Who Are the Zombie Masters, and What Do they Want?

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DISCUSSION PAPER HPRU 93:13D

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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 examine the "zombie-masters", 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 attempt to analyze their behaviour and motivations; in so doing, we identify a number of distinct groups 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.

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.

"The Remarkable Tenacity of User Charges" concisely documents the history of the user charge debate in Canada. It reviews the participation, positions and rationales of Canadian interest groups in debates over patient participation in health care financing.

"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.

Who Are the Zombie Masters, and What Do They Want?

"To Every Complex Problem There is a Simple Answer:
Neat, Plausible, and Wrong"

H.L. Mencken

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"Nothing that is regular, is stupid." (American policy analyst T.R. Marmor). Arguments for user charges in health care have been with us for a very long time. The same arguments have been advanced and rejected for at least thirty years in Canada; they were all thrashed out at the time of the Hall Commission [1], and on a number of occasions since [2].

Yet they recur. Like zombies in the night, these ideas may be intellectually dead but are never buried. They may lie dormant for a time -- in the late sixties, for example, or the late eighties -- but when stresses build up either in the health care system or in the wider public economy, they rise up and stalk the land. So far, the fundamental principles of the Canadian health insurance system have been strong enough to hold back these challenges each time they have arisen, but this is no assurance of future outcomes.

But why do these same ideas constantly recur, to be met with the same refutations, time and again? The answers may actually be quite straightforward. First, they offer a simple and intuitively appealing 'solution' to a complex and urgent policy problem. User charges, and their putative effects, are easy to understand. They are consistent both with the "pop" economics to which virtually every one of us is continuously exposed by the media, and with the simple-minded "supply-and-demand" models that are offered in elementary economics courses as general "explanations" of economic behaviour. Most of those who are involved in the process of developing and 'selling' policy changes have had some formal training in economics. Very few have any experience with or understanding of health care systems, which are among the most complex forms of human organization.

And second, while ineffective for many of the purposes claimed, user charges do in fact provide significant benefits to some members of society, although at the expense of others. The patterns differ depending upon the form of the charge [3]; but all redistribute incomes from users of care either to health care providers or to upper-income taxpayers. Those who stand to gain the most from the introduction of such charges have an obvious interest in promoting them, and in trying to convince others of their merits.

Each of these answers is plausible, and has elements of truth, although neither alone represents the whole story. Simple ideas which are generally agreed to be wrong, or which serve no organized interests, may survive at the fringes of society but receive no serious policy attention. On the other hand, an interest group which cannot translate its objectives into policy proposals which are understood by a wider audience, will also gain little support.

To stay on the agenda, it helps if simple and intuitively appealing solutions to social problems also favour concentrated and influential interests. Such "solutions" may on balance be harmful, but if the interests that they threaten are diffuse, so that there is no organized "voice on the other side," the policy may be hard to suppress. The larger and better organized are the supporting interests, the more frequently and forcefully the idea will be repeated.

In some cases, agricultural marketing boards, for example, or Bill C-22 extending patent protection for prescription drugs, the concentrated interests are sufficiently powerful, and their opponents so diffuse, that they win a clear-cut victory, despite general understanding that the principal result is to transfer large amounts of wealth from the many to the few. But when the opposition is also strong, the policy idea neither disappears not sees the light of day. It becomes a zombie.

In this paper we focus our attention on "zombie-masters", those people and organizations who over the years have consistently revived and promoted the idea that user charges will achieve any number of good things. We interpret their behaviour as motivated by the expectation that they, or the people they represent, would benefit; this expectation seems well-founded. This is not to imply that all those who might support user fees are so motivated. There are undoubtedly many Canadians who have become increasingly concerned about the problem of public deficits, and who are becoming uneasy about the 'sustainability' of the Medicare system. But this paper is not about them. Elsewhere we attempt to disentangle the many "popular" arguments about the effects of user fees [4].

Thus we find advocacy of user charges maintained over many years by the same interest groups [2]. But the translation of this advocacy into policy has so far largely failed, because there has been insufficient resonance of these ideas in the rest of the Canadian community. Thus to understand the longevity of user charge proposals requires an understanding both of the sources of support, and of the nature of the policy environment. The interests are always present, and always hopeful that <u>this</u> time they will get their way.

Who Benefits from User Charges?

The potential beneficiaries from the introduction of user charges in the Canadian system appear to fall roughly into five groups:

1) Those who hope to contribute less to funding health care;
2) Those who hope to have improved access to health care;
3) Those who presently provide care but hope to be better paid;
4) Those who hope to become paid by the health care system; and
5) Those who advocate on behalf of any of those in the above four groups.

The fifth group is comprised of individuals or organizations that identify, coalesce, and promote the interests of those in the first four. They may be specific to an industry -- medical associations, or associations of insurers, for example -- or may represent a "class" interest of the generally healthy and wealthy, such as chambers of commerce or the Canadian Federation of

Independent Business. But they also include "ideological entrepreneurs", like the Fraser Institute or the National Citizens' Coalition, which provide an umbrella for a wide range of diverse persons and interests who expect to benefit from a reduced role for government -- in or out of health care.

Unlike members of the first four groups, the advocates in group 5 would not benefit directly from the introduction of user charges. But they receive financial and other support from those who would, contingent upon their credibility and effectiveness. They play the role of "transmitters", drawing their power from the groups they seek to represent, sending out an unvarying signal over time, and trying to find the wavelength which will generate enough resonance among the rest of the community to support a change in policy.

All benefits to any of these five groups, however, can be shown to result from either the shifting of costs onto other -- and equally identifiable -- individuals or groups, and/or the generation of additional direct or overhead costs in the health care system.[1] User charges serve primarily to move money from one set of pockets to another [3]. They also influence the distribution of access to health care, and possibly of health benefits, but their overall effects on population health are likely to be negative. And to the extent that they meet the aspirations of members of groups (3) and (4) above, they will raise the overall costs of health care.

Paying Less and Getting More: Groups (1) and (2)

In all collectively funded health care systems, that is, all systems in the real world (outside the imaginations of neo-classical economists [6]) most people pay for more than they get, while a few get much more than they pay for. Given the realities of illness incidence, this is how it has to be, and there is no significant political support for change. Only the lunatic fringe imagine a health care system wholly funded from individual out-of-pocket payments. The real policy issue is not whether the healthy and wealthy will subsidize the poor and sick -- they must and they will -- but the extent and pattern of financial redistribution, and its influence on access to care.[2]

If we begin with a system like that of Canada, where effectively all spending for hospital and medical care is financed through general taxation, then the introduction of user charges shifts part of the cost burden from those who pay taxes to those who use care. Since tax payments are

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[1]. If the simple-minded economists' story were true, that user charges reduce the overall costs of health care, members of groups (3), (4) and (5) would not be advocating them. But it is not [5]; and they are.

[2]. Even so, the financing of health care may still be regressive. In the United States, for example, "[l]ow income families spend over eight times as much out-of-pocket as do upper-income families (8.5% vs. 1% respectively)" [7]. Yet even there, health(ier) and wealth(ier) subsidize poor(er) and sick(er) through both public and private insurance programs.

closely related to income, and use of care is closely related to sickness, it follows that in general and on average the healthy and wealthy gain, the poor and sick lose. Those whose business it is to represent the economic interests of the former, advocate user charges.

There may be other effects. Access to care may change, total costs may rise or fall, as may the relative incomes of different types of providers. But whatever else happens, costs have been shifted. Money has been taken out of one set of pockets, and put into another. And in the economist's useful but treacherous framework, "holding everything else constant", the gainers and losers are as described. Those who refer to user fees as "taxes on the sick" are quite correctly pointing out that the degree of subsidy through the tax system is reduced, and the slack is picked up by the users of care.

But what of the healthy and poor, or the wealthy and sick? And what about the rest, who are neither perfectly healthy nor very sick, and neither wealthy nor destitute. In reality we are all distributed along continua in both dimensions. But we can with a little less violence to reality analyse the intersections of three arbitrary divisions on each continuum -- high, middle and low, (as displayed in Figure 1) -- without knowing exactly where each division may be [3].

The interests of those in the top left and bottom right corners are easily identified, as above. But the opposite corners bring out additional interests. The wealthy and sick may also gain from user charges, in two ways. First, if

Figure 1

The Distributional Effects of User Fees

Health Status	Financial Status: High	Financial Status: Medium	Financial Status: Low
High	Large Tax Reduction, Small or No User Fees		Small or No User Fees, Small or No Tax Reduction
Medium			
Low	Large Tax Reduction; High User Fees; Improved Access to Care?		Small or No Tax Reduction; High User Fees; Reduced Access to Care

one is sufficiently wealthy, and the tax system sufficiently progressive, then the savings from paying less for the illnesses of others may well outweigh the costs of paying for one's own.

Secondly, however, user charges may actually improve access to care for the ill and wealthy, and conceivably even enhance their health. In any case they may believe so. In a health care system which is entirely tax-financed, there will generally be restrictions on access to certain types of care. Access will depend upon professionally determined criteria, rather than self-determined willingness to pay. But partial user charges could change all this, by discouraging those with lower incomes and permitting the deeper pockets to move to the head of the queue.

When they get there, of course, most of the cost of their care is still publicly supported. Hence the enthusiasm for partial, rather than full, user charges. After all, such charges provide preferred access to a public resource. A wealthy Canadian always has the option of heading south to buy whatever s/he wants, at full (U.S.) cost. But how much more convenient and less costly it would be to have others subsidize his/her care closer to home!

The last corner, the poor and healthy, may also gain from user charges, at least in the short term. Everybody pays some taxes; not everybody uses health care. But they are also exposed to increased risk -- illness is unpredictable -- and (almost) everyone grows old.

For the rest, whether one gains or loses from user charges depends upon one's relative position in each continuum. At any level of health, the more wealthy are the more likely to gain; at any given level of wealth, the more healthy are more likely to gain [3]. Thus one would expect to find -- and one does find -- that when people are surveyed about their attitudes towards user fees, the proportion of positive responses goes up with income [2].

While people's principles are correlated with their economic interests, they are not wholly determined thereby. As emphasized above, the Canadian health care system -- and every other in the modern world -- depends upon a substantial degree of subsidy from the many to the few. And most Canadians, in the middle of the matrix in Figure 1, accept and approve of that. But if the boundaries in this matrix are seen as shifting, then opinions may shift with them.

Declining incomes and tax bases, rising tax rates, growing public deficits, and a perception of relentlessly rising health care costs, may all contribute to a growing unhappiness with the extent of the present subsidies. The gap between (perceived) personal cost and personal benefit may be growing. "Tax the sick? Why not? Tax anybody, so long as it isn't me." If in addition the escalating rhetoric of cut-backs from the providers of care leads more people to fear that care will not be available when they need it, more in the middle ground may come to identify with and behave like those in the lower left corner. They want to pay less for others' care, so as to be sure of being able to get their own, when they need it.

The task for advocates of user charges is to encourage more people to see things from this perspective, and not to dwell on the possibility that in a declining economy they too might become unemployed and sick.

More and Better Fed 'Places at the Health Care Feast': Groups (3) and (4)

The channels through which providers and would-be providers stand to benefit from user charges are somewhat more easily portrayed. Some years ago, Uwe Reinhardt introduced the graphic metaphor of "places at the health care feast" to represent the numbers and sizes of the incomes which people draw from the health care system [8]. Since by definition, every dollar of health care expenditure is equal to a dollar of someone's income, it follows that any increase (decrease) in health care expenditures, regardless of the source from which it is funded, must be reflected in a corresponding increase (decrease) in the income (from health care) of some (potentially identifiable) persons. This may take the form of additional persons drawing income from health care -- new places at the feast -- or increases in present incomes -- larger helpings.

The latter is the simplest relationship to observe. Extra-billing by physicians, for example, was a quite specific way of increasing the prices of care, and correspondingly the incomes (or at least the hourly rates) of those providing it [3]. But there are more indirect relationships as well. User fees for hospitals or other facilities, if they are used to expand capacity and activity levels, will increase the billing opportunities of fee-for-service physicians as well as create more jobs and incomes for support personnel.[3]

But providers are far from uniform in whether they support user fees, and in what form. Physicians tend to be supportive, for example, while nurses and other hospital staff are generally opposed. Apart from differences in ideology and personal income level, there may be other explanations. In hospitals, there is no necessary connection between a user fee, and the income of any employee. The funds raised may be used to pay higher incomes to existing workers, but need not be. On the other hand, the extra-billing physician sees the money go directly into his own bank account -- at least as gross revenue.

Yet another possibility may be the quite different mix of clientele served by physicians and by hospital workers. A large and increasing share of hospital bed capacity is taken up with very elderly patients with ill-defined conditions, who are commonly both low income and very long stay [9]. The prospects for substantial self-pay revenues from this group are small. The patient load of the average physician, in or out of hospital, tends to be on average younger, healthier, and wealthier.

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[3]. Fee-for-service physicians in a publicly funded system are in the peculiar position of depending to a considerable degree upon public capital and complementary labour in their "private" practices. In the jargon of the economist, these are public inputs in a private production function. The extent of this "public subsidy" to private practice is obviouly very different in the different specialties, being very low for General Practice, and very high for surgical sub-specialties. Since the physician does not pay for these inputs, but does get paid for their output, she has an obvious economic incentive to promote their expansion. Given this incentive, continuous claims of hospital "underfunding" should come as no surprise.

Physicians' associations have long championed their members' interest in raising more money for health care from private sources. They offer both economic and non-economic reasons, although in fact the latter ("professional autonomy" or "the integrity of the doctor-patient relationship") tend to reduce, on examination, to the hope of higher fees and incomes [2]. Taylor, Stevenson and Williams [10, p.138], for example, found in the early 1980s that 57% of Ontario physicians who were paid fees for service would have supported 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..." (see also [11]).[4] But hospital workers have always opposed user fees, and hospital associations have been ambivalent [2].

Other health professionals, such as chiropractors and optometrists, have from time to time advocated user charges on physicians' services with the hope of re-directing more work and more revenues to themselves [3]. Dentists have always and successfully supported "private" insurance for their own services (although with a hidden subsidy from the income tax system), which permits them to extra-bill above the insured rates.

Pharmacists have also recommended user fees for prescription drugs, paradoxically arguing that these were needed to encourage the user "to not obtain drugs that are not absolutely essential" [12].[5] On the other hand, pharmacists in British Columbia remain quite unhappy about a user fee which requires elderly patients to pay, not a flat fee per prescription, but a large percentage of the dispensing fee (though none of the ingredient cost). This fee is set by the individual pharmacist, so the user fee is intended to encourage price comparison by consumers, and competition among pharmacists. The unhappiness of the latter suggests that such a carefully targeted user charge might, in fact, improve dispensing efficiency, lowering costs and, therefore, pharmacists' incomes.

In general, then, user fees have been advocated by those provider groups whose members expected either increased fees or increased billing opportunities as a result, and have been rejected by those who saw no such opportunities. Hospital administrators (and therefore their formal associations) appear to have been doubtful about the net revenue effects of any charge low enough to be politically acceptable in Canada.

But recognized health care providers are not the only ones who may draw incomes from health care. For hospital middle management, or private health care entrepreneurs (suppliers of, e.g. accounting, legal or financial services), the interests in increased levels of overall health care funding are similar to those of the providers -- more jobs, and/or higher incomes. Quality assurance, continuous quality improvement, and other related new initiatives whose 'official' objectives are to improve the overall quality of care, are supported by many who would benefit

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[4]. As Tommy Douglas is reported to have said: "When someone says. "It's not the money, it's the principle", you can be sure it's the money."

[5]. One wonders what the physician who prescribed the inessential drugs was believed to be doing.

from increased levels of such activity, even though this may not in fact be their primary motivation.[6]

Private insurance underwriters and marketers also stand to benefit from any reintroduction of user fees in a form and of a scale as to create a market for private insurance. In both the United States and France, the only two countries in which significant user charges are imposed in the public system (allegedly as ways of controlling costs), there is an active market in private coverage against these charges.[7] The result is thus not cost control, but cost expansion through the creation of additional private incomes in the financial services sector.[8]

Is Anybody Listening?

The messages sent out by the groups above have not yet generated sufficient resonance in the wider community to bring about a significant change in policy -- user charges are still marginal in the Canadian health care funding system. But who is this wider community? In fact we can identify at least three communities -- the political, the bureaucratic, and the general public (citizens, voters, taxpayers, actual or potential patients).

The minimal role played by user charges in the Canadian health care system is not an accident. It is the result of explicit policy choices made by elected officials; and those choices

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[6] This poses an interesting dilemma, for example, for students of health services administration programs in the United States who, on the one hand, may understand perfectly clearly the problems with private financing, but on the other recognize equally clearly that such private financing may represent their most likely professional futures.

[7]. But it can happen here. As noted elsewhere [2], the Ontario Hospital Association suggested in the late 1970s 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 [13].

[8]. There is a direct opposition between the interests of the underwriting industry, and that of the wider society, which is neatly expressed in their contrasting rhetorics. From the wider social perspective, the proportion of premium income which is not paid out for health care represents the "overhead" burden of the financing system. An efficient payment system minimizes this overhead. To the industry, the proportion of income paid out as claims is the "loss ratio", which a for-profit insurance company must attempt to minimize if it is to remain healthy. It is worth noting that the insurance industry is not sitting idly by waiting for the re-emergence of user fees. For only $540/year a plan designed by a Canadian and offered by a U.S. company offers Canadians "wait list" insurance, which entitles them to access to U.S.-based care if they are on a wait list in Canada for more than 45 days for a condition that did not exist at the time they took out the insurance [14]. The marketers of this plan have a clear interest in supporting those who claim that waiting lists in Canada are a serious problem, and getting worse!

have been largely maintained in the face of the periodic resurgence of widespread calls for their introduction. The odd politician has over the years expressed a personal ideological predilection for such charges, but a balancing of the political costs and benefits has, at least until now, dictated staying the course.

The obvious benefits of user charges for politicians are financial, although not personal as for groups (1) and (2) above. User charges provide an alternative to explicit tax revenues. Raising taxes is never popular; nor is accepting escalating deficits. So if costs can be shifted from the public treasury to private individuals, particularly if this can be described in a positive way -- people are "taking responsibility for" or "participating in" their own care, or user fees are weeding out "abuse" of the health care system -- politicians can reduce pressure on the public treasury without jeopardizing their political careers.

The political costs, however, are that most ordinary voters do not yet see things this way. To be seen as "against Medicare" continues to be tantamount to political suicide (although this may be changing as politicians successfully convince the public that the deficit is public enemy #1). These political costs have clearly been perceived as outweighing the benefits -- since we do not have user charges.

The recent renewal of interest reflects the substantial increase in financial pressure faced by all governments, combined with the potential political costs of taking serious steps to limit health care costs and "reform" health care. Several provincial governments have begun to move down the latter road -- and are incurring those political costs. The alternative of letting the health care industry go where it will, and of shifting the economic burden back to the users, begins to some to appear as the lesser evil.

Moreover, as the federal government appears intent on continuing to phase out its cash transfers and, in so doing, shifts its own deficits onto the provinces, the financial advantages of user charges are increased. Under the terms of the Canada Health Act, a provincial treasury cannot benefit from user charges because any money raised in this way, regardless of the recipient, creates an off-setting reduction in the federal cash transfer. But once these cash transfers are reduced to zero (as they will be, in some provinces, within the next decade if current federal legislation remains in place), there will no longer be any obvious penalty (at least within current federal regulations) for such provincial cost-shifting. Indeed, the federal government's own actions bave been interpreted by some as a covert invitation to the provinces to do as they please with the "sacred trust" of Medicare. In any case, if no other federal penalty emerges the political costs and benefits will have shifted again, in the direction of favouring provincial user charges.

This scenario suggests, not so much that politicians are becoming more convinced by the arguments made by those identified above, but that the balance of the other pressures imposed upon them makes any new revenue source attractive. The existence of a ready-made supportive constituency, wealthy and influential, with a convenient set of cover stories, adds to the attraction. The fact that the overall health care system would as a result become more costly, less equitable, and probably less effective, is not irrelevant, but is only part of the balancing act.

Don Mazankowski vs. Benoit Bouchard?

In this balancing act politicians are to a considerable extent dependent upon their professional advisors. These bureaucrats are, however, far from uniform in their understanding of the dynamics of the health care system, and the potential negative effects of user charges. Some have considerable experience with, and understanding of, the objectives and strategies of the different participants in that system. But others, particularly those in the core treasury and finance ministries, seem to view this field through a standard set of analytical lenses, all ground with the same tools.

People in the financial ministries tend to be recruited from economics or commerce programs, where their training is largely based on all-purpose economic theories developed to "explain" the workings of private market systems. Knowing little about the areas dealt with by the line departments, they appear to fall back on familiar "supply-and-demand" models which, as descriptions of how health care systems 'work', are "neat, plausible, and wrong".[9] The more complex and often contradictory reality is not in fact beyond their grasp; indeed these are mostly bright and highly motivated individuals, and they learn fast. But they also seem to turn over fast. The system within which they work rewards the honing of generalist fiscal management skills, not the accumulation of specialized institutional knowledge.

The deteriorating fiscal climate forces a re-balancing by politicians -- this time of sources of policy advice. In an expansionary environment, those in power look to line ministries to develop and fine-tune policy. But the power of the financial ministries increases as the "bottom line" sags [15]. Line Ministries may be reluctant to make many of the hard choices necessary in tight fiscal environments. Since the financial ministries bear the (deficit) consequences of this reluctance, we observe financial ministries' policy reach extended during periods in which expenditure control is the paramount policy concern.

The professional advisors, however, hold very few votes. Ultimately, the reason that we do not have user charges in Canada would appear to be that most politicians believe that most people do not want them -- and the ones who believe otherwise are not in power. Most people see themselves as using care only when they need it, and see user fees as getting in the way of their access to necessary care. Moreover, collectively they take pride in the Canadian health care system as one which goes out of its way to ensure access for all, irrespective of financial status.[10] They **are** concerned about "abuse" -- by others -- and a growing number appear to believe that user charges might alleviate this problem [2]. But at the same time most continue

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[9]. If such "off-the-shelf" models provided helpful descriptions of health care systems, we would not have separate health care systems, with all their complexity. Health care would be provided through the private market-place like most other commodities.

[10]. "There is no social program that we have that more defines Canadianism or that is more important to the people of our country." [Then Premier David Peterson of Ontario, opening the International Conference on Quality Assurance and Effectiveness in Health Care, Toronto, November 8-10, 1989.]

to believe strongly that everyone should get the care they need "on equal terms and conditions" regardless of ability to pay.

Thus the members of the public are also engaged in a continuous balancing act, balancing their commitment to a collective enterprise against their concerns as individuals. Pride in our humane egalitarianism competes with some resentment at the thought of "abuse" by others, and even more important, the fear that maybe the system will not be there when I need it. These latter concerns are more likely to come to the fore in tight economic times, fueled by the claims of "underfunding" from those who hope, through private funding, to increase their own scope of activity, markets, and incomes.

Final Thoughts

While the messages have undergone some changes over time (see [2]), the messengers have not -- they have been around for a long time, and they will be around for a long time. There is a good reason for this. Human nature is such that most people and organizations tend to promote their own interests. There is nothing inherently "bad" or "wrong" with this (although some people can get carried away some of the time). The trouble is caused by the "zombie masters" dressing up their interests as being in the "public interest".

The beneficiaries from substituting user pay for tax finance can be readily summarized. The wealthy will pay less of the costs of the system and get more of the care; the poor will pay more and get less. The higher your income, the more likely you are to gain; the sicker you are, the more likely you are to lose. In the United States, where user charges are a prominent feature of health care financing, families in the lowest income group (in the 1987 National Medical Care Expenditure Survey) spent 8.5% of their incomes on out-of-pocket charges, 7.9% on health insurance premiums, and 4.1% on (health-related) taxes. Those in the highest income group spent 1%, 2% and 7.2%, respectively [7].

Others will benefit as well. Some providers of care (and eventually private insurers) will earn more, as total costs rise; but governments will pay less (than they otherwise would); thus Michael Rachlis' warning of an "Unholy Alliance" between provincial governments, medical associations, and private insurers, backed by those with higher incomes who have most to gain from tax reductions.

What is new in the current brew is the greatly increased concern over government deficits. The collapse in general economic growth rates after 1980 has placed great strains on all government budgets, while increasing public resistance to new taxes. "Tax and spend" is no longer acceptable policy, but people still strongly support the health care system. This double bind pushes governments in the direction of alliance with the more "traditional" zombie-masters.

As governments become more successful in convincing the general public of the seriousness of the deficit problem, they may simultaneously be eroding opposition to user fees. These can be presented by their beneficiaries as a necessary component of a deficit reduction strategy. In reality, the strategy is one of deficit transfer, not of deficit reduction, raising more

money for health care by "taxing the sick" while avoiding the more fundamental reforms in health care which really are necessary (but politically far more bruising) for the long-term survival of Canadian Medicare. The losers, though many, are diffuse, confused and without any obvious channels of influence in a world where their elected officials are constantly having to decide how to respond to advances from "zombie masters" making fiscally attractive offers. There is no entrenched, concentrated interest on the other side, nor (as yet) any obvious means of channeling and focusing the broad opposition so as to counter the alliance. Yet failure to do so moves us closer to an American-style system.

References

1. Canada, Royal Commission on Health Services (1964), Report, Volume 1 (Hall Commission), Ottawa: Queen's Printer

2. Barer, M.L., V. Bhatia, G.L. Stoddart and R.G. Evans (1993, forthcoming), "The Remarkable Tenacity of User Charges", paper prepared for the Ontario Premier's Council on Health, Well-being and Social Justice, September.

3. Evans, R.G., M.L. Barer and G.L. Stoddart (1993, forthcoming), "Charging Peter to Pay Paul: Accounting for the Financial Effects of User Charges", paper prepared for the Ontario Premier's Council on Health, Well-being and Social Justice, September.

4. Stoddart, G.L., M.L. Barer, R.G. Evans and V. Bhatia (1993), "Why Not User Charges? The Real Issues", paper prepared for the Ontario Premier's Council on Health, Well-being and Social Justice, September.

5. Stoddart, G.L., M.L. Barer and R.G. Evans (1993, forthcoming), "User Charges, Snares and Delusions: Another Look at the Literature", paper prepared for the Ontario Premier's Council on Health, Well-being and Social Justice, October.

6. Parker, R. (1993), "Can Economists Save Economics?", The American Prospect 13(Spring):148-160.

7. Rasell, E., J. Bernstein, and K. Tang (1993) "The Impact of Health Care on Family Budgets" Economic Policy Institute (April) cited in Healthcare Trends Report 7:7 (July) p.5.

8. Reinhardt, U.E. (1982) "Table Manners at the Health Care Feast" in D. Yaggy and W. Anlyan, eds. Financing Health Care: Competition vs. Regulation, pp. 13-34, Cambridge, Mass.: Ballinger.

9. Evans, R.G., M.L. Barer, C. Hertzman, et al. (1989), "The Long Goodbye: The Great Transformation of the British Columbia Hospital System", Health Services Research 24(4):435-459.

10. Taylor, M., Stevenson, H.M. and Williams, A.P. (1984). Medical Perspectives on Canadian Medicare. Attitudes of Canadian Physicians. Toronto: Institute for Behavioral Research, York University.

11. Bagley, G. (1988). Money was the main reason for Ontario strike. The Medical Post, May 31, p. 5.

12. Ontario Pharmacists' Association (1977), Brief to Joint Advisory Committee of the Government of Ontario and the Ontario Medical Association on Methods to Control

Health Costs. October.

13. Ontario Hospital Association (1978), Presentation to the Select Committee on Health Care Financing and Costs. Don Mills, Ontario, p. i.

14. Dineen, J. (1993), "U.S. insurer hopes to profit from Canada's health 'delays'", Toronto Star April 4, p. A4.

15. York, G. (1992). "Michael Wilson's quiet revolution." The Toronto Globe and Mail, July 24, p. A1, A7.