of organizing a health care system. To understand that, we have to consider the circumstances of differently placed individuals, and to note that the identity does not hold for each individual, and probably not for any individual. For an individual – or household – the amount of revenue contributed to, expenditure accounted for in, and income received from the health care system will each be different, and the differences will typically be quite large.

The different relative sizes of these amounts divide the population into three groups, whose (economic) interests with respect to the health care system are in significant conflict. The fracture lines among them have opened up as the economic environment has deteriorated, increasing the degree of conflict over the distribution of resources and threatening the supply of ingenuity necessary to manage an increasingly complex health care system.

The clearest line of fracture, defining a corresponding axis of conflict, is between those who pay and those who are paid for health care. The latter group are those people or households who receive more in income from the health care sector than they contribute in revenue or cost in service use; the former are everyone else. The latter are (net) providers of health care; health expenditures are their incomes. But within the former group of (net) users of care there is a distinction between those who contribute more in revenue than the

cost of the services they receive, and those whose care costs more than their contributions. Since in every modern society the principal source of revenues for health care is taxation, and since taxation tends to be proportionate to income, we may call the former the healthy and/or wealthy and the latter the unhealthy and/or unwealthy.

Conflicts between those who pay and those who are paid are a continuing part of the daily news in Canada, and have been throughout the history of Medicare. They are almost always framed as conflicts between "government" and some professional organization or representative of providers. But governments are acting on behalf of citizens more generally, in their various roles as voters, taxpayers, and (actual or potential) patients. To the extent that particular providers get "more," everyone else will get "less."

Arguments over doctors' incomes are as old as Medicare, and seem most readily to command public attention. What began as overt arguments about fees either within the public plans (fee schedules) or outside (extra-billing) has broadened to arguments in the public system about capped public budgets, fee roll-backs, and the justification for utilization increases, along with efforts to introduce various forms of private service charges such as "facility fees." But the core issue is still doctors' incomes, though for negotiating reasons medical associations try to blur the distinction between "more money for health" and "more money for doctors."

But the conflict between payers and paid extends across the whole range of health care providers; doctors are simply the most prominent. The reference pricing system for drugs introduced by B.C.'s public Pharmacare system is designed to transfer money from the shareholders of drug companies (mostly non-Canadian), to the B.C. taxpayers who pay for Pharmacare. When the medical evidence shows that two drugs, though chemically different, are equally effective, Pharmacare will no longer reimburse the more expensive one. Its producers must either cut their prices, or lose their share of the Pharmacare market. Either way, public outlays and company profits are reduced – payers gain, payees lose. Needless to say, the larger pharmaceutical companies find this system outrageous and have brought a variety of public and private pressures to bear to dis-

courage this policy. The public claims are variations on the theme that reducing provider incomes represents a threat to the health of the population.

An earlier example of this same conflict is provided by the B.C. Hospital Labour Accord. Reducing the use of in-patient beds – which in the past were widely believed to be over-utilized in B.C. and in Canada generally – implies eliminating nursing, dietary and housekeeping jobs. (Many diagnostic and therapeutic services can be moved to ambulatory settings.) The Labour Accord was intended to mitigate this process by providing job transfers and letting "attrition" shrink the workforce after beds were closed. Critics argued that it resulted in higher expenditures than if people had simply been laid off. Again there was a direct conflict of interest between payers and paid.

Most of the high profile public conflicts in health care take place along the payer-payee axis, with the latter attempting to influence government payers by convincing the public of the link between level of payment and quality or effectiveness of health care. The link may be tenuous to non-existent in some cases, but by no means all. (Such a link is easier to see in arguments to expand particular forms of service capacity [people and/or equipment] than in income claims by current personnel – unless there is reason to believe that recruitment is suffering.) The problem is that the claim will be made in *all* cases and is thus of no help in drawing the distinction. (Payees may also make appeals to "fairness," or threaten unacceptable levels of service disruption.)

While conflict along the payer-payee axis is a fundamental and eternal feature of any health care system, it obviously varies in intensity over time. Conflict flares up when the economic environment deteriorates. The general deterioration described above, translated through accumulating government deficits and much more restrained provincial budgets for health in the first half of the 1990s, was focused by the Canadian Health and Social Transfer of 1996.

The CHST consolidated federal transfers to the provinces for health, education and social welfare, and reduced the total by about $7 billion. This reduction did not, strictly speaking, reduce the allo-

cation of funds "for health," because despite the surrounding language, federal transfers were not earmarked for health spending at the provincial level. They simply transferred funds from the federal to the provincial treasuries. But in transferring $7 billion less — in effect transferring part of the federal deficit to the provinces — the federal government did substantially reduce provincial resources for *any* program — including health. Provincial governments could make up the difference by increasing taxes, borrowing, or cutting program spending. Since they in turn were already struggling to bring their deficits under control, and facing strong taxpayer resistance, the third option was unavoidable. But health spending is the biggest program area in all provinces.

Going back to Figure 8, this implies a lower flow of funding through the top pair of pipes. Expenditures are, as an accounting necessity, equal to incomes, so provider incomes must then be lower – fewer and/or less well paid jobs – unless they can open up or increase the flow through the other two channels of funding. The accounting is simple and stark.

Consequently the fundamental payer-payee conflict has broadened. Frustrated in dealing with governments as the representatives of the public – or the "rest of us", providers are trying to go around them to deal directly with individuals – more private funding. The ancient debates have been re-energized, over "two-tier" medicine, user charges, private facilities, core services/ basic benefits, etc. All are being driven by the pressure from providers to expand the flow of income from private sources, so as to compensate for the reduced flow through the public sector. There is a great deal of surrounding rhetoric about waiting lists and unmet needs, on the one hand, and inefficiency and inappropriate servicing on the other hand. These are just the old arguments, of providers trying to link expenditure with health, in the public mind, and payers trying to de-link it. But beneath that rhetoric, the mainspring of the current policy debate is laid bare by the fundamental accounting identity. If governments reduce their payments, then either private funding must be tapped, or provider incomes (in total) must fall.

There is, however, a particularly sneaky way of opening up

private channels. That is to introduce various forms of private charges for hospital and medical care, and/or "two-tiered" services, and then bring back private insurance to cover them. In Canada (and in most other countries), private insurance for such things as drug, dental, and extended health benefit plans, is all subsidized through the income tax system. (Private health insurance premiums, when paid by the employer, are deductible from the employer's income just as wages would be, but unlike wages they are not taxed in the hands of the employee. Thus "private" health insurance is paid for with before-tax dollars.) Economists long ago introduced the term "tax expenditures" to describe subsidies given by governments to private enterprises in the form of tax breaks rather than by direct payments. Tax breaks show up as reduced government revenue; direct payments as increased expenditures, but their effect on the budgets of both governments and beneficiaries is the same. The big difference is political visibility. Direct subsidies show up in the public accounts (and are readily targeted by opponents and general budget-cutters). Most people are unaware of subsidies that take the form of tax breaks.

Their beneficiaries, however, are *very* aware. The 1995 federal budget included a "trial balloon" that would have made employer-paid health insurance a taxable benefit for the employee. The Canadian Dental Association allegedly raised a war chest of a million dollars; they ran advertisements all over the country saying: "don't take away this exemption." Like any other industry, they did not want to lose a government subsidy.

So private insurance for medical and hospital services, if introduced on the same pattern as already established in this country for other health benefits, would bring more government money in through the back door. Quite a lot can come in this way; the Congressional Budget Office in the United States estimates that their "private" insurance system receives over $100 billion in public subsidy through this route. But unlike a direct subsidy, it is invisible and – especially important – the amount is not controllable by government. That is why the industry, both insurers and health care providers, greatly prefer tax expenditures to direct subsidies. The specialists all know this, but the general public is blissfully unaware.

Or at least most of them are. Another interesting feature of the subsidy to private insurance, however, is that because it is a tax exemption, its value to the employee varies by tax bracket. The higher the marginal tax rate, the larger the subsidy; conversely if one has no taxable income, a tax exemption is worth nothing. Thus in a system with expanded private health insurance, more public money flows into health care in a way that is difficult to see or control. It is disguised as "private" money; and notably, yields the greatest benefits for people with higher incomes.

That observation draws our attention to the second fracture line noted above, between those who contribute more than [the cost of what] they use, and those who use more than they contribute — the healthy and/or wealthy, and the unhealthy and/or unwealthy. This second conflict is entirely played out on the left hand side in Figure 8 — taxes, premiums, and user charges. It is hardly rocket science to observe that if a health care system is funded through taxes, the total costs — whatever they may be — will fall more heavily on those with higher incomes.

All modern tax systems tend to collect more from people who have more (Willie Sutton's Principle). On the other hand, to the extent that the system is financed through private payments, whether user charges or private premiums, the costs are borne by those who are ill (or most likely to be). It follows that a shift in funding from one channel to another redistributes the burden of payment from one group to another. If the proportion of private funding is increased (decreased) people at higher incomes will bear a smaller (larger) share of the overall burden. Even if higher income people pay more (less) out of pocket, this will be offset in lower (higher) taxes. (This transfer is larger because of the negative correlation between health and income, but does not depend on it.)

In case the effect of the financing mix on the distribution of burden across income classes was not sufficiently obvious *a priori*, there is now increasing empirical evidence to demonstrate it. But it should be obvious. Economists have a bad habit of using what are called "single sector models," in which it is assumed that everyone is identical at least for purposes of analysis, and these critical distri-

butional effects disappear. But it is worth noting that support for private financing of health care tends to be stronger the higher up the income distribution one goes, suggesting that people do have some notion of where their economic interests lie.

This axis of conflict tends to align with that between providers and payers. As noted above, when there is a tight clamp on public payments, the income aspirations of providers depend upon their being able to tap private money. Healthy and wealthy payers are likely to be supportive, because even if total expenditures do go up, their share of that total can be reduced. The interests are not precisely identical; providers want public payments to stay constant and even increase while private payments rise, while healthy and wealthy payers are better off if public sources shrink. They are the ones advocating smaller government and lower taxes. But so long as the increase in private funding is large enough, both can come out ahead.

Not all providers gain, of course. Those who earn their livings caring primarily for the unhealthy and unwealthy will, along with their patients, be worse off. So one finds that private funding is advocated by those who expect to be able to collect it. But they seem to have the best media access – perhaps because the media are owned by the healthy and wealthy.

But there is a third axis, that is not quite as simple as the straight conflicts over money outlined thus far. Apart from payment issues, who gets care? So long as most of us are confident that the system can provide "all medically necessary care" when we need it, this is not an issue. But as the system has come under increasing fiscal pressure, this confidence has begun to wane. Suppose there really *isn't* enough to meet all the needs? Should those who have the money be able to buy their way to the head of the queue? The answer is likely to depend, at least in part, on whether or not one has the money – another line of fracture.

But the answer will also depend, to a very large degree, on ones' perception of risk. Does the public system really fall short of meeting needs? Is it getting worse – falling apart? Is my, and my family's health – even life – at risk if anything serious goes wrong, and is the only path to safety, one with a private toll-gate? If so, this

opens up the clear fracture line between those with more and those with less money. If we both get into serious trouble, I want to be sure that my money will get me out. If your lack of money means that you get squeezed out – well, that is unfortunate. *Sauve qui peut*.

The adequacy of the health care system is always a serious question, and it has become much more serious now that the long fiscal expansion has stopped. For years, the ancient cries of "underfunding" have resounded in a system that was getting more funding, per person, above inflation, every year. But now, for at least five years, it has not grown. Are the widespread and lurid anecdotes of system failure and inadequate care, evidence that finally there is real underfunding and harm to patients – the wolf is really here?

These questions *do* deserve to be addressed – in Homer-Dixon's terms we do need to bring to bear greater ingenuity to deal with our genuinely less favourable environment. But, as in his framework, the task is made much more difficult by the opportunistic behaviour of "narrowly based interest coalitions" struggling for a larger share of the more slowly growing national pie. When doctors' representatives claim that "people are dying" because of lack of money for health care, it turns out that they really mean lack of money for doctors. It is unclear why increasing doctors' fees and bank accounts would save lives. One might have thought that, on the contrary, this would draw away money that might have been used for other purposes.

Similarly when the spokesmen for the wealthy seize upon the present stresses to bring forward ancient arguments for private funding, their objective is clearly two-fold. They are trying to shift the costs of care farther down the income distribution – to pay a smaller share themselves – and to assure themselves preferred access to better quality care at the same time. Their basic tactic, like that of the doctors, is to spread fear and undermine support for collective public financing and management of health care. When public coalitions fragment, and people act like frightened individuals, they can be more readily victimized by the wealthier and more powerful. "*Divide et impera"* was undoubtedly practiced long before the Ro-

mans.

Part of this process of fragmentation, of what some have called "medical terrorism" (in the United Kingdom they refer to "shroud-waving"), includes spreading a message of inevitability. Aging populations, technical progress, popular expectations, and the limited capacity of the state, make it impossible to meet all the needs. "Rationing" is inevitable: so make sure *you* can buy what you need." Someone must be rationed, but those of you with greater means can make sure it is the other guy. Why not? — it is inevitable, after all.

On the other hand, it turns out that every group to study this issue with some care has reached the opposite conclusion – the "inevitability" message is false. It serves only to discourage the application of the ingenuity needed to cope with this more difficult environment. Extensive research refuted the "aging" story long ago, and the "technology" and "expectations" stories are at best gross distortions. It is true that the overall level of funding has stopped growing – at least for the moment – but there is already a great deal of money in the system. Roughly a decade ago, Royal Commissions (or their equivalent) in every province concluded that the system needed "more management, not more money." (David Sinclair's words, in the Seaton Commission report). That's another way of saying, more ingenuity.

Those studies did not address the impact of pulling out $7 billion of federal transfers in one shot. There is a real issue for concern, in how fast the "new ingenuity" can or should be applied when so many people's livelihoods are at stake. System staff who are demoralized or in shock may not show much ingenuity. But a remarkable amount of adjustment has already taken place, with quite astonishing declines in the use of in-patient hospital care in particular, with no indication of harm to anyone's health. Indeed, there is considerable evidence that further major reductions are possible, if suitable alternative forms of care are available.

The possibilities of and directions for adapting our health care system, so as to maintain and improve its quality and effectiveness in a more restricted economic environment, are not the subject for the closing sections of an evening address. Royal Commissions have

written volumes on the subject, and so have many others. Our focus here has been on the inevitable structural conflicts within our system that keep the same issues coming back and back and back, decade after decade, and make progress so difficult. Placing these in the broader context provided by the work of Homer-Dixon and his colleagues permits us to see our experience as part of a much more general pattern of social responses to deterioration in the external environment. How does a society mobilize the ingenuity to deal with that deterioration, and continue to progress, rather than dissipating energy in communal violence, or endless wrangles over "underfunding," user charges and doctors' incomes?

But the "management versus money" issue *is* contentious, and clearly the position I have put forward is not universally accepted. It seems only fair, then, to offer an example of the application of ingenuity to health care, impeded by structural conflict.

There is a movement currently underway in medicine, called "Evidence-based Medicine" whose participants believe that one really ought to go out and look at medical care, quite rigorously, to find out whether the things that are being done work or not. If they really do work, you should continue to do them and maybe even do more; and if they don't work, you should stop. Radical. A bizarre idea. Some members of this movement are even trying to act on the idea. And why should this notion be restricted only to medical practice? Maybe it should be extended all the way through our health care system – including administrative practices. The key messages are: "If it doesn't work, don't do it." And "If you don't really know, find out."

But if something is not done, somebody is not going to get paid for doing it. And that means somebody's income will be lower – perhaps non-existent. So a sort of side conversation has developed, sounding similar to evidence-based medicine but actually quite different, about the possibility of defining so-called "core services" or basic benefits. This approach would define a set of services to be covered by the public health insurance system. These would be the services for which there is good evidence of significant benefit to patients — they work. And then the private market will provide….[*fill*

in the blank]. Phrased that way, it sounds silly. All of the services that are of little or no benefit, or that have little or no clear evidence one way or another — these we should allow private marketers to sell directly to patients? (At one time physicians worried about quackery.)

The evidence-based medicine movement emphasizes the question: "Does the service work?" If not, stop — and save the money. (Of course the process is "revenue-neutral" one might well find that a number of services ought to be expanded. But the movement is powered by the understanding that there is overwhelming evidence of a large and expensive mismatch between current evidence and current practice.) The "core services" focus is on "Who pays?" If it does not work, move the costs from public to private budgets and keep the income stream flowing. If public budgets can be maintained at the same time, total expenditures and incomes can be increased. (And if they cannot, well, at least taxes will be lower.) That's the solution to an income shortage, not to inappropriate care.

And these two conversations go straight past each other. The people who are using one form of rhetoric simply do not meet the people who are using the other form. Two people on a panel this past summer (at the Canadian Health Economics Research Association meetings) made presentations, one after the other. The first said: "Ineffective care should not be paid for, *by anybody*" and the second went on to talk about why private markets should be opened up for non-core services. The radical inconsistency bothered no one, and then we went and had coffee.

The scene on that panel illustrates the larger "conversation of the deaf" that takes place at the national and provincial levels. (Actually the deaf, ingeniously, would be signing.) In setting up the National Forum on Health in 1994, Prime Minister Chrétien asked why, if all the major European countries can provide health care at a cost of 8%-9% of national income, or less, Canada was spending over 10%? The question is important, though it cannot be answered at the aggregate level. God is in the details – as is the devil. But the response of providers, at least in the public arena, has been simply to ignore the question and continue to demand more money.

This escalating racket is then fed by other interest groups, opportunistically using the general confusion and anxiety to try to rearrange the financing system – reducing their contributions and increasing their share of benefits. In much the same way, in less stable societies individuals and families re-open old private grievances under the cover of more general conflict.

Somehow we have to maintain, extend, and protect the appropriate institutional structures for focusing our collective attention. We have to try to deal in a rational and informed way with the very real pressures that we're now under. That means a lot of hard work and thought – and as much good will as we can muster – and a good deal of that is now going on behind the scenes. But we've got to do this in an environment which is increasingly contaminated by the noise of fault lines opening under stress, as groups with fundamental conflicts of economic interest re-activate ancient arguments, spread dis-information, and turn up the volume.

Metaphorically, dealing with the drought is going to take a good deal of investment in better water management. That turns out to be technically possible; but it may not happen if we spend all our energy fighting over the water that is left, while being harassed by bandit gangs advancing their traditional income redistribution agenda amid the confusion. Homer-Dixon and his colleagues remind us that success is not guaranteed, and that the price of failure is high. But a better understanding of the situation may help.

Related Reading:

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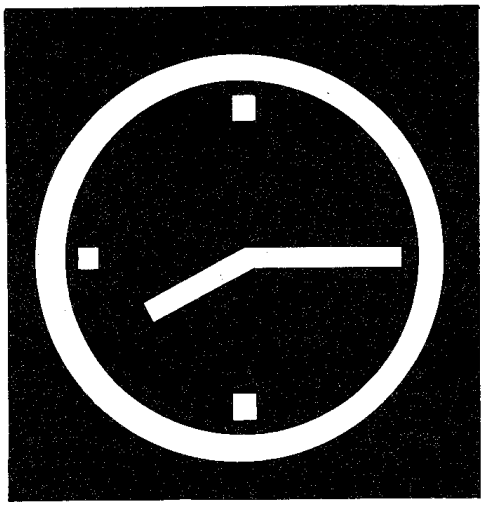

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