The Remarkable Tenacity of User Charges:

A Concise History of the Participation, Positions, and Rationales of Canadian Interest Groups in the Debate over "Direct Patient Participation" in Health Care Financing

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Preface

This is one in a series of articles by the authors about the ongoing debate over user charges in the Canadian health care system.

In this paper we document the history of the user charge debate in Canada. The participation, positions and rationales of Canadian interest groups in debates over patient participation in health care financing are traced over the past half-century, with a particular emphasis on a small number of events in Canadian (and particularly Ontario) health care policy history during which the user charge debate was particularly heated. Our interest here is in who the key organizational players have been, what rationales have been used to underpin positions on the issue, and whether those rationales have changed over time, collectively, and for individual organizations.

Other papers in this series discuss frequently heard arguments for user charges, and focus on specific, and sometimes more technical, dimensions of the user charge debate. A brief description of each paper follows (titles are tentative).

"Why Not User Charges? The Real Issues", describes and analyzes the most frequently heard arguments for user charges and what evidence there is for claims and counter-claims that are often made. We explore the arguments carefully, asking what they really mean, what values they are based on, and what fundamental issues are at the heart of the user charge controversy.

"Who Are the Zombie Masters, and What Do They Want?" focuses on those people and organizations who have consistently revived and promoted the idea that user charges will help meet a number of important social policy objectives, despite the fact that such charges have been repeatedly rejected by policy-makers and the general public (and the claims of their supporters refuted by analyses of the effects of such charges). We identify a number of distinct groups of "zombie-masters" and find that they seem motivated largely by the expectation that they, or the people they represent, will benefit in some way from the (re-) introduction of user charges.

"User Charges, Snares and Delusions: Another Look at the Literature" reviews and extends an earlier in-depth analysis of the effects of user charges which three of the authors published in 1979. The paper assesses whether experience and published literature in the years since then alter any of the (largely negative) conclusions of the earlier study concerning the ability of direct charges to patients to achieve important public policy objectives, including controlling health care costs.

"Charging Peter to Pay Paul: Accounting for the Financial Effects of User Charges" outlines a formal and comprehensive analytic framework in which income transfers - the principal effects of user charges - can be traced between groups in the population (e.g. the healthy, the sick, the rich and the poor), between payers and health care providers, and among providers. The paper uses the framework to analyze the income transfers associated with different types of user charges.

"It's Not the Money, It's the Principle" examines why user charges exist for some health care services and not for others. The paper analyzes the characteristics of services which (do or should) underlie decisions to charge in part or in whole for specific types of services.

In addition, a bibliography entitled "User Charges in Health Care" provides an extensive set of references to articles of relevance to the user charge debate in Canada, drawn from diverse sources including academic research and policy analysis literature, the popular press, government documents and reports, and the publications and reports of non-governmental organizations including the professional associations representing a variety of health care providers.

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> "User fees are coming because they, like the other dogmas of the right, are a matter of faith, not logic"
>
> (Frances Russell [1])

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Just over a decade ago, in the midst of the run-up to the passage of the Canada Health Act, a conference entitled "Medicare: The Decisive Year" was sponsored by the Canadian Centre for Policy Alternatives. One of the key papers presented at that conference was entitled "Charging the Sick: An Idea that Will Not Go Away", and the speaker began by noting that:

> "While most of us at this conference would likely accept a recent characterization of "charging the sick" as "an idea whose time has gone",(1) we are here precisely because it is an idea that will not go away." [2].[1]

Indeed, the focus of the debate which culminated in the passage of this Act was a form of user charges, extra-billing by physicians.

But Canadians have been debating user charges for longer than we have had universal health care insurance. And nothing much has changed since that 1982 conference. As provinces today struggle with major new reform efforts, some continue to place user charges front and centre in the policy debate; in others they lurk just beneath the surface.

The objectives of this paper are to trace the history (or at least the recent history) of the user charge debate in Canada. Our interests are primarily two: first, who the key interest groups have been, what (implicit or explicit) alliances have developed among the policy elites participating in this debate, and whether the strategic alliances have changed over time; and second, what the leading rationales for user charges have been, whether these have changed and, if so, whether the rationales voiced by particular interest groups have changed.

It is clearly impossible to take the pulse of all interest groups at regular points in past time. Rather, we focused on a small number of key events in Canadian health policy history

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[1] Note (1) in this quote refers to [3], from which the embedded quotes were taken.

as an indirect means of collating and organizing the background documentation for this paper. The key events were: the 1964 Hall Report [4], the late 1970's activity in Ontario (1977 Taylor Report [5]), and 1978 Ontario Select Committee Hearings [6]), the 1980 Hall Review [7], the early 1980's debate over extra-billing and the development and passage of the Canada Health Act, the aftermath of the passage of this Act, particularly the Ontario physicians' strike, and most recently the renewed debate over user fees in light of declining federal transfers to the provinces in an environment of economic downturn.

A. An Overview of Competing Rationales for User Charges

At the outset, it is important to distinguish among interests, interest groups, positions, and rationales. An interest group, such as a provincial medical association or the Consumers' Association of Canada, is an organization which attempts to canvass, interpret, and express the views of its members. Those views, in turn, will reflect the underlying interests of individual members. The commonality of those interests is the glue which creates the organization, and holds it together. What we can observe in the public arena, are the interest groups and the positions they express. We can also observe, and evaluate, the variety of different arguments or rationales which they will typically (though not always) offer in support of these positions. What we cannot observe, but can often infer, is the interests underlying these positions and rationales.

As one moves up the sequence from rationales to interests, one finds increasing stability over time. Interests themselves seem to change rarely, if ever. The groups formed to express and promote thoe interests also tend to be semi-permanent, although they may occasionally come into being, fragment or coalesce, or even disappear.[2] Such groups may, in turn, change their positions on particular issues, in response to their changing perceptions of the most effective way of promoting their members' interests. Finally, the rationales which they offer in support of their positions seem to be quite fluid, and to evolve over time in response both to the accumulation of evidence or experience, and to shifts in the direction of the political winds.

The stable underlying interests that keep pushing user fees back onto the policy menu -- that providers of health care would like more money and more autonomy, for example, that taxpayers in general, and particularly those with higher incomes, prefer lower taxes, or that provincial governments do not like either to raise taxes, or make politically difficult decisions -- are dealt with elsewhere [8]. There we also sketch out some of the reasons why, to date, user fees have always been pushed back off -- people when ill do not want to have to worry about financial consequences, or engage in complex negotiations over the cost of their care.

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[2]. National and provincial medical associations appear to be permanent parts of the landscape, for example, but the Medical Reform Group is a more recent offspring of the OMA, whose members felt that the larger organization did not represent their interests. The Reform Party of Canada, which also takes a position in the user charge debate, is a still more recent interest group. In the present state of society, however, disappearance seems to be rare. Rather the trend seems to be towards ever greater fragmentation, as people become dissatisfied with the ability of large organizations to promote their particular interests.

They also do not want people, themselves or others, to be denied care for financial reasons. Here, however, we are interested in identifying the key interest groups in this debate, the rationales they have offered in support of user fees, and the way in which these have been modified over time.

i. What's in a Name?

The framers of these rationales have employed a creative terminology in describing user fees. "Direct patient participation", for example, has a nice positive ring to it, a sense of belonging to something important. "Deterrent fees", on the other hand, convey a much more negative message. While one finds much concern for "patient abuse", and "frivolous use of services", there are suprisingly few references to "deterrents" as the solution. On the other hand, "patient responsibility" is something that can be widely embraced. Who, after all, is in favour of irresponsibility? In the debates over alternative forms of user charges, some advocates claim to reject user fees, while promoting "tax credits" for low users, which would be "an incentive, rather than punitive." (H. Fry, as quoted in [9]).

Similarly, "extra-billing" conveys the notion that the physician is trying to get something more than s/he is entitled to. "Balance billing", by contrast suggests that the fee the physician chooses to charge is in some sense the legitimate one; if it is not fully paid by government, s/he should be entitled to claim "the balance" from the patient.[3]

ii. Challenge for Houdini: Controlling Costs While Increasing Funding

Over the entire last half-century of health care policy discussion in Canada, the rationales offered have undergone noticeable, even if often quite subtle, transformation. In the 'beginning', and throughout most of this period, proposals for user charges have been served up, paradoxically, as both a mechanism of cost control and an additional source of funding for an "underfunded" health care system, often by the same party! Obviously these rationales cannot logically co-exist, but this did not deter advocates of user fees, particularly representatives of provincial and national medical associations, from using both to support their position.

The cost control argument was based on a chain of four assumptions, all of which must hold if user fees are to control costs. The links in this chain are:

- first, that a considerable amount of health care currently being provided is unnecessary, "frivolous";
- second, that a considerable amount of this "unnecessary" care is provided in direct response to patient demands;
- third, that user fees will actually deter the unnecessary care demanded by patients; and

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[3]. As an aside, one might note that in the early 1980s, the term "balance billing" lost out to "extra-billing" in Canada, but won out in the United States.

- fourth, that there will be no compensatory changes in the clinical decisions made by physicians.[4]

The underfunding rationale, on the other hand, argued that funding from a single source, in this case governments, was insufficient to "meet all the needs", and that additional sources of funding were necessary if the system was to be able to continue to provide safe, high quality care to all those who depended on it. Private sources of funding would fill this gap, and user charges, on this argument, represented one means of tapping this additional source of funding. Those promoting this view even went so far as to claim that user charges could serve as a "barometer" or gauge of the extent to which the system was underfunded. But the underfunding rationale seemed to be insensitive to the actual level of funding, and has survived dramatic increases both in that level and in the share of national income taken up by health care.

The only possible way to reconcile these two positions is if by "cost control" one really means only "public sector cost control". User charges, on this interpretation, are simply a means of shifting costs from public to private pockets -- they can be used to limit **public** liabilities, while at the same time leaving unchanged or, better still, increasing total health care funding. This formulation requires none of the four assumptions above, as overall utilization need not decrease at all. In fact, unless the perceived "underfunding" is simply that prices/fees and incomes are too low, utilization must actually increase. But the costs will be borne by different people -- shifted from taxpayers to users of care (see [10]).

iii. From Cost Control to 'Pest' Control?

Both the "cost control" and the "underfunding" rationales for user charges continue to exist and even to co-exist today, although often in slightly dressed-up form. As the international evidence has accumulated to show that user charges do not, in fact, contain overall costs, the volume of 'user charges as cost control' rhetoric has been turned down to a whisper.[5] But the argument that the system is burdened by frivolous patient demand, such that it is unable to meet present or emerging needs, is gaining currency. On this "hybrid" argument, user charges are the way both to free up resources by eliminating that frivolous demand, and to provide additional sources of revenue so as to permit the health care system to continue expanding to keep pace with growing needs.

This hybrid argument abandons, indeed reverses, the "cost control" rationale, along with the fourth link in the chain of assumptions above. But it still invokes the first three, in support of the claim that the health care system could use its existing resources more

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4. A simpler argument offered in the economics textbooks sidesteps the "necessity" issue, claiming merely that if the price people must pay for care is increased, less will be used, and expenditures will be lower. But since this leaves open both the issues of who initiates the "demand" for care, and whether the care is necessary, it is not only unhelpful but misleading.

5. It still reappears from time to time -- see, e.g. [11] -- but only from those unencumbered by any understanding, professional or otherwise, of how health care systems function, or any knowledge of the internationl evidence. One no longer hears it from the medical associations.

effectively. By eliminating frivolous care, or patient "abuse", user fees would free up practitioners to provide necessary care presently going wanting, and would free up public funding for more important (and costly?) interventions -- i.e. would reduce waiting lists and waiting times. This argument is then combined with the old "underfunding" claim, that the system still needs more money, and that user fees are the way to get it.[6]

Hidden in this argument, is an implicit claim about how care comes to be apportioned among prospective patients. It is a "FIFO" (First In, First Out) model, in which practitioners respond to whatever comes through their front doors, in the order in which it appears. If demand exceeds capacity, queues form and grow until enough patients are deterred by the waiting time that they choose to defer or forego care. User charges would also cause some patients to forego care, providing an alternative way of allocating capacity. The argument that this is a better way, requires also that needs are more closely correlated with willingness to pay, than with willingness to wait.

iv. In Search of the Frivolous User: Who's In Charge Here?

But this is a complete misrepresentation of the actual clinical reality. In Canada, about two-thirds of Medicare costs go to finance hospitals, and one third to physician billings. Entry to hospital requires admission by a physician.[7] About sixty percent of physician billings are for specialists' services, which require a referral. Primary practitioners, directly accessible by the public, thus account only for between 10% and 15% of total Medicare outlays.[8] Nor is every visit to a primary practitioner initiated by the

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[6]. If total health care costs keep on rising, what would be the effect on public sector spending? Advocates of the hybrid argument tend to be silent on this point, or else to suggest that public spending would fall -- self-evidently a good thing. Think of the deficit. But the American experience with a mixed funding system has been quite the contrary.

[7]. A portion of hospital budgets, of course, goes to finance ambulatory care, some of which is patient-initiated. But the high growth areas, such as surgical and medical day care, are all accessible only on physician referral. The most frequently quoted example of "patient abuse" is the emergency ward, and this may well be correct. But such facilities are and always have been a very small proportion of hospital budgets -- "Loud cry, and little wool." A number of people are admitted from emergency to inpatient care; but that requires a physician's order, and presumably these are not "frivolous" cases.

[8]. These data should clarify, if clarification were needed, the difference between services of physicians and hospitals, and "supplementary" services such as those of chiropractors. The latter serve an exclusively ambulatory clientele, and can recommend repeat visits but do not serve as gatekeepers to a much larger system. Conclusions drawn from observations of user fees applied to these forms of services have little relevance to the much more complex world of medicine.

Confusion arises, we suspect, because most of the population make one or more ambulatory visits to a physician in the course of a year, but few go to hospital, while still fewer are placed in intensive care, or undergo complex surgery. Yet that is where (almost) all the money goes. On the basis of personal experience, many people think (incorrectly) of the health care system and its costs as primarily visits to primary care.

patient. On the contrary, practitioners often advise patients to return, sometimes several times, presumably (in most cases at least) because they consider a return visit appropriate.

If nearly ninety percent of Medicare expenditures are thus a consequence of an explicit physician admission or referral, and some undetermined proportion of the rest are initiated by the practitioner, this does not leave a lot of scope for savings by reducing patient-initiated "frivolous" demands. After all, no one has ever suggested that all, or even a major proportion, of patient-initiated contacts were frivolous. Furthermore, "frivolous" use implies not only that the service was not "medically necessary", but that the patient could reasonably have been expected to know this in advance. The numbers begin to look very small -- not necessarily insignificant, but small.

Thus chain of arguments above will bear no weight. User charges do discourage some people from seeking care [12], but the patients deterred cannot distinguish necessary from unnecessary care [13]. Moreover, the growing body of evidence on inappropriate care traces most of it not to "frivolous" demand by patients, but to inappropriate decision-making by clinicians.[9] Finally, this hybrid rationale takes for granted the legitimacy of the "underfunding" claim, a claim which has been rejected by every provincial Royal Commission or other formal inquiry over the last half-decade.

Those who offer this more recent rationale for user fees may simply be unaware of the relevant evidence. Or they may implicitly dismiss that evidence, and assume that the least necessary care is defined, not by clinical criteria, but by that which is deterred. "If people are not willing to pay for it, then it cannot really be necessary." Finally, some may be so convinced of the "underfunding" argument that any effects of user fees on patients become unimportant, overwhelmed by the need to raise more money by any means. The story about transferring resources from frivolous to needed care is simply added on to recruit support from among a more naive public, understandably worried about both government deficits and the availability of health care, by repeating the rhetoric of cost control and so giving the appearance of concern.

v. Underfunding, Tax Saturation, and Other Fiction

These latter may believe that in an era of aging populations and burgeoning technological capability, user charges represent the only way to finance a system that governments cannot or will not fund adequately from the public purse. Either governments cannot, because slow (or no) general economic growth makes it "impossible" to raise the necessary tax revenue; or governments will not, because they cannot possibly know what the public **needs**. The necessary knowledge accrues only through clinical training. Even if the public were supportive of government policies to restrain health care costs, this would simply reflect mis-information on the part of the public about the benefits of modern medicine.

In this form the argument still begs the question of whether or not more revenue is

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[9] On this there is an extensive, and still rapidly growing literature (see, e.g., [14-17]).

needed, and if so for what, and side-steps the uniform contrary conclusions of all recent Canadian Commissions. It then adds the assertion that rates of taxation, rather than being political choices, are subject to some externally determined laws of nature -- they cannot be raised beyond some acceptability threshold. Alternatively, it challenges the ability or legitimacy of governments to represent the interests of the public in health matters.

vi. Today's Arguments: Frivolous Use Meets Unmet Needs and Cash-starved Governments

Thus we find that the present-day arguments for user charges are of two types. The first, based on a clinical or "informed lay public" interpretation of "inappropriate care", argues that much of health care use is consumer-driven, that considerable amounts of it are "frivolous", and that user charges would deter only that care. In so doing, user charges would free up capacity for "useful" interventions.

The second line of argument slides right past the issue of appropriateness. It assumes implicitly that all (or most) care is appropriate, but that there is additional appropriate care 'out there' that should be provided. The public sector, this argument continues, is simply unable or unwilling to support all the important clinical work that should be done, for a number of possible reasons outlined above.

As we review the history and evolution of interest group positions below, this general description will be seen to stand as a succinct summary of where the debate has ended up after a half-century of shifts in posturing and argument.

B. On Interest Groups and Rationales: A Historical Journey

i. The Early Years and the Hall Commission (1964)

As noted at the outset, the debate is as old as the debate over the Canadian health care system itself. In the 1930's and early 1940's, discussions about Canadian health care reform were focused entirely on removing financial barriers to access. Half a century later, they seem focused at least in part on re-introducing such barriers. The Canadian Medical Association's (CMA) Committee on Economics produced a report in 1934 that clearly laid out the Association's support for a "state insurance fund" that would **not** involve any user fees "because the main objective is to remove any economic barrier which now keeps doctor and patient apart" (as quoted in [18, pp. 24-25]. At this time in its history the CMA was also favourably disposed to a "state" insurance program, as a means of avoiding "conflicts between the insurance carriers and the medical profession which have had such unfortunate results in other countries" (ibid.). As we will see below, the CMA is one of very few key interest groups whose position on user charges has changed over the past fifty years (and it has done so a number of times). But its stance on the advantages of state insurance also changed dramatically.

As the debate over reform heated up, culminating in the Hall Commission review of the early 1960's, a number of groups became prominent players, and a number of rationales **for**

user charges began to emerge. By the early 1960's, the CMA was on record as not only favouring some degree of 'patient direct participation' in financing, but also opposing any single state-supported insurance program. These 180 degree turnabouts evolved because, in the absence of any federal initiative, physician groups had forged ahead in setting up provincial plans which had developed strong alliances with the private insurance industry. Shillington [19] has suggested that physician groups were 'scared' into such alliances by the private insurance industry's promotion to the medical profession of the dangers of a single government monolith.

Of course the great irony in all this is that it was this dramatic change in the views of the CMA which led to its calls for a comprehensive review of the state of Canadian health care. The establishment of the Hall Commission was influenced to a considerable degree by the CMA, so convinced was it that any inquiry would find in favour of its position (universal coverage provided through private insurance carriers and involving patient direct financial participation, with a government role restricted to covering those unable to afford private insurance).

The rationales for user fees offered by the CMA around this period were numerous and varied. They included arguments about the need to retain the cherished professional privilege of ascertaining the value of services rendered, and to be able to negotiate terms of payment with individual patients; about the dangers of the underfunding of medical care (stalling the progress of medicine in ameliorating illness) inherent in a single-payer model without user fees; and about the virtues of retaining the rights of consumers to choose among insurance plans offering different combinations of benefits and co-payments. ALthough not explicitly stated, this last rationale amounted to an argument that maintaining a choice of plans would improve the efficiency of the system as a whole (shades of the current American health reform saga), and therefore presumably keep health care costs under control. Yet the second of these rationales implies that the retention of user fees would **increase** the overall level of health care funding.

During the debate that raged during and immediately after the Hall Commission's deliberations, the CMA was supported by a number of provincial medical associations, including the Ontario Medical Association. The OMA offered as a rationale the deterrent, cost-reducing, virtues of user fees [20]. But the medical associations also had the support of the Ontario government in this debate. This government had, in the mid-1950's, made proposals to the federal government which led to universal hospital insurance plans without patient direct payments [21]. Medical care was obviously fundamentally different -- then premier Robarts suggested that it was not the "responsibility of Government to provide for the people all necessary services, even though these services are the right of all...the individual has the responsibility to provide for himself and his own" [22, p. PM-6). Since insurance could result in "an undetermined degree of abuse of available services...some form of deterrent may be necessary" (ibid., p. PM-9).

Thus we see the first "patient responsibility/accountability", "reduction in frivolous

demands" rationales emerging in statements by the OMA and the Ontario government. But the Ontario government also took a stance against any compulsory plan for medical services (again reversing the stance it had not long before taken on hospital insurance), thus aligning itself with the CMA position that consumer choice among plans was an important criterion for medical care funding.

ii. Ontario, late 1970's.

Once the provinces 'bought in' to the universal medical care program, little more was heard about user fees, until two Ontario-based reviews of health care in the late 1970's [5,6] became lightning rods for new claims and counter-claims. It is worth noting in passing, however, that the Ontario government was on record in 1971 as supporting extra-billing by physicians [23, p. 3); and the federal Task Force on the Cost of Health Services in Canada [24], which reported in 1971, included calls for the preservation of physicians' right to extra-bill, on the grounds that it was unnecessarily intrusive for governments to impose fee schedules, particularly in light of the fact that "[t]here is as yet no good evidence that the removal of all financial barriers to access to medical care ... has had any significant effect upon the health of the population" [24, Vol. 3, p. 266].

The 1977 Taylor Report [5] was quite explicit about the importance of user fees in health care financing. This committee consisted of three government representatives and three representatives of the OMA, with a 'neutral' chair. Not only did it recommend substantial user fees for hospital care, and extra-billing by physicians, but it also suggested that some services included at the time as insured services be de-insured entirely. Eight of the twenty recommendations were directed at the users of the system, while two focused on providers!

The Taylor Report offers a number of (not always explicit) rationales for this emphasis on direct patient financial participation. The overarching rationale appears to have been distributional, that those who can afford to pay, should -- "those who are self-sustaining should pay their own way" (p. 5). But the Committee was also clearly convinced that user fees were an effective means of deterring patient abuse of the system by encouraging users to "...seek out more appropriate, less costly forms of health care" (p. 22). With respect to extra-billing, Committee members felt that the ability of the physician *and patient* to negotiate their personal contract for services was an important freedom.

The Committee seem to have believed that extra-billing (for physician services) and deductibles (for hospital services) could simultaneously reduce costs and overutilization, ensure adequate compensation of physicians, reduce the **public** costs of the programs, and increase consumer and provider awareness of the costs of those programs. This is a rather tall order. In particular, it is not immediately clear how cost and utilization reductions were to translate into adequate physician income levels if the reason physicians were extra-billing in the first place was because they felt their income levels were inadequate.

It is worth noting as well that were extra-billing actually to achieve all these things, it

would have the effect of redistributing the burden of illness strongly in the direction of those using services [10]. If overall costs are reduced, but at the same time a share of those costs are borne by those using the system, any user-charge-related redistribution of burden from taxpayers to users would be accentuated.

In marked contrast, the following year the Select Committee on Health-Care Financing and Costs of the Ontario Legislative Assembly concluded that "user charges for medical care are inappropriate" and "supplementary charges by opted-out physicians are a form of user charges" [6, p. 30).

A number of groups from Ontario provided briefs or made presentations to one or both of the Taylor Committee and the Select Committee. From these we can distil a wide variety of rationales for user charges, which we list below (with examples of those offering the rationales in parentheses):

1. The system is fraught with abuse by patients who make unnecessary demands; means need to be found to inject some patient financial accountability back into health care (Ontario Dental Association; a number of District Health Councils; some members of the Canadian Federation of Independent Business; Canadian Red Cross (Ontario Division)).

2. The financial transaction between physician and patient is critical to the very essence of that relationship, and is needed to preserve its integrity. An essential part of this process is that physicians must have the right to set (negotiate?) fees for (with?) individual patients (Ottawa-Carleton District Health Council; Ontario Association of Optometrists).

3. New sources of funding are essential to assist fiscally strapped provincial governments with the containment of public costs of the system (some members of the Canadian Federation of Independent Business; Canadian Red Cross (Ontario Division); Ontario Association of Optometrists; Ontario Hospital Association[10]; Ontario Medical Association[11]).

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[10] In its submission to the Select Committee the Ontario Hospital Association went so far as to suggest that the non-profit insurance carriers should be permitted to offer coverage against the user fees that were necessary to increase the funding essential to the survival of the system. In this way, no one would be deterred from receiving hospital care, but an additional source of funds would be found [25, p. i].

[11] The OMA argued that "government is no longer able or willing to finance a comprehensive, high-quality health care system" [26, p. 1), that "the infusion of private money" (ibid., p. 6) was essential to preserve the system's integrity, or to act as a "safety valve for inappropriate or misguided decisions by government in matters of health care", and that "direct charges" were the best way of achieving this (ibid., p. 8). But it was careful to man the fortress against those who would argue about the access-restricting effects of such charges: "..we are not in any way suggesting that access to health care be limited by ability to pay...Rather, we are seeking a

4. The public needs to be made aware of the costs of health care; user fees would create a "visible link" between use and cost (some members of Canadian Federation of Independent Business; Ontario Pharmacists' Association (in context of pharmaceuticals); Ontario Association of Optometrists).

5. Permitting extra-billing by physicians would reduce profession-government friction and so reduce the number of physicians leaving Canada (Canadian Red Cross (Ontario Division)).

6. Sole-source (government-only) funding creates excessive costs; user fees would reduce health care costs (Ontario Chamber of Commence; Ontario Pharmacists' Association (in the context of pharmaceutical coverage); Ontario Association of Optometrists).

7. User fees allow people to "get what they want by virtue of their willingess to pay for it" (Ontario Medical Association [26, p. 7]).

8. An injection of private funding would reduce pressure for supply-side cost control mechanisms (Ontario Medical Association).

9. Most people using services can afford to make direct financial contributions, so why not ask them to (Ontario Nursing Home Association).

In addition, a number of groups such as the Ontario Chiropractors' Association and the Pharmaceutical Manufacturers' Association of Canada provided briefs to one or both of these committees that clearly indicated their support for user fees, while not revealing any particular rationale for their positions.

If one were to attempt to summarize the sentiments of, or rationales offered by, those arguing before these committees for new sources of funding for mainstream medical and hospital services, they would distil into two dominant themes. The first argues that the system is underfunded -- governments can no longer afford to sustain the integrity and quality of Canada's health care system; the only way to preserve it is to inject private funds through user charges. The second argues that the system is rife with abuse, patient-initiated, and that user fees would re-establish a sense of financial responsibility that would eliminate this unnecessary care, in the process either reducing costs or freeing up scarce health care resources for more essential purposes. The compilation also makes clear the overwhelming concentration of support for user fees among the representatives of providers of different forms of health care services.

iii. Mud-slinging over the Canada Health Act: 1980-1986

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method of employing private enterprise to preserve and enhance public enterprise" (ibid., p. 7). Of course this could also be interpreted as seeking a method of providing preferential private access to public resources (see [8]).

The early 1980's featured an increasingly bitter debate over user fees, particularly hospital daily charges and physician extra-billing. The debate took place much like a play with two acts. The first act featured a number of hearings, committees (including the Breau Committee [27] and the second Hall Review [7], and conferences (including "Medicare: The Decisive Year", and "Policy Forum on Medicare in an Age of Restraint"). As the curtain fell, the Canada Health Act became law. But the passage of the Act simply presaged "Act Two" of this era -- the falling into line of all the provinces -- which itself culminated with the resolution of the Ontario Physicians' Strike of 1986.

While the debate was more intense than in the late 1970's, and the stakes much higher, most of the players and most of their rationales in defense of user charges were pretty much 'old hat'. There were a few new wrinkles, largely offered by the medical associations, but in general it was "déja vu all over again". In the interest of continuity, we summarize the rationales and the sources of the 'voices' below, maintaining the numbering introduced above, and then carrying on from that numbering for the 'new' rationales:

1. Patient abuse/unnecessary demands/need for patient accountability (Alberta Medical Association[12]; Canadian Medical Association[13]; Ontario Medical Association).

2. Integrity of physician-patient relationship (Canadian Medical Association; Ontario Medical Association).

3. System underfunded (Canadian Medical Association[14]; Ontario Chamber of

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[12] Then Executive Director of the Association, Robert Clark, suggested, among other things, that the federal government had promoted free health care as a right with one hand while slowly withdrawing funding from the provinces with the other [28]. Calling the Canada Health Act "one of the most oppressive and intrusive pieces of legislation ever fashioned by the government of Canada", he argued that "Quality equals money" and that user fees of some sort were the only way to both increase the availability of funding for health care and to move funding from "low-cost services" to "sophisticated treatment and technology".

[13] "Any service, no matter what it is, will generate unlimited demand if it is perceived to be free" [29, p. 342). Yet one suspects that if endodontists tomorrow offered free root canals, we would not see "unlimited demand".

[14] The main arguments put forth by the CMA on this point were that the system was deliberately underfunded, that this represented a hazard to the health of Canadians, and that extra-billing was needed as a barometer of the extent of this underfunding (which included lack of reasonable compensation for physicians). See, for example, the testimony of then president Dr. W.D. Thomas before the Breau Committee [27, pp. 10:24 and 10:25]. Among other things, Thomas argued that patients should bear part of the hotel costs of hospital care, whereas on the medical care side, he was quite comfortable with the notion that patients should pay part of the care costs directly.

Commerce[15]; Ontario Hospital Association; Ontario Medical Association).

4. Public awareness/"visible link" (Canadian Medical Association; Ontario Chamber of Commerce).[16]

6. Universal first-dollar coverage increases costs (Ontario Chamber of Commerce[17]; Ontario Medical Association; National Citizens' Coalition).

10. Most of health care is low cost, relatively predictable primary care services. Since the benefits of insurance for these types of services tend not to be very large and since providing these services crowds out high technology, expensive services, user fees should be implemented to provide a means for societies to provide the needed 'high tech' capacity (Alberta Medical Association; Canadian Medical Association[18]).

11. Relying solely on government for anything is a threat to civil liberty; providing coverage for specific services (an in-kind transfer) is discriminatory and demeaning (Canadian Medical Association[19]).

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[15] The Chamber of Commerce appears to have been a bit confused at this time. It argued both that user fees were needed to control costs, and that a major goal should be to increase health revenue through "some definite ... relationship between the benefit a patient receives and the cost of services" [30, pp. 1-2].

[16] Nowhere in this debate is there any evidence that the advocates comprehended the contradiction in their claim, on the one hand, that user fees are needed to establish a link between patients' use and the cost of services, but on the other hand that user charges would not deter patients from receiving necessary care. The fact that the creation of a "visible link" that meant anything would require really quite punitive charges which could have been expected to deter some necessary care, appears to have been conveniently ignored.

[17] But the Chamber wanted it both ways, as we noted above.

[18] Marc Baltzan suggested that "For almost all, the use of medical care is not uncertain or chance; it is certain". The treatment of minor illnesses, which are "certain and regular", is "ideally suited for direct payment: financing [them] by insurance is absurd and irrational" (see, also, [28]). Baltzan went on to argue that, since setting up a plan to insure some services and not others would be an "administrative nightmare", the ideal solution would be deductibles. This would have the added benefit of reducing administrative costs for governments [31 p. 552].

[19] "[E]qual treatment demands that [the poor] be given money and be allowed to use it -- the same privilege afforded the affluent" [31, p. 552). It is interesting to note that a survey of physicians during this period revealed that only about 30% felt that extra-billing enhanced patients' ability to "choose the best possible medical care", while 50% disagreed [32]. So while Baltzan may have felt that consumers would be better served by being provided with funds with which to shop for medical care, a majority of his clinical colleagues felt that consumers were ill-equipped for this task.

12. The right to extra-bill serves physicians' sense of liberty; eliminating that right destroys a fundamental freedom for physicians and undermines their ability to maintain professional freedom (Ontario Medical Association; Canadian Medical Association).

13. Extra-billing is needed to satisfy the economic needs of physicians. Incomes are too low (Ontario Medical Association; Canadian Medical Association).

Rationales #12 and #13 are particularly interesting because of the contradictions they reveal. The essence of the former is that extra-billing has nothing much to do with fees or incomes, and everything to do with liberty and freedom, economic **and professional**. Thus we find the then president of the Canadian Medical Association, Marc Baltzan, quoted as suggesting that "direct billing does not serve the income of physicians well, but it serves their sense of liberty and that is why they wish to defend it" [33, p. 27]. But this is contradicted by #13 (and prior CMA statements), implying that physicians require the freedom to extra-bill in order to ensure that they receive the incomes to which their training and professional contribution entitle them. Nevertheless, Baltzan's successor as CMA president, Everett Coffin, offered the proposition that the Canada Health Act would destroy "some of the fundamental freedoms of all Canadians and Canadian physicians in particular" [34, p. 1D], and Earl Myers, then president of the OMA, suggested that eliminating extra-billing "is not a money problem, it is a freedom problem" [35].

But perhaps the most intriguing claim of all was that eliminating extra-billing would constitute an assault on the **professional** freedom of physicians [36]. Just how the loss of license to charge patients directly was going to affect these professionals' **clinical** decision-making was not spelled out, although Robert Clark may have offered some insight into this matter when he suggested that "[t]he quality of the relationship between physician and patient has changed and experienced physicians are convinced that this must affect quality [of care] and it has done so" [28].

The alleged importance of freedom and liberty in this debate is further undermined by physicians' own responses to the survey conducted by Taylor et al. [32]. Over 60% of all respondents (and about 58% of fee-for-service physicians) indicated that they **would** support a ban on extra-billing if "insured benefit schedules were increased to the point where they were roughly equivalent to those recommended by provincial medical associations".

As noted above, the medical associations attempted to maintain the freedom/liberty rationale along with #13, at least for a time (see, e.g. [37]). But on closer scrutiny, economic interest appears to have been the more important [32,38,39].

14. Since the burden of extra-billing is borne by those who can afford it (because those who cannot are not charged), the elimination of extra-billing would shift costs from those who can afford it to all taxpayers (Ontario Government in 1984).

15. If user fees (extra-billing) are eliminated, a two-tier system will be created for

Canadians, with the rich going to the U.S. and the rest staying at home to get second class medicine because the best physicians will also all have fled to the U.S. (National Citizens' Coalition).

During this period of intense negotiation, largely over extra-billing but also over hospital daily charges, the claims that user fees would reduce health care costs virtually disappeared. The old rationales that they would reduce patient abuse, maintain an important and inherent feature of physician-patient relationships, and (especially) provide a badly needed source of additional funding for an underfunded system remained. But they were joined by new claims about the (professional and economic) freedom of private practitioners, along with a few other variants less often heard.

iv. The 1990's Resurrection

Following the 'settlement' of the Ontario physicians' strike, user fees fell off the policy radar for a number of years. They have recently re-appeared largely because of the dramatic erosion in the general economic circumstances of the provinces over the past few years. The (mis)fortunes of the provinces have been accentuated by the reductions in federal cash transfers for health care, induced by the federal government's own flagging fiscal fortunes.

Not surprisingly this 'denominator crisis'[20] has reinforced the calls for user charges as a means of shoring up a publicly financed system that the public "can no longer afford", has refocused attention on frivolous and unnecessary use of the system, and has seen the re-emergence of the "people who can afford it should pay something for their health care" rationale. The frequency with which all other rationales are heard these days pales alongside these three.[21]

But the discussion has become somewhat more focused as well. The renewed attack on "abuse" is being translated into calls not for wholesale implementation of user fees, but for completely deinsuring certain services or for imposing user charges for such things as hotel or accommodation costs in public institutions. And a number of those advocating user charges are suggesting their application not within the mainstream of medical and acute hospital care, but in areas such as continuing care, pharmaceuticals, and other types of services and products. We evaluate some of these more focused recommendations elsewhere [41].

The other interesting feature of the last half-decade has been another round of apparent

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[20]. Health care costs in Canada have increased significantly as a share of gross national product during the last decade, after remaining stable during the previous decade. But all of the increase occurred in two sharp economic downturns -- 1981-82 and 1989-91. There was no 'health care cost explosion'; rather health care costs continued to grow at about the same rate as in the 1970s. The rest of the economy did not [40].

[21] Conspicuous by its absence, for example, is any claim in recent years (at least of which we are aware) that such charges are essential to professional freedom or liberty.

flip-flopping by the Canadian Medical Association. In 1991, the CMA appeared to have moved from a pro-user charge position to a more neutral stance. By the following year, although official policy had not swung back behind the calls for private participation, all the unofficial noises suggested that the Association had moved back to the right. But we are getting ahead of ourselves.

Our review revealed the following rationales offered during the 1990's (maintaining and extending the numbering from above):

1. Patient abuse/unnecessary demands/need for patient accountability (Pharmaceutical Inquiry of Ontario (for pharmaceuticals); Government of Québec (Castonguay[22]); Ontario Chamber of Commerce; Alberta government (Klein)).

3. System underfunded (Canadian Medical Association; majority of members of Canadian Federation of Independent Business; Pharmaceutical Inquiry of Ontario).

4. Public awareness/"visible link" (Ontario Chamber of Commerce; Green Shield Prepaid Services Inc. (in context of pharmaceuticals)).

9. People who can afford to pay, should be charged a small fee (Alberta government (Klein) [43]).

16. User charges are needed on certain types of services in order to induce patient movement to more appropriate/efficient levels of care (e.g. copayments for chronic care in acute care hospitals, because patients in nursing homes already face such charges, and their absence in the acute hospitals creates a perverse incentive to leave patients there too long) (Ontario Hospital Association).

17. The only way to balance supply and demand, or to control patients' expectations, is if patients have to pay something for care. "When someone else pays the bill, you destroy intelligent consumerism" [44, p. 999] (Reform Party of Canada).

18. "It's rational to have user fees. Everyone else has them in a publicly funded health system" [45].[23]

Thus, as noted above, we find very little that is new in the way of rationales in the renewed debate, we see a more focused discussion, and we find few new voices.

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[22] Castonguay suggested that charges should be imposed for pharmaceuticals for seniors, and for hospital rooming and food costs, home care, nursing and physiotherapy care [42].

[23] This is not only not a sensible 'rationale', but also not true (for hospital and medical care). While every health care system, including Canada's, uses some charges for some services, several other systems do not impose charges for the core hospital and medical services.

In 1991, the Canadian Medical Association appeared to have ended at least thirty-five years of official support for user charges, although they never did say so explicitly. Statements such as "[t]he CMA is committed to preserving the right of reasonable access to high-quality health care, regardless of ability to pay" [46, p. 60A], and "[i]t recognizes access to health care programs and services as a "core value"; as a right for all, independent of ability to pay" [47, p. 5] suggested that, along with its leadership role in the establishment about this time of the Health Action Lobby (HEAL), had come a true change of heart.

Whatever the explanation, if there was a shift in position it may have been short-lived. By 1992, the CMA had a resolution on the table at its summer convention that, among other things, implied that "current legislation" (presumably the Canada Health Act) required amendment "..so as to permit the emergence and development of both alternative and complementary private health insurance and health care arrangements to meet the varied needs of patients and physicians, particularly in matters of free choice, access, availability and quality" [48, p. 7]. Our reading of this situation is that the CMA is suffering from internal divisions over this matter. In particular, while the CMA itself may have softened its earlier opposition to user fees in recent years, its provincial counterparts have not (at least we have found no evidence of any change in position among the provincial associations). This leaves the CMA in a rather awkward position. While the 1992 resolutions are still said to be merely "policy directions", not official CMA policy, they are, nevertheless, still under consideration at the time of writing. And if they survive the internal CMA policy development process, they will reflect a return to the earlier pro-user fee policy course.

Finally, we should note that a number of groups have been steadfastly opposed to user charges of any sort.[24] Without attempting to be exhaustive, we note the Canadian Council on Social Development; the federal government; the Canadian Hospital Association[25]; the Canadian Nurses Association; the Consumers' Association of Canada; the National Council of Welfare; the Ontario Federation of Labour; the Ontario Health Coalition; the Ontario Nurses' Association; the Ontario Social Development Council; the Patients' Rights Association; the Registered Nurses' Association of Ontario; and, at least most of the time, the editors of a number of prominent Canadian newspapers.[26]

While some of these groups -- most obviously nurses' associations -- represent

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[24] We do not claim that none of these groups has **ever** been on record as supporting user charges of some sort. But our canvassing of the literature produced at least one statement in opposition to user fees for each of these groups, and none in support.

[25] Although at times they have appeared to 'waffle', in large part because they are caught in the same sort of internal politics that plague the Canadian Medical Association. Their opposition to user charges has, at times and on particular user charge issues, left them at odds with their provincial counterparts.

[26] The Toronto Star, Globe and Mail, and the Winnipeg Free Press come to mind immediately, but there have been many others.

members who make their livings in the health care system, it is quite apparent that opponents of user fees are predominantly representatives of potential users of health care. This, like the heavy representation of provider groups among advocates, is consistent with the distribution of potential gains and losses [10] .

This section has attempted to trace the history of rationales and participants in the user charge debate in Canada. But except for brief mention of findings from one survey published in 1984, we have omitted the voices of two very critical groups -- individual practising physicians (as distinct from their official 'leadership'), and individual consumers/taxpayers/patients. It is to their views that we now turn to complete this paper.

C. The Views of the Practitioners:

There have been at least three major surveys of physicians which covered issues relating to user charges. One of these we have already mentioned [32]; the others were surveys undertaken for the Medical Post in 1979 and 1992 [49].

In general physicians have supported user fees, and particularly extra-billing, since the first reported survey in 1979. Like their leadership, respondents offer a mix of "autonomy" and "additional revenue" arguments in support of their position. Physicians have generally been slightly less supportive of fully deinsuring services (cosmetic surgery being an exception) than of imposing partial user fees, although a majority do support the deinsuring of certain services (mostly reproduction-related interventions), and in the 1992 poll about 60% supported Oregon-style "rationing" (which is, after all, nothing more than deinsuring certain services for certain people).

Not surprisingly, support for user charges is greatest among physicians paid fees-for-service, and greatest among specialists. In the 1984 survey, physicians clearly indicated a belief that they were able to distinguish those patients unable to pay, and that they could, therefore, ensure that user charges did not impede reasonable access. (Evidence from Ontario [50] and Alberta [51] appears inconsistent with this belief). A majority also claimed that without extra-billing they could not spend sufficient time with their patients because fees are too low.[27]

At the same time, respondents felt that "extra-billing is primarily a means by which the profession can maintain autonomy". These rationales appear inconsistent on the surface, unless one interprets "autonomy" as meaning "economic autonomy". The medical leadership

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[27]. This statement appears to carry three implications significant for the interpretation of physician behaviour. First, it implies that physicians do have some sort of "target incomes". Second, when their incomes fall short of this level (because fees are "too low"), they are able to shorten visit times and increase visit rates so as to increase incomes. This is otherwise described as "physician-generated demand". And third, while expressing distress with this form of "revolving door medicine" (our phrase) as a threat to quality, physicians declare that they nevertheless practice in a way that threatens quality in order to maintain incomes which a majority regard as acceptable [49; this mirrors earlier comments by Robert Clark [28]).

(see above) also seemed rather confused on this issue. In any case, almost two-thirds of respondents to the Taylor et al. survey indicated that they would accept a ban on extra-billing if "insured benefits were increased to the point where they were roughly equivalent to those recommended by provincial medical associations" [32], all of which makes the discussion about autonomy ring a bit hollow.

D. The Views of the Public

It is extremely difficult to draw out rationales from the surveys of the public because in most instances the framing of the questions has actually set up rationales for respondents. For example, individuals will be asked about alternative ways of dealing with growing health care costs, and offered user charges as one of the possible answers. This sets up "cost control" as a rationale, but of course respondents are never given any information on what is known about the effectiveness (or rather lack of it) of user charges in controlling costs.[28]

Respondents are not told, for example, that all those provider groups that advocate user fees do so quite explicitly in order to increase health care costs, in an "underfunded" system. "...there is no reliable evidence yet to suggest that user fees achieve the stated aim of 'reducing or controlling health care costs.' [Indeed], the Canadian experience suggests they only make matters worse." [52, p. D2].

For what they are worth, the polling data suggest four key trends. First, there has been a marked increase over the past 10 years in the level of support of the public for some form of user charges. Particularly in the context of questions about solving health care financing issues, higher taxes were preferred to user charges in 1983. Since then, there has been a steady decline in support for increased taxes, and a commensurate increase in support for user charges. In the most recent polls, support for user charges has been 'flirting with a majority' (but see below).

Second, despite this declining opposition to user charges, opposition to extra-billing by physicians has remained steadfast throughout (although it peaked late in the debate in Ontario over the Health Care Accessibility Act, in 1986).

Third, the increasing support for user charges other than extra-billing is tied to an increasing perception of "system abuse". Thus, we find much greater support for targeted user charges for specific types of services or for high users, or deinsuring services of questionable effectiveness or medical necessity, than we do for blanket charges on services, or for tax-based charge-back schemes.

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[28]. Rarely, if ever, are respondents asked to consider the difference between public and total health care costs; as emphasized throughout, a user charge necessarily shifts costs from public to private pockets. But cost shifting is not cost control. Similarly, respondents are asked whether they support private sector involvement in health care, but are offered no sense of what this means, and are posed the question within different contexts by different surveys.

Fourth, support for user charges is positively correlated with income of the respondent. In every survey which reported results by income category, support for charges was lowest among the lowest income groups, and tended to increase with income level. This is precisely what one would expect; the substitution of user fees for tax finance will on average leave the well-off, better off [10].

In general, then, information on the public's support for user charges is drawn from questions that tend to 'set up' respondents by offering as 'truth' a particular (and highly suspect) interpreted state of the world (cost explosions; revenue crisis; system abuse), and then asking their preferences about solving these alleged problems. The framing of questions generally has been shown to have a clear bearing on responses [53], although no framing experiment has been tried in the context of health care financing or reform. Nevertheless, "[p]oliticians should be wary of pollsters posing loaded questions" [52, p. D2].

A recent Angus Reid survey provides a good example of this problem. While nearly three quarters of respondents indicated support for a $5 fee for visits to hospital emergency rooms, two-thirds rejected a $25 charge for overnight hospital stays. The proposals were explicitly presented to respondents as alternative policies "for reducing or controlling health care costs" [54]. But respondents were not told that all the evidence indicates that inpatient use is insensitive to patient charges, or that emergency room visits account for such a small proportion of hospital costs (five percent or less), that neither of these charges could possibly play a significant role in controlling health care costs.[29] They were also not invited to consider how long it might take for a $5 charge to become $25, or for $25 to become $75. "...anyone who thinks politicians would keep user fees at $5 for very long should have their (sic) head examined -- free of charge." [52, p. D2].

How much one can infer about the rationales for user charges lying behind the opinions offered by the public to pollsters (or for that matter whether they would really support such charges) is questionable. Such polling is often carried out as much to influence public opinion as to measure it. The poll results are picked up relatively uncritically as "news", particularly if they appear to show something "new." [55, p.A22). Media accounts of poll results seldom, if ever, offer any critical examination of the validity of the results. In particular they ignore the way in which questions are set up to bring out certain responses.

E. In Conclusion

Those who have supported user charges over the period examined here have offered up a remarkably rich and creative set of rationales (we counted close to twenty, although many are closely related). These rationales have changed somewhat, and there has been some movement of, and by, interest groups. But a few key generalizations appear to be supported

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[29]. Implicit in the common focus on "unnecessary" emergency room visits is an assumption that patients so "deterred" will seek no alternative care -- from their own practitioners, for example.

by the foregoing analysis:

(a) support for user charges has been spearheaded by provincial medical associations; the Canadian Medical Association was also a strong supporter for most of this period, but was also one of very few interest groups whose position changed (and possibly more than once);

(b) user charges have been consistently supported by those representing primarily self-employed practitioners paid by fees for service. Organizations representing salaried health care workers have consistently opposed user fees;

(c) the business sector (at least in Ontario) has also been a consistent supporter, along with a few other agencies such as the Ontario Division of the Canadian Red Cross, and the National Citizens' Coalition;

(c) the predominant rationales for user charges have been that they serve as a badly needed source of additional revenue for an underfunded system, and that they would serve to reduce or eliminate abuse/frivolous use. Interestingly, the former rationale has persisted through fat and lean times, and through periods of both rapid and slow growth in health care expenditures;

(d) early in this period user charges were also put forth as a means to control overall health care costs. By the early 1980's, this had pretty much disappeared as a rationale;

(e) despite the fact that virtually all organized interest groups advocating user fees now concentrate on the need to raise more revenue, and have abandoned the (global) "cost control" claim, surveys of the public continue to frame polling questions which specifically embody the presumption that such charges represent one way of controlling costs.

(f) public support for health care user charges appears to have grown over the past decade. This support is increasingly tied to the notion of system abuse; support for desinsuring medically unnecessary or ineffective services appears much stronger than support for blanket user charges. Concurrently, there has been a sharp drop in public support for increased taxation as a means of generating additional revenue for health care. The structure of the surveys from which this information is drawn, however, and the incomplete and often misleading "information' which is given to respondents as background, makes any conclusion tentative at best.

(g) support for user charges continues to be correlated with expected benefits. Self-employed providers, and upper income respondents to polls, will both (on average) benefit economically from greater reliance on user fees.

(h) although the private insurance industry would be a key beneficiary of the re-emergence of user charges of any magnitude, this sector has been largely silent on the issue, at

least within the public debate (a recent exception, in the context of pharmaceutical coverage, was Greenshield Prepaid Services Inc. [56]). On the other hand, Sun Life Assurance Chairman John McNeil may have succinctly captured the sentiments of this industry with his recent challenge that "[w]e must get the hands of better-off Canadian families out of the public purse and into their own pockets" [57]. Of course as we show elsewhere [8,10], it is precisely these "better-off" families who would stand to benefit most from the re-introduction of user fees!

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