It's Not the Money, It's the Principle: Why User Charges for Some Services and Not Others?

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It's Not the Money, It's the Principle: Why User Charges for Some Services and Not Others?

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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 why user charges exist for some health care services and not for others. The paper analyzes the characteristics of services which appear to, or might, underlie decisions to charge in part or in whole for specific types of services. We propose a framework for evaluating the justification for, and feasibility of, user charges for particular types of services in particular situations.

Other papers in this series focus on other aspects of the user charge debate, including the popular arguments in support of, the common rationales for, the key supporters of, and the principal gainers and losers from such charges. A brief description of each paper follows.

"The Remarkable Tenacity of User Charges" 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.

"Who Are the Zombie Masters, and What Do They Want?" likens the recurring proposals for user charges to zombies - the so-called 'walking dead' - because although they have been repeatedly rejected by policy-makers and the general public (and the substantive claims of their supporters refuted by analyses of the effects of such charges), these proposals refuse to remain buried. This paper examines why that is the case, and who stands to benefit from the 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 and the sick, the rich and the poor), between payers and health care providers, and among providers. The framework is used to analyze the income transfers associated with different types of user charges.

"Why Not User Charges? The Real Issues" examines some of the most frequently heard arguments for user charges and looks at what evidence there is for claims and counter-claims that are often made. Because statements in the "popular" debate sometimes seem inconsistent with each other, or unrelated to or at odds with the facts,
we explore the statements more 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. This paper in particular is intended for a wide general audience and assumes that most readers will have heard - or perhaps made - the arguments described, but will have little detailed or technical knowledge of the issues involved.

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.
User Fees: A Theme with Many Variations

The expression "user fee", and its various pejorative and euphemistic equivalents (e.g., deterrent charge, or patient participation), are all too often used, by advocates and opponents alike, as if they referred to a well-defined and homogeneous concept or policy. The attachment of a single label tends to create the false and misleading impression that there is a corresponding "something" to which it refers. But in fact, there is an extraordinarily wide diversity of charges, policies, and proposals included under this general term.

All "user fees" have the common characteristic that they require the user of health care services to give up some amount of money as a direct consequence of that use of services [1]. It is simply erroneous to apply the term to an insurance premium, whether public or private. More generally, it is misleading to apply the term to any tax ostensibly to be used for health care funding, whether the tax is labelled a "premium" or a "health care surtax". None of these link an individual's liability to her use of services. On the other hand a tax on "health care benefits", administered through the income tax system, for example, is a user fee for the very simple reason that it does directly link an individual's financial liability to her own use.

But apart from this one common feature, user fees are not a single policy, or even a species, but a zoo. Moreover, the diversity continues to grow, as advocates of such policies add proposals to the collection. Few are genuinely new; most are versions or minor variants of old ideas. But the differences do matter, both in principle and in practice. In principle, the strength of the arguments for and against "user fees" varies considerably depending upon who is charged, for what, and how much. And in practice, while no health care system in the developed world, not even that of the United States, relies primarily on user charges for its funding (indeed, except for the United States the rest make relatively little use of this method of financing), nevertheless certain types of charges appear to be very widely accepted.

In Canada, for example, user fees for dentistry and ambulatory prescription drugs, and "claw-backs" in long-term care have never raised much political debate. The strong opposition to user fees for hospital and medical care does not extend to these categories, which account for most of the roughly one-quarter of total health care expenditures now coming from private sources. Some analytic work (though not a lot) has been done to try to identify the principles that might underlie this distinction. These range from quite obvious in the case of claw-backs, to quite obscure in the case of prescription drugs. But it is difficult to know how much influence, if any, such principles have had on the evolution of the present pattern.

Elsewhere [1] we have identified five dimensions of variation in user fees:

- how the user pays (the form of the user fee),
- for what services,
- how much the user pays,
when the payment is made, and
who collects or keeps the payment.

The first three of these can be represented analytically, as components of a function relating the amount of any user fee to the use of services which generates the liability. The type and amount of services used are represented by the argument(s) of such a function, how the user pays corresponds to the structure of the function itself, and how much the user pays is determined by the values taken by the parameters of the function.

The last two dimensions could be represented analytically, by dating the variables and embedding the function determining the fee within an accounting framework like that developed elsewhere [2]. But this additional complexity would, we believe, add little to understanding, because in practice there will not be much variation along these dimensions. User fees can be collected, or at least billed, at the time of receipt of services, or can be in some way linked to subsequent tax liabilities [3]. And the ultimate beneficiaries can be either the providers of services (in the form of higher fees and incomes), or those who would otherwise have carried the burden of payment -- in Canada (and most other developed societies), taxpayers.¹

The first three dimensions of user fees, how, for what, and how much, can be represented quite simply (see [2] for more detail). If we designate by $q_{ij}$ the amount $q$ of

¹. In a system with private insurance, the beneficiaries would include premium-payers. But very little of health care is supported from true private health insurance [2]. Even in the United States, usually identified as the home of private coverage, the private system depends on large public subsidies. And the "premium-payers" are predominantly employers, making it very difficult to identify with precision the gainers from increasing the share of health care funded from user fees. Would it be workers, in the form of higher wages, or shareholders, in larger dividends, or the purchasers of the firm's products, at lower prices? Or might it be "future generations," as decreased costs for health care benefits reduce pressure on firms' retained earnings, permitting them to increase investment? The answer depends on ones' beliefs about structure and behaviour in the relevant markets -- labour, capital, and product -- and these beliefs have a large ideological component. Not surprisingly, there is no agreement.

If the introduction of user fees leads into more extended forms of private finance, of course, the beneficiaries will include those who will be able to sell increased amounts of financial and other "overhead" services, both private insurance and accounting and "management" for providers, thus adding to the total cost of health care [2].
some health care service of type $j$ which is used by an individual $i$, then the user charge which individual $i$ has to pay, as a consequence of using that amount $q_{ij}$, can be referred to as $C_{ij}$ -- the charge $C$ paid by individual $i$ with respect to use of services of type $j$. The equation:

$$C_{ij} = F(q_{ij})$$

is thus a general form for this relationship. The base (for what) is determined by the type of service to which $j$ corresponds -- what sorts of services are subject to user charges? -- while the form (how) and level (how much) are implicit in the general function $F()$.

The simplest form of user fee is a flat charge of $C_j$ per unit of service of type $j$, resulting in:

$$C_{ij} = C_j \cdot q_{ij}$$

Here the choice of $C$ sets the level, and $j$ sets the base. Almost as simple is the flat coinsurance rate, making the user fee a percentage of total expenditures. If the price or unit cost of services of type $j$ is $P_j$, then:

$$C_{ij} = cP_j \cdot q_{ij}$$

where $c$ is a parameter between zero and one, and the user fee automatically increases not only with the amount of use but also with the price charged by the provider. "Deinsurance", or removal of a service from the benefit package, is represented in this formula by setting $c = 1.0$.

The traditional form of user fee imposed by private insurance companies, the "deductible plus coinsurance", requires the user of services to pay their full cost, up to some fixed amount in a given time period (the "deductible") and then some percentage thereafter. The deductible is typically not defined separately for each type of service, but rather by the total outlays of individual $i$ (or the family associated with him/her). This form of user fee is then represented by:

$$C_{ij} = P_j \cdot q_{ij} \quad \text{if } \sum_j(P_j \cdot q_{ij}) \leq D;$$

and

$$\sum_j C_{ij} = c[\sum_j(P_j \cdot q_{ij}) - D] + D, \text{ or}$$

$$= c\sum_j(P_j \cdot q_{ij}) + (1 - c)D \quad \text{if } \sum_j(P_j \cdot q_{ij}) > D.$$

where $\sum_j C_{ij}$ is the total amount of user charges, for all (chargeable) forms of care, paid by person $i$ in the relevant time period. If this total is less than the parameter $D$ set by the user fee scheme, then the individual simply pays full cost for all such services used.
Once the total exceeds \( D \), only a proportion \( c \) of all additional costs must be paid by the user.

Variants on these forms which exempt certain people, such as the aged or those with incomes below a certain level, are equivalent to setting \( C_{uj} \) to zero for some values of \( i \), while letting it be defined by one of the expressions above for the others. If the user charge scheme places an upper limit \( L \) on the amount which an individual must pay in charges for care received during a given time period, then (assuming the scheme is of the traditional "deductible plus coinsurance" type) we get:

\[
C_{uj} = P_j * q_{uj} \quad \text{if} \quad \sum_j (P_j * q_{uj}) \leq D;
\]

and

\[
\sum_j C_{uj} = c \sum_j (P_j * q_{uj}) + (1 - c)D
\]

if \( \sum_j (P_j * q_{uj}) > D \) but \( < [L - (1 - c)D]/c; \)

and

\[
\sum_j C_{uj} = L \quad \text{if} \quad \sum_j (P_j * q_{uj}) \geq [L - (1 - c)D]/c.
\]

Such a formulation implicitly assumes that the share of total outlays borne by the user can be controlled by the reimbursers, whether government or private insurer. But if providers are free to set their fees at whatever level they wish, then reimbursers may seek to protect themselves by placing an upper limit on either the per unit level of reimbursement, or the total amount reimbursed per time period. The user's liability then becomes open-ended, as the "insurer" in effect protects itself by transferring risk to the user.

Proposals for the integration of user fees into the tax system, or for the introduction of "tax credits", are minor variants on the above. If the outlays for health care services on behalf of each individual are added to that person's taxable income, then the user charge with respect to services of type \( j \) will be:

\[
C_{uj} = t_i [P_j * q_{uj}]
\]

where \( t_i \) is the marginal tax rate of that individual, lying (like \( c \) in the general coinsurance case) between zero and one.\(^2\) It differs from coinsurance only in that the user fee rate will be higher for higher income individuals. But this by no means implies that the introduction of such a user fee would result in higher income persons making a greater contribution to the financing of health care than they do in a fully tax-financed system. Quite the contrary. Such a policy will lead to a reduction in the overall rate of

\(^2\) If an individual's use of care is large enough, it could push him/her from one tax bracket to another, and so add one or more linear terms to the formula, but there would be no change in principle.
taxation needed to finance any given amount of health care, and higher income people will gain more by this reduction in tax liability than they will lose through the taxation of health care expenditures (unless they are very high users of care) [2].

The effect of a "tax credit" on the formula depends upon whether the amount of an individual's credit is linked in any way to her health expenditures. If each taxpayer receives the same credit of $T, then the actual user charge, the amount of money an individual must give up as a result of using health care services, is in no way affected by this flat "demogrant" (or "taxogrant"). If on the other hand the tax credit is the lesser of $T or actual tax liability resulting from costs incurred on the user's behalf, then it would be equivalent to a "reverse deductible" of $T.\footnote{As far back as 1976, the Ontario Economic Council described a number of different ways in which user charges could be related to taxable income, and provided examples of their effects on individuals' liability [3]. This class of schemes was critiqued in a subsequent OEC publication [4].}

\[
C_{ij} = \begin{cases} 
0 & \text{if } \sum_j(P_j^*q_{ij}) \leq T/t_i, \\
\end{cases}
\]

and \[
\sum_j C_{ij} = \left[t_i\left[\sum_j(P_j^*q_{ij})\right] - T\right] & \text{if } \sum_j(P_j^*q_{ij}) > T/t_i, 
\]

As an example, consider a taxpayer whose income places her in a 30% marginal tax bracket. If health expenditures on her behalf are added to her taxable income, her marginal tax rate is the equivalent of a flat coinsurance rate of 30%. But if she is eligible for a tax credit of up to $300, she will pay nothing with respect to her first $1000 of health expenditures, and 30% only of those above $1000. Under the "deductible plus coinsurance" schemes of private insurers, on the other hand, the user pays all of the costs up to the deductible amount, and a percentage thereafter.

If her expenses are large enough to push her into a higher tax bracket, however, her coinsurance rate on further outlays will be increased to the higher marginal tax rate. Thus under a tax-linked scheme the share of costs carried by the user increases as her liabilities increase. Risk is transferred back from the reimbursers -- in this case the government -- to the user. The case of an upper limit on liability has already been

\footnote{As discussed in more detail elsewhere [2], a "tax credit" for health expenditures which was based on some measure of the expected health care outlays of each individual or family, taking into account personal characteristics which are correlated with need, could have much more complex distributional consequences. But it would also be much more difficult and complex to administer, if it were possible at all. It would be in effect "reverse underwriting", precisely what private insurers have to do, and that process is very expensive even when most of the high risk groups in society are excluded from private coverage.}
The principal point of this algebraic tour is to show that most, if not all, proposals for user fees are in fact minor variants upon one or two basic functional forms. Apparently "new" schemes can appear very different from the old models in form and impact when presented in language, particularly when presented by advocates of user fees looking for a way around entrenched opposition. But algebraic representations cut through the verbiage and show that we are actually dealing with "the same old things", or something very like them, with new labels attached.

What, then, of our initial claim that there are many different types of user fees observable in the Canadian and international experience? There are, but the major dimension of variation is in the base to which they are attached. While there are relatively few choices available as to how to structure the linkage between use of/expenditure on services, and the liability assigned to users, the number of different types of care to which one can attach (and different systems have attached) user charges, is much more diverse. This, in fact, is where the really interesting arguments arise.

Rather than attempting to catalogue all types of services to which charges could be applied, and to analyze each separately, in what follows we develop a framework or algorithm against which to appraise present and proposed user charges. We illustrate the use of the framework by applying it to a number of recent user charge initiatives.
An Algorithm for the Classification and Evaluation of User Charge Proposals

At first sight, there appears to be little if any pattern or logic to the array of user charges in the Canadian, or any other, health care system. In Canada, the visit to the doctor is free but the drugs prescribed at that visit may not be -- depending upon ones' age, income, and province of residence. Hospital care is free, but not the ambulance which brings one there. Drugs used in hospital are free, but the patient who is still using the same drugs after discharge must begin to pay for them. The same is true for bottled oxygen. A tooth extracted by an oral surgeon is a private transaction, unless it is done in hospital, in which case it is free. And so on [5]. It is hard to resist the conclusion that one is observing the more or less random outcome of a number of competing political and administrative pressures.

Yet on closer examination it does appear that there is a certain logic to (at least some of) what we observe, and that many -- though by no means all -- of the present array of charges can be fitted into a logical framework. That framework categorizes different health care services according to the characteristics which seem, in a number of cases at least, to serve as a basis for either "free" provision or charges. It gives specific content to the phrase "medically necessary", and permits us to understand the rationale for some of the present -- or proposed -- charges, while identifying others that have no obvious logic beyond the political and financial pressures of the moment. It is

5. There is relatively little overlap between our attempt in what follows to identify a rationale for some of the user charges now present in Canadian health care (and some possible extensions), and the "common arguments" discussed in Stoddart et al. [1]. Here we start from the principle that all "medically necessary" services should be free, and explore various ways in which a service might be "not medical" or "not necessary". No account, therefore, is taken in our algorithm of the patient's income, although "those who can afford to pay" would in fact be the net beneficiaries of a general policy of user charges for hospital and medical care [2].

We share some common ground with those who argue for charges to limit "abuse". But our approach would target charges (and indeed complete deinsurance) to specific and identifiable abuses, rather than basing them on a blanket and unsubstantiated (and implausible) claim of general abuse.

We are not convinced that any manipulation of charges and coverage is likely to be very effective in controlling overall costs -- in contrast to a mix of policies to limit budgets, and change the numbers and mix of, and incentives faced by, those who actually provide care. But we believe that a serious effort to identify, and remove from coverage, services which provide either no benefit or very little benefit relative to their cost, would be both more effective and more in keeping with wider social goals than the rather mindless approach of uniform user fees.
laid out as an algorithm in Figure 1.
Figure 1: A Decision Framework for a User Charge

START

Go To A

Is it Health Care?

Y/N

Do Not Cover (1)

Go To B

Is it Effective for a well-defined Clinical Condition?

Not Sure

Sometimes

Do Not Cover (2)

From C

Is it Necessary?

Y/N

Do Not Cover (4)

Are there alternative, equally effective, ways of delivering it?

Charge for, or do not cover, more costly options. (5)

Cover Fully (6)
Can Health Care and Non-Health-Care be Separated?

- If yes (Y), do not cover non-health-care component (1).
- If no (N), discretionary.

B: Are we "not sure" or is it effective "sometimes"?

- If not sure (Not sure), do not cover subject to future evaluation.
- If sometimes (Sometimes), possibly cover, subject to future evaluation.
- If can we tell for whom? (Can We Tell For Whom? Y)
  
  - If not effective (Not Effective), not cover (3).
  - If effective (Effective), go to C.

C: Go to C.
a) Is It Really Health Care?

This is the first question that should be asked. Services provided by a recognized health care practitioner, or in a health care institution, are not ipso facto health care services in the sense of services intended to improve the health of the recipient. An obvious example is "preferred accommodation" -- private or semi-private rooms -- in hospitals. Like a television set, these are "extra" services which have always carried an extra charge to the patient, and no one seems ever to have questioned the principle. It is understood that if the responsible physician determines that the patient's condition makes such accommodation "medically necessary" (e.g. isolation for certain infectious illnesses), then it will not be charged for.

On the same principle several provincial governments have been moving to "deinsure" certain physicians' services -- the performance of examinations to attest health or sickness, for example [6,7]. Such services are not intended to improve health, but to provide administrative information. An insurance company or a prospective employer may want information on an individual's health, before issuing a policy or offering a job, or an employer may want assurance that an individual is ill before paying for work loss due to illness.

It is understandable that the parties to such a transaction should prefer that the physician be paid by Medicare. But it is not obvious that the service is, in fact, "medical", let alone "medically necessary", even though the examination requires the application of medical skills and knowledge. The examination or documentation is motivated not by medical need of the patient but by requirements external to the health care system imposed upon one of the transactors.6

6 The principle in this case is clear, but the practice is not. Strictly speaking the government of Ontario (or of other provinces) cannot "deinsure" or delist insurance examinations and sickness notes -- because they have never been insured benefits. But physicians providing these services have billed OHIP for "office visits" or "partial exams" because they "have not wanted to present a bill to their patients, and have tried to recoup at least the cost of the office visit through the OHIP plan" [8]. Until recently, OHIP has chosen (or has had) to turn a blind eye to such practices.

Indeed it is difficult to see how the Plan could avoid paying for these services without the cooperation and support of physicians. Thus the "new" policy consists of an agreement between the OMA and the Ministry of Health to try to enforce rules that have always been in place. But even now one might expect that some such billings will continue as physicians choose, for whatever reason, to protect their patients from direct costs.

Nor is the principle itself as clear as might appear -- suppose the practitioner, in conducting an examination, discovers
Ultrasound pictures of the fetus in utero provide yet another example. The diagnostic value of many such investigations is controversial; we will return to this point below. But the entrepreneur who quite explicitly offers to provide "baby's first pictures" as a memento for the family, without any pretense of providing diagnostic information, is offering a service which while medical in form, is not medical in motivation, intent or outcome, and has no claim to public reimbursement. (Nor, we believe, has anyone suggested that it should have.)

The distinction becomes less clear in the case of procedures such as elective cosmetic surgery. Again, Medicare has always excluded many such services in principle, although the practice has been less clear. If people have to pay to have tattoos applied, presumably it is reasonable for them to pay to have them removed. On the other hand, "elective" cosmetic surgery for a burn victim falls well within almost anyone's definition of a health care service.

Somewhere in between, is the person who is simply dissatisfied with nature. If most of the members of a community believe that facelifts or "tummy tucks" do not address a health problem, or fail to recognize micromastia or microphallus as diseases, then presumably the associated services should not be covered by public reimbursement programs, even though they require the services of a surgeon rather than a "cosmetician".

Our purpose is not to generate a comprehensive list, but merely to give examples of "health care" services which have in the past or might in the future carry a 100% "user fee", in the sense of being outside the public reimbursement plans, because they are not in fact health care services. In some cases the distinction is clear -- preferred accommodation or insurance examinations. In others -- cosmetic surgery -- there is an unavoidable element of judgement or need for application of community standards.'

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and treats an illness? A service which was intended only to generate administrative information, might nevertheless represent medically necessary care.

' It does not seem to us that the individual can set the standard -- one person may suffer acute distress from some aspect of body shape that most others regard as well within the bounds of normality. But an individual might equally well be very distressed by the condition of his car, or clothing -- this does not provide an argument for public subsidy. So if the rest of us would be quite satisfied, or at least not overly distressed, if we shared your appearance, why should we have to pay for you to have it "remedied"? This too, however, is a political judgement, on which we as analysts deserve one vote each.

But might the distress itself be a form of "illness"? The boundaries between "normal" and "abnormal" psychological states are very unclear, and one might very well find someone willing to
But there are also forms of service which combine health and non-health care, and which in practice appear to be much more important, quantitatively, than the above. ("Deinsurance" of minor surgical procedures may generate much public debate over principles, but they are a trivial part of health care activity or costs.) Most obviously, the institutional care of the elderly combines "room and board" and general maintenance care along with nursing services. Again, the provincial funding systems have always recognized the mixture of the two by levying a "user charge" set to recoup the basic level of public pension received by residents, less a "comfort allowance" [9]. But this payment does not generally cover the full costs of such institutional care.

If it were possible to isolate with some certainty the costs of nursing and other "health care" services received by persons in long-term care, without placing an undue load on the process of accounting and cost allocation, it might well be argued that residents should be charged an amount equal to the costs of the "non-health care" component. At present the health care funding system may be bearing some of the costs of services which are not, in fact, health care.

Such services may go beyond "room and board" to include physical assistance and support for the frail elderly, and custodial care for those with psycho-geriatric problems. They may be very necessary, and their provision may be considered in whole or in part a social responsibility, even though they are not health care services. Accordingly, explicit subsidies would presumably have to be available to pay for such care for those who cannot afford it. But for those who do have the resources, it is again not clear why the public at large should subsidize the non-medical living costs of people who can afford to pay for themselves.

Again, our point is not to recommend such a policy -- one can also envision some potentially significant problems in practice. But the rationale for the per diem charges label surgery to correct an unsatisfactory body shape as "medically necessary" on psychological grounds. Yet this is a non sequitur. If a person were distressed to the point of illness by his unsatisfactory possessions, Medicare would not, e.g., buy him a new car. The distressed individual has a psychological, not a surgical, problem (and it will probably be transferred, not relieved, by surgery).

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8. First, such charges generate an obvious incentive for the institutionalized elderly or their representatives to resist transfer from "free" acute care to more appropriate long term care. This is of course an old problem; possible remedies include the assessment of long-stay patients in acute care and their reclassification as de facto long stay for purposes of both hospital reimbursement and patient charges. Secondly, charges for long term care which are related to a resident’s own resources will tend to -- and are intended to -- draw down those
we now have in long term care, as well as for proposed extensions, is based on the
distinction between what is, and what is not, "health care". If that distinction can be
made more explicit, and if the associated cost allocation can be done in a reasonably
reliable manner, then there might be grounds for some extension of charges for the non-
health care component.

We suspect that the primary effect would be to transfer costs from health to
social services budgets. There would be some gain for taxpayers, at the expense of (the
heirs of) those people in long term care who have significant incomes or assets. But it is
doubtful (to us) whether there would be any great change in actual patterns of use or
cost. Nevertheless, if the collective health care funding system is intended to pay for
"medically necessary" care, then presumably such a redistribution of burden would be
consistent with that intent.

Moreover it is at least possible that a shift in funding sources, even if only from
hospital to social services budgets, might contribute to reversing the "medicalization" of
long term care. A number of observers have pointed out that treating residential
facilities for the elderly as second-class hospitals, rather than as homes with a care
component, leads to dependence as well as extra expense. The B.C. Royal Commission
on Health Care and Costs [10], in choosing its title "Closer to Home", explicitly referred
to the need to maintain a more home-like atmosphere, with more personal control and
less professional intervention, for people who are residents, not patients, of the
institution. But we ourselves have no basis for going beyond raising the possibility that

resources. This can foreclose any opportunities for the resident
to return to independent living, or threaten the independence of
a spouse.

It is not clear how serious such problems may be, in
quantitative terms, nor whether effective remedies can be
devised. But they emphasize the potential dangers of simplistic
solutions based on a priori notions, in a complex environment.

The distinction will not be simple, particularly for
that large proportion of the institutionalized elderly with
psycho-geriatric problems. Is the extra supervision required by
an Alzheimer’s patient "medically necessary", or not? And how
much care is "necessary", the minimum required to prevent injury,
or must there be a "quality of life" component in the "medically
necessary" package? Again, there is no escaping the making of
judgements, and the per diems we find in provincial plans may in
fact be quite pragmatic and reasonable solutions to a very
complex set of problems.
a change in funding form might help. 10

Where a line can be drawn between "health care", and "non-health care" services, the appropriate policy -- consistent with the fundamental principles of Medicare -- would seem to be to cover the former and exclude the latter rather than imposing part charges for either. But there may be services in which the contribution to health and that to general well-being are inextricably mixed; if so there may not be any firm principle on which to base a decision about user charges. 11 We suspect, however, that such situations will be relatively unusual, and that more commonly advocates of user charges, providers in particular, can draw such distinctions -- how else can they so confidently refer to patient "abuse" of health care? -- but for various reasons do not wish to do so. We will return to this point below.

10 On the other hand, it may simply serve to 'de-integrate' services that are presently integrated. The compulsion to compartmentalize things into their 'logical' places may, in fact, have quite deleterious effects because of the inability of large social agencies to coordinate their efforts.

11 We should note here, however, that it would be quite misleading to identify "non-health care" services with services that improve "quality of life". Many, perhaps most, health care services contribute to quality of life rather than to life expectancy. Relief of pain and suffering, restoration or preservation of functional capacity, relief of anxiety, are all obviously part of the role of health care. Our rough test would be, if you were authoritatively assured that a particular service (or product) would not contribute in any way to your health, would you still want it? If "yes", then the service must, for you, have a non-health care component. But for what health care services would this be true? Contrary to some of the public rhetoric, anyone who has undergone any significant health care interventions can say very easily that being healthy, and foregoing the services, would be better -- much better. In the economist's jargon, independently of its health effects, most health care lowers utility rather than raising it.
b) Does It Work?

Specialists in the evaluation of health care commonly point out that a significant proportion of the care that is provided in any modern health care system is not in fact effective, either at all or in the circumstances in which it is provided, and much more is simply of unknown or incompletely evaluated effect [11, 12].

Services which are effective in remedying a well-defined clinical condition clearly should be reimbursed, and those which are not, should not be. Thus a service may be, in form and intent, health care; but if on the basis of current knowledge it cannot be expected to do more good than harm (relative either to no treatment at all, or some well-defined alternative) for those to whom it is offered, then it should not be reimbursed. A good deal of "alternative medicine" -- chelation therapy for heart disease, for example -- may be excluded (rightly or wrongly) on this principle.12

More commonly, however, the answer to "Does it work?" is either "Sometimes, and for some people" or "Well, possibly, but we're not sure." These two answers have different implications. If the form of care does appear to benefit (more often than not) some people in some circumstances, then the obvious response is not to impose a part charge equal to some estimate of the proportion of recipients who do not benefit, but to see if it is possible to identify the persons and circumstances in which the service is (likely to be) effective.

This is what protocols are all about. One reimburses the service if it is provided in accordance with an approved protocol -- presumably based on the best available evidence of effectiveness -- and not otherwise. Thus one might reimburse mammography screening for non-symptomatic women over fifty years of age, for example, but not for those between forty and fifty. Or one might, and provincial plans do, place limits on the frequency of reimbursement for periodic health examinations -- again on the basis of judgements about probable benefit. This is obviously a large area for future research, and any such decisions must be made conditional upon the current state of knowledge and subject to revision. But the general principle is clear, and seems to us hard to argue with. Do not reimburse any service for which there is no reason to believe that it will do the patient to whom it is offered more good than harm.

In Canada, we have barely begun to address the possibilities in this area,

12. Note that we are not taking a position on whether particular "alternative" therapies are or are not effective, either at all, or as commonly offered. We are only suggesting that their exclusion from the public reimbursement plans may rest on a judgement (By whom? On the basis of what, if any, evidence?) about effectiveness.
possibilities for improving the quality of medical practice as well as limiting costs. The underlying logic is, however, quite different from that of proposals for crude, across-the-board partial user fees. Rather, one uses a highly selective, information-based approach to determining what services should and should not be provided, and then uses the coverage decision -- 100% "user fees" for ineffective services -- to steer patterns of care. If the policy is effective, very few people (if any) should actually be paying a fee, because identifiably ineffective services will no longer be provided. 13

Protocols may be developed for particular procedures or services; it is more difficult to imagine them applying to whole fields of practice. These become problematic where the borderline between "alternative" and "mainstream" medicine is contested, as evidenced by the ambiguous treatment of chiropractic or naturopathy. Here coverage is at provincial option; these such services are not included under the Canada Health Act principle of "comprehensiveness". Most provinces do provide some degree of coverage, but impose limits on the number of reimbursable visits per year, and require copayments. Why?

There are several possible answers within our framework. Traditionally, many medical practitioners have argued that these services "do not work" -- that they represent ineffective and possibly harmful interventions based on fallacious, pseudo-scientific "theories". If so the ground of exclusion is obvious -- services which cannot be expected to contribute to health are not health care services. Partial coverage is simply a concession to political pressure, without any basis in broader principle. 14

This "absolutist" position, however, appears increasingly difficult to sustain as evidence accumulates suggesting that some of the interventions offered by chiropractors

13. The policy may not be effective, however, if the decision not to provide coverage simply permits private providers to offer the service on any terms they choose. Opportunistic "marketing" by those who profit from providing a service to an ill-informed and sometimes desperate clientele could easily swamp any "steering" effect. If a health care service is excluded from public coverage, it may still require a good deal of other regulation; see below.

14. An explanation which side-steps our framework entirely is that provinces impose restrictions and user fees simply because they can do so, without penalty under the Canada Health Act. If not restrained by federal standards, they would introduce user charges for medical and hospital services as well. But this alternative "unprincipled" interpretation fails to account for the contentiousness of user fees for hospital and medical services, and the diversity of provincial approaches prior to the CHA, compared with the comparatively tranquil responses to such fees for "alternative" services.
in particular do improve the health of some of their recipients. In some cases they achieve better results than their competitor medical practitioners. Yet the conclusion immediately drawn by chiropractors, that their services should henceforth be reimbursed by the public plans on the same open-ended basis as those of medical practitioners (and if there are user charges, they should apply equally to both), appears no closer to acceptance either by those who pay for health care, or by the general public.

The difficulty seems to be in drawing inferences about entire fields of practice, and their practitioners, on the basis of evidence about particular procedures in particular settings. The views expressed publicly by individual chiropractors, as to the patterns of services which they regard as appropriate for healthy, non-symptomatic "patients" as well as to the effectiveness of spinal manipulation therapy for e.g. infectious diseases, or coronary disease, leave room for a great deal of concern. The issue is not so much the efficacy of specific interventions under controlled conditions, but what a group of people with diverse therapeutic theories would do in an open-ended environment. There are at least grounds to fear that the result might be a substantial increase in servicing, at public expense, with little or no identifiable health benefit.15

[Again, our point is not to pass judgement, ourselves, on the effectiveness or otherwise of the services of such practitioners, but only to observe that there are significant restrictions on their reimbursement, and to consider what the basis for those restrictions might be.]

The question "Who benefits?" can be extended to cover another area in which user charges, and proposals for their extension, are alive and well. As noted above provincial ambulance services typically require users to pay part of the costs.16 And

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15. There is, of course, an inconsistency here, in that it is widely believed among the health services research community that a significant proportion of the services of medical practitioners are also without benefit. There is increasing support for, and activity in, the evaluation of services, with the expectation that (eventually) services which cannot be shown to be effective should not be provided, or at least not reimbursed by public programs. From this perspective the appropriate policy towards chiropractic, and by extension towards "alternative" therapies in general, would be to explore with some care claims for the effectiveness of specific interventions in well-defined circumstances. One should reimburse those (and only those) which meet a rigorous effectiveness test (subject to the qualification of "necessity" -- see below), rather than opening up yet another field of unreviewed and uncontrollable activity.

16. The charge in Ontario is currently $45 for ground or air services, unless the patient qualifies for some form of social assistance by reason of age, poverty, or disability, or is being
prior to the Canada Health Act several jurisdictions levied user charges in hospital emergency wards. The justifications offered are that people "abuse" such services, calling ambulances when they could as easily take a taxi, or misusing the facilities of an emergency ward with non-emergent needs (if needs at all) for primary care.

The alternative is to draw explicit distinctions on the basis of need, at the time of service or afterwards, and in fact emergency ward personnel do this all the time. They triage the in-coming patients and care immediately for those in greatest need; the others wait. One could take this a step further. If the "abusers" are so apparent -- and some of them may be -- the solution is not only to assign them a lower priority for care, but to notify them that they can equally well be cared for in an alternative facility -- a physician’s office or clinic, and perhaps at another time -- but that if they choose to stay at the emergency ward, they will be charged a fee.

Similarly the person brought in by ambulance could be charged -- full cost -- if those providing the care judge that his condition was not such as to justify the use of an ambulance. And indeed that is exactly what happens at present (or is supposed to) in Ontario at least. If the attending physician in emergency determines that an ambulance was unnecessary, the patient is to be charged the full cost (deemed to be $220 for land ambulances, and as much as $5000-$6000 for air). Thus the partial user charge applies only to those who, in the judgement of a physician, did require the services of an ambulance. [The rules do not speak to the question of whether an average individual could reasonably have been expected to know his own needs -- presumably the physician is expected to take this into account.]

Even if one took the view that some "abuse" continues, perhaps because physicians are reluctant to make a determination of unnecessary use, the effect of a policy of partial user charges would be (is) to continue to subsidize to some degree the "abusers", while in effect taxing the comatose accident or heart attack victim whose use is entirely appropriate, and unavoidable. It is not obvious what social purpose is served by such a pattern of charges. They will, of course, raise some revenue, but from a particularly vulnerable group of people.\(^{17}\)

As in the case of care protocols, the principle is that if the user of care could not be expected to benefit from it, then it should not be covered. Emergency care by

\(^{17}\). If one finds an accident victim lying on the sidewalk, and removes his wallet, the explanation that one needs the money is not usually considered sufficient. It would seem to follow that a hospital, or the Ministry of Health, should also offer some justification beyond their (admitted) need to raise revenue.
ambulance or in hospital benefits the health of some people -- it is often life-saving -- but not of those who use it unnecessarily.\textsuperscript{18} Do not pay for what does not "work", in the sense of contributing to health.

Such an approach seems transparently obvious, and indeed at least one emergency room physician has called for, not a "user charge" but an "abuser charge" \textsuperscript{13}. The reluctance to take this step may be rooted in professional discomfort with making such explicit judgements of appropriateness in front of the patient, and of personally assigning financial liability.\textsuperscript{19} But it may also reflect the fact that much advocacy of user fees is not really about "abuse" at all \textsuperscript{14,15} and that problems with the emergency services, real or otherwise, are simply a convenient propaganda device, a cover to deflect attention away from the pursuit of other objectives.

But supposing that one cannot tell which people, under what circumstances, will benefit from a service? This brings us back to the more general question of what to do when we are not sure whether a service "works" or not. As indicated in Figure 1,

\textsuperscript{18} As always, an element of judgement must enter here. The individual faced with an unfamiliar health crisis may misjudge its severity and quite properly play it safe by calling an ambulance when a qualified person would know that it was not necessary. But those who complain of "abuse" are not referring to such good faith mistakes. Rather they refer to individuals who are persistent abusers, calling on emergency services in circumstances where "anyone" would know that they were unnecessary. If so, then such persons can be identified and charged for their unnecessary use.

Again the issue arises as to whose standards of understanding should apply. It may be difficult or impossible to establish whether a particular individual "knew" that an ambulance call was unnecessary. But if one instead takes a more general, albeit rough, community standard, that the ordinary individual would know better, a "commonsense" standard, then it should be possible to identify, and bill for, "abuse". The general principle is similar to that in Note 7 above, concerning what is and is not "health care"; the criteria must be those of the community, not those of each individual, if the distinction is to have any meaning.

\textsuperscript{19} It is interesting that while Muran’s \textsuperscript{13} suggested "abuser charges" are quite consistent with the emphasis on "medical necessity" which underlies our algorithm, he seems unaware that the rules on ambulance use already permit the emergency room physician to require patients who make inappropriate use of this service to pay the full cost. This may be indicative of the difficulties in disseminating sufficient information (or incentives) so as to make constructive use of targeted charges.
branch B, one could reasonably respond to this situation in either of two ways. One could reimburse the service, while carrying out further evaluations, or one could refuse to reimburse it, while carrying out further evaluations. Unfortunately both of these "logical" approaches turn out to have significant problems in practice.

Reimbursing services on the basis of incomplete or uncertain evidence of benefit has been the past pattern in Canada and indeed in most other jurisdictions -- "when in doubt, cover in order to avoid problems later". But once a funding precedent has been established, it will influence servicing patterns or habits, and those whose incomes depend upon the provision of the service have a strong and concentrated interest in ensuring that it continues to be funded. Those who pay for it have a more diffuse and general interest in controlling overall costs, but it has been hard to focus this interest on any specific services. In a rapidly changing world it is always possible to create some degree of doubt about the results of any evaluation, and the procedural rules seem to be that in practice established (or indeed proposed new) interventions get the benefit of any doubt.

This would seem to suggest that services, particularly procedures, with uncertain benefits, not be reimbursed until conclusively proven to "work". But this may simply leave the service to the private sector. In the absence of tight restraints on marketing behaviour, a service which is not demonstrably harmful may be quite rapidly expanded as a private service on the basis of misleading representations of probable benefit. The general problem of "opportunistic" behaviour in a mixed payment environment is dealt with in more detail below.

In general it appears that the problem of incompletely evaluated services, while very real, is not well dealt with by simply manipulating coverage. It may be that what is needed is some form of intermediate, "conditional" coverage, with the terms of the conditionality spelled out and enforced. But whatever the approach, it seems clear that user charges to patients have no particular value in dealing with the technical question of determining whether or not a service is effective. If the clinicians and the scientists cannot tell, how is the patient supposed to know?
c) Is It Necessary?

One might argue that if a service is clearly medical, and is clearly effective (in some cases at least) in dealing with a well-defined clinical condition, the test of "medical necessity" has been passed. But we introduce a further criterion, which seems both to be logically required, and to capture an aspect of actual practice, by drawing a distinction between "medical effectiveness" and "medical necessity".

The logical requirement arises from the existence of a large class of what Pete Welch has labelled "epsilon" services -- those which have a very small, but nonetheless positive, health benefit. How small must the benefit be, relative to its cost, before we decide that the service is simply "not worth it", "unnecessary"? The answer one gives may vary depending upon whether one expects to receive the benefit or bear the cost. But if the supply of such services is effectively infinite, as over time it may be, given the pace of technical change in health care, then it follows that some cut-off has to be applied.

The aspect of observed practice which suggests a "necessity" distinction is that there is in fact debate over the reimbursement of certain health care services. In vitro fertilization, for example, is clearly a health care service -- it is provided by a health care practitioner, and is a response to a functional problem. Yet its reimbursement status varies across jurisdictions, and there is room for debate about how or whether it should be covered in a public program. Reversal of sterilization falls into the same category. The conceptual borderline can become thin here, between describing a service as non-medical, or as medical but non-necessary, although there are clear examples in

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20. One must be careful, however, not to allow the economist's axiom that "more is better" to slip in the back door after it has been booted out the front. A priori arguments for health benefit are no more reliable for small than for large gains. In particular, and perhaps unexpectedly, it is not even true that "more diagnostic 'information' is better"; for example Katz et al. [16] have recently shown that more frequent ordering of mammograms is associated with a significant delay in the diagnosis of breast cancer, apparently because of "...the potential disinformation of a nonsuspicious mammogram." (p. 267).

21. No society can provide an infinite range of services. Thus attempts to characterize one or other system of health care financing as leading to "rationing", when all must do so, is misleading nonsense.
each case which are inside the borderline.\footnote{22}

Much of the public debate seems to have focused on the coverage of particular services -- whether or not the public should pay for "X". But the "epsilon" issues are likely to be a good deal more important quantitatively, and like the question of "Does It Work?", these are patient and context specific. A particular pattern of diagnostic testing, for example, may yield much larger benefits for people in a high risk group, than for the general population. The use of non-ionic contrast media in diagnostic radiology, for example, yields substantial benefits, as well as substantial costs, for an identifiable group of high-risk individuals. For the rest of us, the benefits appear to be in the epsilon category and may not be worth paying for.

Should one then allow people to pay extra, at their own option, for this "higher" standard of care? (The same issue has arisen with respect to special, higher cost lightweight cast material for broken bones.) The easy answer would appear to be "Yes", but in fact the problem is a bit more complicated, as we shall see below in the discussion of opportunistic behaviour.

\footnote{22. The practice, in some provinces, of levying user fees for (out of hospital) physiotherapy may be based on some judgement of "necessity". No one seems to have challenged the status of physiotherapy as a health service, nor suggested that its practitioners' interventions were ineffective. On the other hand, the charges may simply reflect the fact that this service is not included in the Canada Health Act principle of "comprehensive", so provinces can impose charges, without penalty.}
d) Is There a Better Way of Doing It?

Finally, a service may be health care, necessary, and effective, but may be available from different providers or in different settings. If the alternative forms of provision are equally effective, then one might charge people who, having access to the less costly form, nevertheless choose to use the more costly. Thus people who self-refer to specialists are, in some provinces at least, required to pay the difference between the general practitioner and the specialist fees; the practitioner is only reimbursed by the public plan at the generalist rate. Similarly, if an effective and accessible system of immunizations is available through the public health system, one might not wish to reimburse such services when provided by physicians.

There is a thin borderline here as well, between the "alternative sources" and the "ineffective care" arguments. The person who self-refers to a specialist with a problem that is well within the capability of a general practitioner, is similar to the person who goes to the emergency ward with a real but non-emergent problem. The extra capabilities of the specialist, or the emergency ward, are "ineffective" in the sense that they provide no additional health benefit. In each case a user charge may serve a steering function, assuming that the alternative, equally effective and less costly services are also equally accessible.

But the "alternative source" ground for (highly selective) user charges could be considerably expanded in the future, if a wider range of service providers could be introduced. And here the encouragement of use of general practitioners in Canada provides a leading and very successful case. In systems as divergent as the United States and Sweden, there has been the same move toward an overwhelming predominance of specialists in medical care. Canada, like the U.K., has preserved a more equal ratio of generalists to specialists. In both the U.S. and Sweden, it is now generally recognized that the over-emphasis on specialization has led both to higher costs and to less effective care, but the mix of practitioners is not easy to change.

The Canadian success has been the result of deliberate policy decisions, by both physician organizations and public regulatory and payment bodies. Left to themselves,
health care systems seem to drift naturally toward over-specialization. The discouragement of self-referral to specialists has been only a part of the policy "package" to maintain the role of the generalist; educational policies have probably been even more important. But the general point is that "steering" user charges may play a helpful supportive role in managing the provider or institutional "mix".

One might wish to take this idea farther, for example by revisiting the nurse practitioner concept which has been dormant for twenty years and providing more of primary care in well-baby or geriatric clinics with a higher ratio of auxiliary staff. Differential charges could form part of such a strategy. The B.C. Royal Commission [10] addressed this same point with its recommendations for an increased use of per diem charges in acute care hospitals for people who are receiving \textit{de facto} long term care.\footnote{There are many reasons for this, not the least of which are the tendency for provincial fee schedules to favour procedural specialties and sub-specialties, and the failure of academic medical centres to promote the prestige and importance of primary care [17].}

\footnote{Such a strategy, however, must recognize explicitly that the employment of less costly, less "human capital intensive" inputs -- nurse practitioners instead of physicians, for example -- does not necessarily result in more efficient care. Duplication of functions, or engagement in "feel good" activities which make both staff and patients happy but have no detectable impact on health, can easily lead to significantly higher costs of care. Alternative providers or institutions must be managed and budgeted at least as tightly as the present system, if they are not to become just another source of system "add-ons". Again, the B.C. Royal Commission emphasized this point in its recommendations for expansion of home care services.}
For services which make it all the way through our algorithm, however, the case for user charges appears rather weak. If a service is incontestably medical in intent, and is effective, and is regarded by the community as necessary, and can be provided in no other, less costly way, why would one want to impose a user charge? At that point one of the standard arguments against user charges, that they tax the sick, seems wholly justified. Such charges may be highly effective as a revenue raising device, but why would one regard the experience of illness, and the use of effective care, as an indicator of taxable capacity or ability to pay? No answer ever seems to have been offered.

In Ontario, oxygen therapy for out-patients provides an example of just such an illogical pattern of coverage and charges. It is fully covered for seniors, at present, under the Ontario Drug Benefit Plan, as well as for people on social assistance, and (up to six months) for those in palliative care. Those born after July 1, 1963 are covered under the Assistive Devices Program, but must pay out of pocket 25% (currently about $1100 per year) of the approved rates negotiated between vendors and the Ministry of Health. (Those between the ages of 30 and 65 are apparently left out.)

Oxygen therapy is clearly a health care service. Both programs require medical certification of chronic hypoxia, and no one appears to have raised a question as to the effectiveness of the therapy, so the question of medical necessity presumably does not arise. So what is the principle underlying the part charges in the ADP, and the exclusion of some age groups entirely? Is there some evidence that people are more careless with their use of oxygen when it is free? Or is there some collective judgement that people with hypoxia should make a larger contribution to the financing of health care?

On a much larger scale, the basis in principle for the survival of user charges in pharmacy seems to be equally obscure. The political, legislative, and administrative history is clear enough, but what possible ground is there in logic for charging for drugs which are available only on a physician’s order? There may be widespread misuse of prescription drugs; certainly there is a great deal of expert opinion, and not a little evidence, to that effect. But the whole point of a prescription regime is to take the utilization decision out of the patient’s hands, and place it with a competent expert.

As Hurley and Johnson [18] point out, user charges are more likely to reduce the overall use of prescription drugs than of hospital or medical services, because those providers whose incomes would be reduced as a result cannot as directly influence the utilization decision. And indeed the evidence does indicate that user charges reduce use, but they do not selectively reduce inappropriate use [18,19]. Students of the use and abuse of prescription drugs have consistently concluded that inappropriate prescribing behaviour is the source of both excessive use and the resulting cost escalation, and that the roots of this problem lie far deeper than can be reached with user charges directed
at patients.

"Though co-payments are a tempting quick fix, they must be viewed as the band-aid solution they are. They can help slow the bleeding of funds from provincial treasuries, but at the price of diverting attention from the cause of the wound."
[18, p. 487]

It is hard to resist the conclusion that user fees are a way whereby payers can shift the escalating costs of drugs onto patients while avoiding the politically difficult actions -- addressing prescriber behaviour and the marketing practices of drug companies -- that would be necessary to limit their inappropriate use. The federal government has taken this process of evasion to a higher level still, by passing legislation deliberately designed to raise the prices of prescription drugs, and then reducing its financial contributions to the provinces and pointing with concern to the high costs of "social programs".

User charges in pharmacy thus provide a good example of the way in which such charges can lead to increased costs of health care, by shifting the financial pressure away from those in a position to take effective action, and onto those who cannot. Effective action is politically difficult, as it necessarily threatens both incomes and professional prerogatives. Cost shifting, particularly once the user pay principle has been accepted, as in pharmacy, is much safer.

A partial exception is provided by a user charge policy introduced some years ago in B.C. Seniors, whose prescriptions were previously fully reimbursed, are now required to pay a proportion of the dispensing charge, up to an annual ceiling. The intent was to reduce the number and amount of dispensing fees, by encouraging patients to demand larger quantities of drugs in each prescription and to seek out pharmacies with lower dispensing charges. This, we believe, falls under the category of a "steering" charge, intended to encourage the choice of an equally effective but less costly style of care.

Policies to encourage the use of lower priced generic drugs have sometimes relied on user charges for similar "steering" effects. Going beyond efforts to inform

26. Pharmacists, whose incomes were the deliberate target of this policy, argued that for a variety of reasons the large-prescription "alternative" was not equally effective. We take no position here on this point; those introducing the policy clearly believed that they were encouraging an equally effective, less costly form of care -- making less use of whatever services are provided during the dispensing process. Apparently the policy did reduce payments for dispensing, but it is not clear that total costs fell because more was paid out for ingredients. The user fee itself, however, transferred part of these costs from public to private budgets -- taxing the sick again.
prescribers about the relative costs of different versions of a drug, public programs have permitted pharmacists to dispense generic equivalents to prescribed brand-name drugs, and in some cases limited reimbursement to the price of the lowest-priced equivalent. If the drug actually dispensed costs more, the patient pays the difference.

But for such steering charges to guide behaviour, the patient must both have alternatives, and know that they exist. In general patients are not informed as to the choices available. And even if they were, the intent and effect of present federal drug patent legislation is to restrict the availability of competitive equivalents and enhance the monopoly power of suppliers of patented drugs. Where there is no choice, there is no steering effect; user charges can only shift costs, not lower them.

Dentistry is also a bit of a puzzle in principle. Do we regard dental care as not a health care service? Is it not effective? Are there alternative sources of care? Or do we as a society simply judge it "not necessary"? Again the realpolitik aspects are clear. Provincial governments did not want, in the early 1970s, to take on an additional large spending commitment, and dentists feared, quite rightly, that a public plan would limit their freedom in pricing and perhaps also in patterns of practice.

The existing system preserves professional autonomy and incomes, and limits the overt financial exposure of governments, although private dental insurance, which is quite widespread, is subsidized by the federal government through the income tax system. As a result, dentistry in Canada is a good deal more expensive and less efficient than it could be, but the resulting extra costs are widely dispersed among taxpayers, employees, and purchaser of products, very few of whom know that they are bearing such costs. The beneficiaries, on the other hand, are highly concentrated and self-aware, making change unlikely. The outcome reflects interest, if not principle.

In terms of our algorithm, virtually all of dentistry falls comfortably within the realm of health services. Questions arise at the next step, as much of what is offered as "preventive" dentistry may be of questionable effectiveness. The "six monthly check-up" apparently never had any evidentiary foundation, and the benefits of topical fluoride treatment for populations whose drinking water is fluoridated, are also doubtful.

At the third step, the borderline between "needed" and elective cosmetic care is as always thin. But there seems little doubt that a substantial share of orthodontic treatment is purely cosmetic, and indeed some dental organizations have begun to market it on this basis. On the other hand, the provision of comprehensive dental treatment for children (which in practice requires a school-based, public program, not subsidized private care) yields not only immediate payoffs in dental health, but important preventive benefits over adult life.

Finally, there is extensive evidence, and has been for many years, that there are
much less costly alternative sources of care than the general (or the specialist) dentist, which dentists collectively have used their self-regulatory privileges to suppress.

In general, dentistry provides an excellent example of the irrelevance of user fees, their powerlessness to induce structural change and improve efficiency and effectiveness in a sector of health care which remains under the tight regulatory control of the established providers. It also illustrates the strength of the phenomenon of "regulatory capture" -- governments which are not themselves at financial risk from provider behaviour, are responsive to concentrated provider interests, not diverse public ones. Just as in the case of the federal patent drug legislation, providers are able to secure a legislative and regulatory environment in which patients are denied both information, and access to alternatives. The "free market", isn't; patients can only respond to user fees by paying (or doing without) [20,21].

There are some remaining anomalies in the relationship between dentistry and government. If dental care is outside the public health care funding system, why is it subsidized by the federal government through tax expenditures? Dental insurance premiums paid by an employer are a deductible expense, a labour cost, but (unlike medical insurance premiums in those provinces which retain them) they are not taxable in the hands of the employee. This form of subsidy is more valuable to those in higher incomes and higher marginal tax brackets; it also provides absolutely no influence for the donor government over either dental fee levels or practice patterns. It would be interesting to know how much dental insurance coverage would continue if this subsidy were withdrawn (by making employer-paid premiums a taxable benefit) and what the impact would be on dentists' fees and incomes.

Another form of public subsidy is provided for those dentists able to use free public facilities -- hospitals -- in their work. Most dentistry requires a considerable investment in equipment and support staff. The dentist who has access to a hospital operating room need not bear these costs, yet he can charge the same fees as his colleague in external practice, thus pocketing a substantially higher net fee. Moreover the oral surgeon, who works at the intersection of medicine and dentistry, can bill the public medical insurance program for certain surgical services if they are provided in a hospital setting, as well as having the costs of anaesthesia and other support services covered from public budgets. And while the fees from the public plan may be negotiated, the dentist retains the right to bill the patient in any amount he chooses for associated office services -- in effect open-ended extra-billing.
Patrolling the Borders, and Beyond

Such questions lead us into a much wider area, the general problem of "opportunistic behaviour" in an environment of multiple funding sources, public and private. What opportunities for profitable manipulation or malfeasance are created by alternative forms of financing? And in a market or quasi-market environment, what are the possibilities for controlling them?

As Wennberg [22] has pointed out, even in an environment hedged around with professional norms and restrictions on opportunities for overt profit-seeking behaviour the fertile imaginations on practitioners and their natural optimism and urge to intervene will generate plausible new manoeuvres (or variants on old ones) faster than these can be tested for safety or effectiveness. When these expansionary tendencies are combined with direct economic incentives, the problems of regulation and control become an order of magnitude more difficult. The current American experience in trying to combine "market forces" with regulatory protection of the public do not encourage optimism [23,24].

Public regulation of health care, whether direct or through delegation to professional bodies, has always been justified as providing protection for "vulnerable interests" -- the interests of those who, for a variety of reasons, would be unable to protect themselves in arm's-length transactions, or who are simply not represented in a transaction which nevertheless may have significant effects upon them. Indeed, the protection of vulnerable interests underlies all professional regulation.27

Regulation of health care services has tended to emphasize the protection of people whose interests are vulnerable because their capacity is impaired, either by temporary or permanent physical or mental disability, or more commonly because they do not have and cannot reasonably obtain the information necessary to make decisions on their own behalf [26]. Despite the rhetoric of consumerism, most health care is provided to people who are in fact patients, heavily reliant on the expertise and good faith of physicians or other professionals to guide their decisions in their own best interests.

The emphasis on good faith is critical; the mere possession of expertise is no guarantee that it will be used in someone else's interest. In an arm's-length transaction between parties each pursuing their own interests, knowledge is power -- or wealth -- and the party who is ill-informed may expect to come out on the short end. Professional ethics backed up by professional regulation is intended to discourage (though in an imperfect world it cannot wholly prevent) opportunistic behaviour by professionals using

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27. One of the best expositions of the justifications for and forms of professional regulation is provided by Trebilcock et al. [25].
their superior information to exploit their patients (or clients, or consumers).

In this process there is always a tension between professionalism and economic incentives. There is money to be made (or other benefits to be gained) by exploiting vulnerable interests, otherwise there would be no problem. In general, and most of the time, professionals do seem to behave ethically, that is, they forego opportunities for personal gain which would involve exploiting the informational or other vulnerabilities of their patients. But all systems of payment, of whatever form, embody patterns of economic incentives; and professional behaviour is the resultant of a shifting balance struck between these incentives and prevailing ethical norms. (The balance shifts because, even if the payment system itself is static, the changing technology of health care is constantly changing the incentives embodied in that system.)

Changes in the payment structure, in particular changes in the mix of public reimbursement and user payment, may also shift that balance. Thus the importance of considering the possibilities for opportunistic behaviour implicit in such changes. In general, the interests which may be vulnerable fall into two categories: (i) patients themselves, who may be at greater risk of financial exploitation in a user charge system, and (ii) other citizens, who may find themselves carrying extra costs as a result of the "private" transactions of patients and providers.
Privatize the Profits, Socialize the Costs

The latter form of opportunism, threatening the interests of other citizens, is perhaps the easier to recognize and to deal with. We mentioned above the example of the private dentist who gains access to public hospital facilities, in which he performs procedures for which he bills the patient (or the patient’s insurer) privately, and for some services may in addition bill the public medical insurance plan. The overhead costs are paid by the taxpayer; the revenues accrue to the dentist.  

A similar "cost spill-out" has been identified in the case of in vitro fertilization. There has been some contention as to whether such services are "necessary" in the terms of our algorithm above, or whether they should be left to the private sector and private payment. The recent Royal Commission of New Reproductive Technologies [27] has recommended that coverage for IVF be included within the Canadian health insurance programs, but only for demonstrably effective services.

But could IVF services be treated as a purely private transaction, even if one wanted to? IVF patients have an increased risk of multiple births, and of low birth weight babies. These can be exceptionally expensive to care for; at present such costs would be covered by the public reimbursement plans. The fees for the service are collected privately, but (some of) the cost is borne by the public. Could one impose a tax on the private clinics, or require them to post a bond or purchase private insurance, to cover any downstream health care costs arising out of the "private" medical transaction of IVF? If so, those costs would have to be passed on to patients, and one can confidently predict protests not only by private providers of such services, but also by their patients. But if IVF is to be treated as a private transaction, with private, for-profit provision, why should the rest of us cover part of the costs?

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28. Physicians also use hospital facilities to care for their patients; several specialties could hardly practice at all without such free "overhead". In (Canadian) medicine, the public provision of facilities for private practice is the norm. The difference, however, is that physicians' fees are negotiated with, and paid by, the same public agency -- typically the Ministry of Health of the province -- which funds the hospital services. That agency is in a position to take into account, in its negotiating position, the fact that it is through another budget providing these overhead services for free. Private dentists, on the other hand, set their own fees unilaterally, and those fees include a substantial overhead allowance. A dentist who enjoys free access to public facilities thus collects a larger net fee. (As noted above, fees for oral surgery services provided in hospital are negotiated and paid by the provincial insurance plans, but the fees for any associated services not so reimbursed are completely under the practitioner's control.)
Yet another example: it can be (and has been) argued, that seniors with their own means should be allowed, or even required, to purchase long-term care privately. If a well-off elderly person chooses to pay for particularly comfortable and expensive surroundings, that is surely no one else's concern. But the facts of biology are that elderly people, like everyone else, become progressively older, and their capacities progressively fail. And incontinent or deranged patients are not welcome in comfortable and expensive facilities, either by the operators (they are expensive to look after) or by the other residents (they are unpleasant to have around). Thus the "private" contract between facility and resident may well specify that residents whose physical capacities deteriorate past a certain point must leave -- the facility is not equipped to handle "medical" problems.

This makes perfectly good commercial sense, and is probably quite acceptable to residents as well. But it opens the very real possibility of a form of private "spend-down", in which the aging person is welcome in private facilities until her health and her money run out, after which she is "dumped" into public facilities, at public expense.29

Private contracts which have annuity elements, specifying an initial large capital payment in return for care until either death or deterioration, would be particularly open to this form of opportunism. Like the private insurer, the private facility operator is very interested in "customers" with ample resources of health and money, but must shun those without. The financial transition may be speeded up by offering expensive services early on in the institutional stage of life.

29. The term "spend-down" is drawn from the American Medicaid program, where patients must become impoverished to qualify for public coverage of long-term care. The American experience illustrates how easy it is to go down this road, and how difficult to get back, precisely because all the private incentives push in this direction.
Are Markets "Free", When Services Are Not?

Perhaps the most difficult problems of protecting vulnerable interests, however, arise from the opportunism which threatens patients themselves. There is a deep inconsistency between long-established practices and habits of thought in the health care sector, and those in the private marketplace. In the marketplace, the fundamental protections for "consumer" interests are information and choice. Knowing your own needs, knowing what products are available at what prices, and being able to choose among alternative and competitive suppliers or products, permits you to identify and avoid opportunistic behaviour -- over-charging, faulty products, false advertising -- by suppliers. In addition, of course, there are various regulatory restraints and legal remedies to discourage such activities.

But in the health care field, both the regulatory framework and the behaviour of providers has always worked deliberately to block the operation of market forces, on the grounds that the patient's interests were better protected by a combination of professional ethics and public regulation. This argument should not be dismissed lightly. There is neither experience nor a priori grounds to support a casual assumption that "the market" -- whatever that means -- would necessarily lead to a better functioning health care system [26].

But if, through "de-insurance" or user charges, we move services outside the present framework, how do we mobilize the alternative forms of protection for consumer interests through the market? If we do not, then users are open to exploitation, financial or otherwise, by providers. The problem is two-fold. Do consumers have choices available to them, and do they have enough information to make the right (for them) choices?

As an example, consider a situation in which opportunism has not been a problem, although it could be. "Preferred accommodation" in hospitals, that is, private accommodation for which there is no medical indication, carries an extra charge which is retained by the hospital. Suppose a hospital administration adopted a policy of limiting access to regular ward beds, such that patients unwilling or unable to pay extra for "preferred accommodation" had to wait longer for admission. If the hospital could also set its own preferred accommodation charges, this could be quite a profitable strategy.

As far as we know, this has not happened in Canada. The limitations on such behaviour include physicians, who would object to limitations on their patients' access to beds, hospital trustees, representing the community interest as well as the hospital, and patients, who would be able to create a political response. Most hospital managers in Canada would also regard such opportunistic behaviour as improper, even if profitable.
But "the market" does not impose any restraint. Patients go to the hospital at which their physician has privileges; in many communities there is only one hospital, and in any case hospital managements have many avenues for collusion, which they regard, quite properly, as co-operation. When Canadian hospitals are presented with the opportunity, e.g., a foreign patient with insurance -- or even without -- they do price quite "aggressively", and the patient has little or no recourse.

Fear of hospital and medical opportunism also underlies resistance to proposals to permit Canadian hospitals to expand their resources by offering services to U.S. patients, on a fee for service basis [28]. If this could be done without in any way reducing access by Canadian patients, it is hard to see a basis for objection. But it is equally hard to see how hospitals and physicians, presented with the opportunity to increase their incomes by caring for Americans, would not begin to favour the more profitable clientele. Assurances to the contrary are worth very little without an effective monitoring and enforcement system; such does not now exist and it is not clear how one might be designed.

Coming back to the "easy" cases -- illness certificates, or tattoo removal, for example, if they are "not health care" for payment purposes, are they health care for licensure purposes? Must the "customer" receive the care only from a specifically licensed person, or could others compete for the market? Could licensed practitioners not only set their own fees, but advertise them, and would collusion over fees or restrictions on advertising be in violation of federal competition legislation?

The core of the problem is, how does one encourage, and indeed enforce, competitive behaviour by professional providers in a small set of "markets" while simultaneously protecting the pattern of ethical, regulated, and necessarily highly cooperative behaviour in the rest of their work? But if providers of services for self-paying "consumers" are not under the discipline of a competitive market, how can one ensure that fair prices are charged, and an appropriate range of services is made available?

The problem may not be insoluble, but if a larger range of services is to be left to "the market", it must be understood that free markets do not come into existence or persist automatically. They are a human creation, an institution, not a law of nature, and there is always a strong incentive for some of the participants in a market, usually the sellers, to seek out ways of manipulating the market so as to limit consumer choice and raise prices (as Adam Smith pointed out long ago, though many of his more recent admirers have conveniently forgotten).

In both dentistry and pharmacy we find strong and generally quite successful efforts by professional organizations to limit consumers' access to alternative providers, to restrict the availability of comparative information on service prices, and to encourage price collusion. In both of these fields, public authority has been co-opted by
professionals to serve their private interests by protecting their prices and their markets, at considerable cost to the consumer. Concentrated professional interests have carried much more weight, politically, than the diffuse interests of consumers, because governments themselves are not paying the bills.

One possibility for overcoming the natural professional reticence about overt market competition, is to encourage entry by new forms of provider organization [21]. Thus one might permit for-profit corporations to offer for a fee those services which are excluded from the public reimbursement plans because they are judged "not health care", or "not necessary", or simply not yet proven effective. And indeed such organizations are now attempting to move into the "market" for IVF, as well as offering some forms of prostate and eye surgery whose effectiveness is as yet open to question. There are also moves afoot to offer for-profit diagnostic services over and above those publicly available in the hospital system.

Such developments, however, can also represent serious threats to the vulnerable interest of the uninformed patient -- threats of several different types [21]. The firm stand taken by the Report of the recent Royal Commission on New Reproductive Technology [27] against for-profit enterprise in this field, and in support of national licensing and stringent regulation of providers of fertility services, is based on an explicit recognition of these threats and a judgement as to their seriousness. But the same concerns underly the long-standing and widespread unease about, if not out-right hostility to, the operation of "normal" commercial enterprise in the health care field.

The traditional concern is for "quality of care" in the narrow sense of "doing things right". It is feared that a concern for profits will lead to cutting corners, relaxing standards of procedure, in a way that endangers patients. Such behaviour is not unheard of in not-for-profit organizations; hence the need for external regulation and accountability. But profit-making is believed to add another powerful motivation competitive with quality maintenance.

Professional organizations have over the years developed a number of institutions and procedures intended to maintain "quality" in this narrow sense. More recently, however, students of health care have begun to draw attention to the equal importance of "doing the right thing" -- of providing services which are effective for the purposes claimed, and which match the needs of the particular patient. Again, the Royal Commission [27] identified and raised concerns about the widespread provision, in the private sector, of fertility services which are ineffective or frankly experimental, to patients whose likelihood of benefit is minimal at best. They concluded that the only feasible remedy was to eliminate for-profit provision of fertility services, while providing

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[30] The Royal Commission, for example, found cases of private clinics providing artificial insemination services without testing the donor semen for HIV infection.
coverage under the public insurance plans for those known to meet some minimal standard of effectiveness.

The same "marketing" problem arises with respect to the suggestion that private providers be permitted to offer services parallel to the public system. The patient will be told she "needs" a particular procedure that is either not available through the public system, or available only after an unacceptable wait. The provider who has an equity interest in a for-profit facility, has a powerful economic incentive to oversell the value of the service, and to minimize its risks. This is not to say that there are no ethical restraints remaining to restrict such behaviour, but only that the balance of interests is shifted. The greater the economic interest, the greater the marketing effort.

This is not a hypothetical possibility. The special problems with new reproductive technologies are new, but the extraordinary marketing efforts of the for-profit drug industry are notorious, and have been for decades. The medical literature also contains clearly documented examples of patients undergoing higher, sometimes very much higher, rates of diagnostic investigation when the practitioner has an equity interest in the facility [29]. And the public advertising for certain new for-profit surgical facilities in the Toronto area, contains no warnings of the professional uncertainties associated with the procedures they offer. Leading figures in the medical profession, world-wide, have sounded very direct warnings about the threat to both physicians and patients from increased reliance on economic incentives to motivate professional decisions [30].

Yet "marketing" in the encounter between provider and patient is virtually impossible to control from outside. The provider may be offering a service performed in a "high-quality" manner, to a patient who is unaware of the evidence (or lack of it) of effectiveness and emotionally vulnerable. Hence the heavy reliance placed by professional organizations on inculcating and maintaining professional ethics, backed up but not substituted for by regulations and external oversight. Thus if services are simply excluded from public coverage and left to the private marketplace, the problem of acquisition of valid information on which to base decisions is likely to become even more acute than it is in a professionalized system.

This may not be a conclusive argument against withdrawing coverage -- imperfect information is a problem for consumers of other products as well. But it emphasizes yet

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31. If in addition that provider has access to, and some influence over, the corresponding public facilities, the possibility arises that s/he may deliberately manipulate patients' access to those facilities, so as to encourage the use of the private service. This has been, prior to the recent reforms, a long-standing complaint about the behaviour of private consultants in the British National Health Service.
again that if one expects any forms of deinsurance or user fees to change consumer behaviour, to encourage them to make informed and rational choices, then the transactions which they participate in have to be structured such that they can get valid and relevant information, and have the opportunities to use it. Otherwise charging patients is merely a "tax on the sick", with or without opportunities for providers to circumvent public controls on prices or marketing behaviour.
REFERENCES


