WHY NOT USER CHARGES?
THE REAL ISSUES

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Preface

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

In this paper we examine some of the most frequently heard arguments for user charges and look 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. The paper 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.

While this paper provides an overview of the issues from a popular perspective, other forthcoming papers focus on specific, and sometimes more technical, dimensions of the user charge debate. A brief description of each paper follows (titles are tentative).

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

"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 claims of their supporters refuted by analyses of the effects of such charges), the 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, the sick, the rich and the poor), between payers and health care providers, and among providers. The paper uses the framework to analyze the income transfers associated with different types of user charges.

"It's Not the Money, It's the Principle" examines why user charges exist for some health care services and not for others. The paper analyzes the characteristics of services which (do or should) underlie decisions to charge in part or in whole for specific types of services.
In addition, a bibliography entitled "User Charges in Health Care" provides an extensive set of references to articles of relevance to the user charge debate in Canada, drawn from diverse sources including academic research and policy analysis literature, the popular press, government documents and reports, and the publications and reports of non-governmental organizations including the professional associations representing a variety of health care providers.
Why Not User Charges?
The Real Issues

Like the pink Energizer rabbit with the sunglasses and the drum, the debate about user charges in Canada's health care system keeps going...and going...and going. It began at least fifty years ago, during discussions about how or whether to create a universal, publicly-financed hospital insurance programme, and it has re-appeared at regular intervals ever since [1].

The debate seems particularly likely to re-appear whenever strong government efforts are being made to hold down increases in health care costs. These efforts are most apparent when economic times are tough, and at present they are very tough. With the Canadian economy still wobbling from recession, provincial treasurers fighting to hold down deficits, the federal government restricting the flow of funds to the provinces for social programmes, and the newspapers full of stories of cutbacks in public services, the question that more and more people are asking is, "Why not have user charges for health services?" Why not indeed?

There is no simple answer to this apparently straightforward question, because it is nowhere near as straightforward as it at first appears. In other articles in this series we identify the numerous and changing reasons that a variety of organizations and special interests have historically used to advocate user charges [1,2]. We examine the likely impact of different forms of charges on important policy objectives [2,3]. We also examine who gains and who loses when user charges of various types are implemented and how the distribution of expected gains and losses is, not surprisingly, related to who proposes and who opposes such charges [1,2,4,5].

Here, however, we have a more modest goal. In this article we examine the most popular reasons given today for introducing user charges, in the language and spirit in which they are typically presented. Our presentation of the leading arguments is based on a variety of sources including stories in the media (newspapers, magazines, radio and television), discussions with people in government (both elected politicians and civil servants), discussions with health care providers (including doctors, nurses, other clinical professionals and hospital administrators) and, most important, conversations with ordinary Canadians with no special knowledge of the health care system, nor any special interest in it except that they want it to be there when they need it, providing effective services at a reasonable cost.

We try to probe popular statements and untangle their mixture of arguments in an attempt to uncover the fundamental issues in the debate and present more clearly some of the choices that Canadians are making, whether they know it or not, when they support or oppose a user charge policy. It is an important debate and one that is not likely to end soon, if ever; this is all the more reason to raise the level of information available and to encourage discussion of the real issues.

What are User Charges?

User charges can take many forms and different people may mean quite different things when they talk of user charges. As its name implies, a user charge is a cost to the patient that
varies directly with the amount of service used - the more you use the more you pay. How much you pay can vary; charges, like prices, can be high or low, and they may vary from one person to another depending on age, income and how much a person has already paid. When you pay can vary; charges might be paid at the time of service, or later, say at the end of an episode of care, or a taxation year. Who collects (or keeps) the charge can vary; charges may be paid to providers like doctors and hospitals, or may be paid to government. What services the charges apply to can vary; physician services (both general practitioners and specialists), hospital services (including acute in-patient care, chronic or extended care, emergency room, and out-patient services), laboratory services or drugs inside or outside hospital, long term residential care, optometry, or any other type of health care may be subject to a user charge policy.

How you pay may also vary. Extra-billing by physicians (billing patients for amounts above the provincial medical insurance plan benefit) and a flat fee per service (a fixed fee for each physician visit, every day in hospital, every visit to the emergency room, or every prescription filled) are the types of user charges that Canadians are likely most familiar with. Charges may also take the form of deductibles (the patient pays the entire cost up to some fixed amount, as is common with automobile and house insurance and many provincial drug plans) or co-insurance (the patient pays a percentage of the cost). Combinations of types of user charges are also possible; for example, a coinsurance charge of 10% or 20% up to a maximum "out-of-pocket" cost to the patient of $200 or $500.

Premiums of the type which used to exist in most provincial health insurance plans (and still do in Alberta and British Columbia) are also sometimes referred to as user charges, but they are not. The premium may vary with income or family size, but does not depend on actual use of health care. In fact, these premiums are not really insurance "premiums" at all, but a form of tax. They are unrelated to risk, and are compulsory for most people. Moreover, provincial residents are fully entitled to health care services whether or not they have paid premiums. (Although this is not widely known, it is the law.)

Two forms of user charges which are increasingly mentioned are deinsurance and taxing insured health care benefits. The first refers to the removal of specific services from the schedule of insured benefits for which provincial governments will pay health care providers. For example, Ontario recently deinsured visits to physicians to obtain medical certificates required by third parties for absences from work, for travel, or for participation in sports, camps or other recreational activities. If physicians choose to charge for these, patients (or the third parties) will pay the full cost for each service. The second refers to the inclusion of the value of publicly insured health services used during a year in an individual’s income, as a "taxable benefit", for the purpose of calculating personal income tax. For example, if an individual’s physician visits or hospital stays cost the provincial health insurance plan $500 in a year, then the individual would pay tax on this as if it was $500 of income. Again, this may be combined with some upper limit on the cost for which patients are liable.

It would not be useful, and is probably not possible, to try to consider here every conceivable form of user charge, let alone how each might be applied to different services. This
is done, in part, in other articles in this series [2-4]. In this article we deal with general themes and with characteristics which most user charges have in common. When the point being discussed pertains to one specific type of charge, we make that clear. Also, we focus on physician and acute hospital services unless otherwise indicated.

**Popular Arguments for User Charges**

Those in favour of user charges usually make one of two popular arguments. The first stresses "responsibility" and the second stresses "affordability". They go something like this:

*People abuse the health care system because it's free; user charges would reduce unnecessary use and encourage people to act more responsibly.*

and,

*Health care costs are out of control. We can't afford our current system. We need more money, and what's wrong with letting people who can afford to pay a little more do so?*

Let's take a closer look at each of these arguments.

**The Responsibility Argument**

There is no doubt that people believe that patients abuse the health care system, though when asked individually, few think that their own use was unnecessary! More troubling, however, is the fact that people can't seem to agree on what "abuse" means, how important it is, or who really causes it. Even if it is significant and patients are to blame, there is a big question about whether user charges are the best way to eliminate it.

*What is abuse?* The usual reply is that it is use that "isn't necessary", but what exactly does that mean? Does it mean the use of services that did not improve the patient's health because there wasn't really a problem requiring medical care (either because the physician could do nothing about it or because the patient could have taken care of it personally)? If so, how often can patients be expected to know that in advance? Perhaps it is not unreasonable, for example, to expect a parent who has already raised three young children to recognize that a common cold in a fourth child is only that - a common cold that will go away on its own and the symptoms of which can be taken care of with home remedies or medications easily purchased at the drug store. But what if the cold seems "a little different" than usual? And what about more complicated situations, like the person who has been under a lot of stress and feels tightness in his chest at midnight after eating a spicy meal? Diagnosing problems, including providing reassurance that they do not exist, is an important part of health care. When it is said that user charges will make people think twice before going to the doctor, what that in part means is that people will have to diagnose themselves more often and decide the likely seriousness of their condition. Often they may make the right decision, but sometimes they may not, and the consequences may not be good. What proportion of health problems people can accurately judge
for themselves is a question on which there is much disagreement and little evidence.

Experts and officials also have difficulty defining in advance what is medically necessary. Although provincial health insurance plans exist to provide payment for "medically necessary services", no province has explicitly defined what that means. Need is often defined by health policy analysts and physicians as the capacity for the patient to benefit from using a service. But what is "benefit", and who determines it? The usual reply is that medical experts are best able to determine it, though often only after the fact. (As a thoughtful physician colleague says, "necessity is a diagnosis of hindsight"). A study of unwarranted use found, however, that a random sample of one-thousand Ontario family physicians could not agree on examples of abuse whenever questions of medical necessity were involved, although they were able to agree that inconsiderate behaviour (like failing to show up for an appointment) was abuse [6].

Abuse might also be interpreted to be frivolous use, or use of services that isn't worth it. In these cases, there is a medical benefit to the individual patient who uses the service, but it is small. More to the point, it is seen by others as being small relative to the cost to taxpayers as a whole.

This raises a very different set of issues about how society wants to establish priorities and/or distribute the costs of beneficial services. If "medically necessary" doesn't mean any and every service capable of improving (even by a little) at least one patient's health -- a definition which leads to an infinite range of services -- then lines must be drawn. 

Research studies can provide important information to help with this task, but they can only go so far. They can, and should be used to, establish the size of the benefits and costs of specific medical services, and determine how these vary across different groups of patients and under different clinical circumstances. But they cannot decide whether the medical benefits involved are worth buying and, if so, for which groups or under what circumstances. These are political and ethical judgements rather than technical ones [3,7]. They involve society's basic values and the way in which those values will be applied to the financing of health care.

How important is patient-initiated abuse? This depends partly on how abuse is defined. Estimates of the extent of abuse will likely be larger if it is defined to be "use that others think isn't worth it" than if it is defined to be "use that is not medically necessary". If it is defined as "use that is known in advance to be not (or even probably not) medically necessary", then it will be smaller still; indeed, with this definition it could be very small.

Solid evidence on the extent of abuse, by any definition, is very hard to find. A study of Montreal physicians shortly after the introduction of public medical insurance in the early 1970s found that they felt that less than 2% of patients sought medical advice without reasonable cause [8]. A 1980 study of Ontario physicians reported that they felt that 8-12% of contacts by patients were unnecessary [9]. These are old studies, however, and we are unaware of any recent, more accurate estimates, or more importantly, any studies that take into consideration what patients might reasonably be expected to know in advance of seeking advice. So, although
it is commonly claimed that patient-initiated abuse is important, and most people can think of one or two good examples of abuse, statistical support for the claim is weak at best.

In fact, it is difficult to see how patient-initiated abuse could make up a large share of overall health care use and costs, because patients have little control over most of the decisions about the use of care. Call-back visits, referrals, hospital admissions and prescriptions, for example, all depend on the judgement and approval of a physician. No doubt there are some patients who "demand" a hospital procedure or a prescription, but the picture of patients eagerly requesting surgery or wanting to take medication just because the services are "free" makes even advocates of user charges laugh. (What is meant by "patient" demands is not always clear either. For example, patients are increasingly requesting cholesterol tests, but would they be doing this if there had not been the massive recent publicity campaign about cholesterol, largely organized by pharmaceutical companies, despite controversy over the effectiveness of their cholesterol-lowering drugs?)

In very rough numbers, physician services make up about 16-20% of all health care expenditures (hospital services and drugs are the other two main categories). Patients can probably get access to about half of physicians services (including general practitioners', and some of the services in paediatrics and internal medicine) without a referral. So the potential for patient-initiated abuse exists in approximately 8-10% of total health care spending. But all of these physician services are not first-visits initiated by patients. Some are return-visits initiated by physicians. Nor are all patient-initiated, first-visits unnecessary; far from it, most are justified. This means that the maximum share of total health care spending caused by patient-initiated abuse is very small indeed. For example, if one-quarter of physician visits are return-visits, and (say) 10% of the first-visits are unnecessary, then the share of total health care spending caused by patient-initiated abuse is less than 1%. And again, it is even smaller than that if "abuse" is limited to use that patients could reasonably have been expected to know in advance was unnecessary.

Compared to patient-initiated "unnecessary" use, the "inappropriate" use of services generated by physicians themselves is a much larger problem, and one which user charges will not address. Research studies consistently show that physicians order or perform services that are not clinically justified [10,11]. Some procedures are performed too frequently, and others are used in the wrong situations to be effective. (In addition to this, many current procedures have never been evaluated, so their effectiveness is unknown, and many effective and appropriate procedures are provided in facilities or with personnel that are more costly than necessary.)

Estimates of the extent of physician-generated inappropriate use vary, but are sometimes as large as 30-40% of all services including hospital services and drugs [12,13]. Physicians themselves acknowledge that this is a major problem [14,15], and experts agree that this problem deserves more attention than the much smaller amount of unnecessary use initiated by patients. The need to evaluate and restructure the way physicians and hospitals provide services has been a consistent recommendation from the many commissions of inquiry into the Canadian health care system over the past twenty years. In almost all cases, these inquiries have not seen the way
patients use services to be the problem, nor user fees to be the solution.

Do user charges reduce unnecessary use by patients? There is not much evidence that addresses this question directly, but what evidence there is does not support the claim that user charges lead patients to decrease their use of only unnecessary or less necessary services. In a major experiment with user charges conducted in the United States by the RAND Corporation, researchers found that user charges were about equally likely to deter patients from using both unnecessary and necessary services [16].

Although the argument that patients will give up the least necessary services when they have to pay seems intuitively correct - after all, common sense says that this is what they should do - the finding that they do not seem to behave this way is perhaps not so surprising after all. Health care isn't like other products and the "market" for health care cannot be analyzed the same way as the market for shoes or VCRs. As noted above, people often do not have sufficient information in advance to make correct judgements about necessity. This is precisely why they consult their physicians.

On second thought, the answer to the question, "Who will user charges deter from using services?" is "Those people who are sensitive to having to pay a ‘price’ for their care." There is no reason to believe that the "abusers" are necessarily the people who are price-sensitive, nor that price-sensitive people are necessarily the ones who abuse the system. What does seem likely is that people with lower incomes will be more price sensitive, therefore user charges will have a greater impact on those people.

The Canadian experience with user charges confirms this suspicion. Between 1968 and 1971 the province of Saskatchewan had a flat fee user charge of $1.50 (about $6.00 in today’s prices) for a physician office visit. The charge reduced the annual per capita use of physician services 6-7%, but the reduction was much larger, around 18%, for low-income people [17]. (The large reductions in use by lower-income people did not translate into corresponding savings in costs, however, because they were partially offset by increases in use by higher-income people and because physicians shifted toward a more expensive mix of services -- and negotiated two fee schedule increases -- during the period of user charges.) There was no evidence that user charges resulted in a decline in the unnecessary use of physician services.

The Saskatchewan experience also illustrated the limited impact of user charges on services beyond the control of patients. A charge of $2.50 per in-patient hospital day (about $10.00 in today’s prices) had no effect on hospital use. The summary assessment of the effects of user charges by the researchers who did in-depth studies of the Saskatchewan experience is worth noting: "The effect of the user charge is simply to transfer costs from public to private budgets with the burden of such transfers falling disproportionately on the sicker members of the population"[17].

User charges were also found to have a greater impact on low income people by
researchers who studied the effects of extra-billing in Ontario. A 1980 survey found that lower-income people who had been extra-billed were significantly more likely than higher-income people to report that they had reduced their use of physician services or delayed seeking care because of the cost [18]. As for the claim made frequently by advocates of extra-billing that physicians did not extra-bill those who could not afford to pay, both the Ontario survey and data from Alberta refute it. In Alberta, for example, researchers concluded, "It is an unquestionable fact that the aged, welfare recipients and the lowest income groups in the province are forced to bear additional out-of-pocket charges in order to receive medical attention" [19].

If poorer Canadians are more likely to be deterred from seeking care by user charges, and if -- as is also the case -- they are more likely to be sicker than richer Canadians, then instead of reducing unnecessary use, charges will almost certainly affect the use of necessary services. No doubt there is a (very) small number of patients who (perhaps even blatantly) misuse the health care system, but to try to eliminate this problem with a general policy of user charges for most services for most Canadians seems like weeding your lawn with a bulldozer, without any guarantee that you will get all of the weeds!

If, as is often suggested, there needs to be a more fundamental change in the way patients view the health care system and use it -- for example, not going to the doctor for common colds or other minor problems -- then educating rather than penalizing patients is an alternative that deserves increased attention. Physicians could be an important part of this strategy, if they wished to instruct patients in self-care and had some incentive to do so, precisely because patients look to them for advice, and because they do control access to the resources of the health care system.

Critics of user charges make one final point on the issue of unnecessary use. Suppose a user charge policy works perfectly, they ask, what then? The discussion and evidence presented above suggests that the effects of user charges will be far from perfect, but to the extent that they do eliminate unnecessary use, and just unnecessary use, then the only people left paying the charges are people who are truly sick and in need of care. User charges, in effect, become a tax on illness. They redistribute the costs of the health care system from the healthy to the ill, in ways which are discussed further in later sections of this article.

Do user charges encourage people to act more responsibly? This is the last part of the popular argument stated above, and it is hard to disagree with its apparent goal. But again it is difficult to know just what is meant by the words in italics. If acting responsibly means not going to the physician for unnecessary services, then it leads back to the questions discussed above and there is nothing new to be said. It is worth repeating, however, that this argument is not as straightforward as it seems and not well supported by what we know of how patients behave.

If acting responsibly instead means taking more responsibility for one’s own health, as seems to be implied by some advocates of user charges, then it is a different line of argument. The question is not whether user charges for health services would make people think twice
about going to the doctor, but whether they would make people think twice about smoking, or eating more fruit and vegetables, or exercising or not driving after drinking alcohol. Although it is possible that people might react this way, it seems very unlikely that whatever complex social, psychological and environmental factors determine personal lifestyle decisions today would be outweighed by the prospect of having to pay part of the cost of possible health care tomorrow.

This line of argument about user charges is filled with problems. First, there is considerable evidence that many so-called "unhealthy lifestyles" are as much the result of the environments in which people live, work and grow up as they are the result of conscious personal choices [20]. Second, the argument is a long chain, with many weak links [21]. Two examples: it would be necessary to show that an illness was caused by a lifestyle in a specific individual (or in all such cases), and that user charges later actually change personal behaviour now. Third, implementation and enforcement would be major problems -- would an emergency room physician refuse to treat an injured skier unless he agreed to pay the charge? Fourth, in many cases there are simply better alternative policies -- taxing cigarettes, or arresting drunk drivers, for example. At best, levying user charges for health care appears to be a very indirect way of attempting to encourage people to take greater responsibility for their health, and is a method about which there is no evidence to our knowledge.

There is yet another interpretation of responsibility which may or may not be related to notions of abuse, but which is highly significant for the insights it gives about what some people may really be thinking, and about the values they hold. This is responsibility for payment - the idea that there is something beneficial about the act of patients paying some amount of money that is directly related to use of services, preferably (though not necessarily) at the time of use. This sentiment is illustrated by three statements that are frequently heard in conversations about user charges and which progressively shift the discussion from claims about how charges will affect patient behaviour to claims that are ideologic views about how health care should be financed - in other words, who should pay.

*People have no idea what the system costs; they should be made to realize that their care isn't free.* This popular refrain raises a number of questions. Even if they are unaware of precise costs, are not most people aware that they are "paying" for health care with their taxes? Would knowing what the overall system costs affect your decision to go to the doctor on a particular occasion? Would even knowing what your own visit cost change your pattern of use or the way you behave? And are user charges (which usually represent only a small fraction of the cost of care) the best way to inform patients of the cost of care? If letting the patient know the cost is all that is desired, wouldn't having the patient sign a card showing the services that were rendered and their cost to the provincial insurance plan be all that is required, as is often suggested. (This would also discourage fraud.)

The unstated, but implicit assumption here may be that people would behave differently - presumably use less care - if they had better knowledge of its cost. If this is the underlying objective of the user charge, then there is little new in the argument and we return to the issues
discussed earlier. The objective may be a different one, however. It may be to establish a symbolic act -- paying the physician or hospital for at least a (small) part of the service received -- so that those who are paying in taxes for more than they (are likely to) use know that their opposites know that care isn't "free". In this argument, distributing a portion of the cost of care on the basis of use is necessary to establish the proper "attitude" toward health care, and toward those who provide it and finance it, even if it does not lead to more responsible use. This is presumably what opinion-maker and columnist David Frum has in mind when he writes, in support of user charges, that "all too many Canadians... expect something for nothing", and "People who live on the taxes of others should be aware of it" [22]. It is a statement of values that seems to reject the principle that access to health care regardless of ability to pay is, or should be, a "right" of Canadians.

People don't value things unless they pay for them, is a closely related belief that appears frequently in the responsibility argument, and which can be viewed in much the same way as the previous italicized statement. If it is meant to be a statement about how user charges will change patients' behaviour, then issues of the definition of abuse and necessity, the extent of patient-initiated unnecessary use and the effectiveness of charges in selectively reducing unnecessary use need to be worked through and resolved, if possible. If it is meant to imply that people feel that they have somehow received a "better" service because they (at least partly) paid for it, then it seems curious and contradictory that user charges are most often supported or advocated by providers, and opposed by groups representing the consumer of services. On the other hand, if it is an indirect statement about what social values ought to be used to distribute (more of) the costs of the health care system, then it must be accepted and debated for what it is, rather than entangling and perhaps disguising it in discussions of abuse. Then it looks more like the next statement.

People should pay for what they get; it's unfair that they get something for free. This is the clearest and most direct statement of an ideology which often, though not always, is part of the responsibility argument. Here there are no longer any claims that patients are abusing the system, although this may have been where the argument began. In fact, medical necessity -- the need for care - no longer apparently plays a role in the discussion. The statement asserts that costs should be borne in proportion to use and implies that users of health services are not paying their "fair" share relative to other taxpayers whose taxes support the system. This amounts to a statement that the sick (who are also disproportionately the poor) should pay more and the healthy (who are disproportionately the rich) should pay less.

Pushed or carried this far, the user charge debate again becomes one about social values and the distribution of financial gains and losses, rather than one about the effectiveness or efficiency of the health care system. The debate also becomes detached from notions of merit or "deservingness". Contrary to the view that illness is not in general a person's own fault, and therefore that health care should be provided on the basis of need and financed separately, the social values being advocated in the statement in italics either ignore the issue, or imply that illness is (even if only in part) a person's own responsibility.
The Affordability Argument

Like the responsibility argument, the affordability argument consists of a general perception that there is a problem, followed by an apparently common sense suggestion as to how to solve the problem through user charges. In the responsibility argument, the problem was that people were abusing the system; here the problem is that the system needs more money. There, user charges were supposed to solve the problem by encouraging people to stop using unnecessary care; here, user charges are supposed to solve the problem by generating additional revenue to help pay for care. In both cases the arguments make user charges sound desirable in part because they seem harmless. There are apparently no other, undesirable effects that need to be considered.

But, also like the responsibility argument, the affordability argument is not as simple or as innocent as it seems. In fact, the way in which the idea of "affordability" is typically used in the popular debate is both confusing and misleading, because the argument begins by implying that the objective is to lower health care costs but ends with user charges as the way to "afford" even higher costs.

Upon closer examination, the affordability argument is really a mixture of two separate and inconsistent arguments, which may reflect a genuine confusion in Canadians' minds about whether the health care system currently costs too much or too little. The claims "Health care costs are out of control. We can't afford our current system." are a statement that the system costs too much. User charges are presumably one way to reduce or control those costs. On the other hand, the claim "We need more money." is a statement that not enough is being spent on the health care system. User charges are seen to be one way of increasing rather than decreasing total spending. Both cannot be correct, although people making the affordability argument in its full form typically ignore this, and those making just one or the other of the separate, inconsistent arguments typically do not confront each other.

Are costs out of control? It is easy to see why there is a general perception that the system is in a financial crisis. Both governments and health care providers constantly talk about money - in newspapers, on television and radio, in speeches by politicians and in conversations in doctors' offices. What is not well understood, however, is that this has always been more or less the case since Medicare was introduced over twenty years ago, and that the Canadian system is designed to produce this tension between health care providers and their paymasters, the provincial governments acting on behalf of taxpayers.

Governments are concerned with limiting expenditures and taxes; providers are concerned with increasing services, incomes and spending. Each side pleads its case to the public. This is a natural tension in a publicly-financed system and, although it does not always work perfectly, it has served Canadians well so far and has resulted in a balancing of expenditures, taxes, services and provider incomes that has been a compromise everyone could live with [23]. One of the less desirable features of this model, however, is that the general public can be caught in the crossfire, especially when the tension "flares up", as it does periodically when government,
for various reasons, tries to tighten controls.

Worries about the needs of an aging population and the effects of rapidly advancing, expensive medical technologies also fuel the perception that there is, or soon will be, a financial crisis. These are certainly developments which will require attention. But they are often talked about as if they are things beyond anyone’s control - outside forces battering the health care system, like meteorites falling from outer space. In fact, although there is little that can be done about the aging process itself, or even technologic progress perhaps, the choices about how to respond to these developments are well within a society’s control [24]. (Furthermore, perceptions are often exaggerations. For example, careful research has demonstrated that the increase in the number of elderly Canadians has had very little effect by itself. Rather it is the growing number of services and procedures done for (or to) the average elderly person that is the source of the cost pressure [25].) Calling everything that comes along "health care" and finding money to pay for it, is one possible response. Carefully considering what should and shouldn’t be called "health care", and what to pay for from public money and what not to pay for (a subject we deal with in another paper [3]) is a different response.

This does not mean that there aren’t serious fiscal pressures on the Canadian health care system. There are, and there always have been. But two recent developments are increasing those pressures. The contributions of the federal government to the provinces for health care are being reduced, and the Canadian economy is not performing nearly as well now as it has in earlier decades. Therefore provincial governments are finding it harder to sustain previous rates of increase in health care expenditures.

It is quite a different matter, however, to conclude from this that costs are "out of control". The Canadian health care system has always been one of the most richly supported in the world, but costs are not increasing faster now than during the last forty years. Contrary to the popular wisdom, they are not "spiralling" up; they are continuing to increase at about the same rate as they always have. What is different is that the growth of the Canadian economy has slowed considerably, so that health care in 1991 took up about 9.9% of our gross domestic product. But, if the two major recessions of the 1980’s had not happened, we would still be spending about the same share (7 1/2%) of our national income on health care as we did in 1971 [7].

The widespread belief that public funding of health care weakens the ability to control costs is also not supported by the evidence. Health care costs rose more quickly on average before Medicare than after it was completed in 1971. Furthermore, since 1971 costs for the categories of health services included in Canadian public health insurance have increased less rapidly than those for services outside the public plan [7].

The comparison of the Canadian and American experiences is even more dramatic. Both countries had similar profiles of health care cost growth prior to 1971, when Canada completed its system of universal, publicly-funded medical and hospital insurance. The U.S., meanwhile, continued to rely extensively on private funding and insurance, with a major emphasis on user
charges of various types to control costs. In 1971, each country spent approximately 7 1/2% of its national income on health care; today the U.S. spends in excess of 13%, which is over 3% more than Canada, and the gap is still widening. (It is also worth noting that, internationally, Americans are the least satisfied with their system, while Canadians are the most satisfied [26]).

Nevertheless, slower economic growth continues to force Canadian provincial governments to choose between tightening spending controls on the health care system or allowing it to consume an increasing share of society’s income. Any government that chooses the first option (tightening controls) will pay a political price, as health care providers will almost certainly accuse the government of "underfunding" health care (no doubt at the same time as other commentators are criticizing the same government for not controlling "runaway" costs). It is not a coincidence that providers’ claims of a funding crisis in Ontario, for example, have greatly intensified just recently. After a decade of average annual growth in Ministry of Health spending of 11%, which ended in 1992, the increase for 1993 was 1% and is expected to be even less for 1994 [27].

What does "affordability" really mean? The dictionary defines "afford" as "to be able to bear the cost of". In a country as wealthy as Canada, it is clearly possible to bear the expense of the health care system, if that is what its citizens want to do. So where is the problem? The problem is that it may not be possible for governments to do all of the things that they think their citizens want at rates of taxation that they think the same citizens will accept. Thus the pressure for governments (which really means taxpayers) to "live within their means". Or in today's words, control or reduce deficits.

If deficits are to be controlled or reduced, then one or both of two things must happen -- reduce spending or/and raise revenue. But there are further options within each of these routes. If spending is to be reduced, should the health care system be the target? Canadians apparently don’t think so. In public opinion polls Canadians consistently rate the health care system as the top priority for public spending. This would seem to imply that the health care system is affordable if Canadians are willing to accept less of other things that governments spend money on. Is this what people really mean by affordability? It is hard to know, because the popular debate and the opinion polls are not typically framed in these terms and it is difficult even to speculate on what Canadians might actually do if faced with a real choice of how they want public monies re-allocated. Perhaps it is time for a serious and detailed public exploration of how government revenues are spent and whether it corresponds to what people want.

The other option -- raising revenues -- also involves choices. This time the choices are about how the revenues are to be raised. Which taxes will be increased, or what combination of taxes and other instruments, like user charges will be employed (and for which public services)? In this context affordability boils down not to a question of whether costs can be borne, but rather to how they will be borne. How will the costs, (and maybe the benefits) of public services be distributed among taxpayers and users. Who gains, and who loses? This issue -- how costs and benefits are distributed -- is the heart of the matter in any debate about any
form of user charge for any public service, and needs to be put front and centre for exactly what it is.

The way in which revenue is raised, rather than the need to balance expenditures with revenues, is the gut issue in the so-called affordability argument for user charges for health services. It must be, because the argument appears to make little sense otherwise. Supporters of user charges claim that the purpose of the charges is to increase the resources going into the health care system, which is currently funded through general government revenues, which in turn rely heavily on personal income taxes. They frequently state that the system is "underfunded", and that user charges will help to correct this [1]. Taken at face value, this is a call to increase the total spending on health care, by adding private money (directly from patients) to the public money (from taxpayers) that is already being spent. Analyses of the likely effects of user charges on total health expenditures generally confirm that this will indeed be what happens [28,29]. But in the context of "affordability", this amounts to saying that the same society that could not afford the current level of health care spending (out of public funds) can afford an even higher level of spending (out of a mixture of public and private funds from the same people)! At best it is a strange definition of affordability. At worst it is hiding the main issue, even if unintentionally.

Decisions by governments about how much to spend and how much to tax (and what size deficits to allow) are political choices. Similarly, a decision not to control or rationalize health care spending, but rather to allow it to increase while shifting more of the burden away from taxpayers and onto users is also a political choice. To talk of this as an issue of "affordability" is at best a confused and at worst a dangerously misleading use of that word.

Will user charges generate revenue? Yes. With the responsibility argument there was serious doubt about whether user charges would do what their advocates claimed - reduce (only) unnecessary use. Here there is little doubt that user charges of any type will accomplish the goal of generating revenue to ease the pressure on tax-financed government budgets. If people have to pay for at least part of the cost of the care they use, then unless they stop using care altogether, revenue will be generated. In fact, quite a bit of revenue will likely be obtained, because in general studies have shown that the demand for medical and (especially) hospital care is relatively insensitive to charges. Just how much revenue is obtained will depend on how large the charges are, and how many people or services are exempted or protected from the charge. (However, if the main reason for imposing charges is to raise money, then exempting or protecting special groups works against the intent of the policy, especially if these groups are heavy users of services.) But overall, if user charges are intended to generate revenue, they will "work".

Does the system need more money? Despite the claims of underfunding by associations representing physicians and hospitals, almost every commission of inquiry that has examined health care in Canada or in specific provinces has delivered a loud and clear message that the answer to this question is "no". The common theme of the reports of these commissions is that the money already being spent on health care is not being used as well as it could be, and that
there is significant room for improvement in the way the health care system is structured and managed.

As noted earlier in this article, there is widespread evidence that some medical procedures are ineffective or are performed when they are not appropriate. Other procedures and services are provided in more costly ways than they could be, because the system is not organized efficiently or because the incentives simply do not exist for doctors and hospitals to do things in the least costly way.

Reducing the ineffective, inappropriate or inefficient provision of health care will make the system more "affordable", in the proper sense of that word. It will lower costs. Until now, however, the general public has remained relatively uninformed of these findings and their implications for tax dollars that may be being wasted. (This contrasts sharply with the high profile and steady flow of stories about underfunding in the media.) Although it is too optimistic to expect improved management of the health care system to remove all financial tensions, there is little question in the minds of experts who have studied the system that this is the place to apply pressure to reform the system in order to get "better bang for the buck". By providing a financial "escape hatch" for those opposed to reform, user charges will deflate this pressure.

Are user charges the way to let the rich help out? Part of the appeal of the affordability argument as it is usually presented is the Robin Hood tone of the suggestion. If more money is needed, let’s take a bit more from "the rich" by letting those who can afford it pay user charges. By implication, "the poor" are no worse off and the health care system can go on its merry way. There are one or two nagging questions, such as how to decide who can afford to pay (if too many people are exempted, then user charges don't help much) and whether people might forego some necessary care if the charges are too large (though the smaller they are, the less they help), but these are often brushed off in the popular argument with a comment such as "we're not trying to hurt anyone who can't pay or who needs care." With these doubts cast aside, the thrust of the argument is that all that is going to happen is that more of the costs of health care will be borne by the rich, whoever they are.

Is this the case? Well, no, and this is where the affordability argument becomes both more complicated and more deceptive than it at first appears.

The two main points to keep in mind are first, that there is already in place a method designed to spread more of the costs of public services onto those with higher incomes (the personal income tax) and second, that any user charge will by definition redistribute costs on the basis of use, regardless of income. Various schemes may be proposed to lessen this effect, such as making the value of health care used part of taxable income, thereby taxing use by richer people at higher rates, but no tinkering with the specific form of the user charge can eliminate it [4]. By definition, for those who pay them, user charges distribute part of the cost of care on the basis of use, regardless of income and regardless of the need for care. That is precisely their purpose.
For any level of health care spending, therefore, user charges shift the burden of costs away from taxpayers generally (both rich and poor) and onto users of services (both rich and poor). For people at the same income level, user charges redistribute the costs of health care away from the "healthy" and onto the "sick", because they are the ones who use relatively more care. For people who are equally healthy or sick, or more accurately, for people who use the same amount of care, the same user charge places a greater burden relative to income on those with lower incomes.

Of course, most people are both taxpayers and patients, so they both gain (as taxpayers) and lose (as patients). Whether they gain or lose overall depends on the amount of taxes they pay and the amount of care they use. In general, wealthy people pay more taxes and sicker people use more care; moreover, wealthy people tend to be healthier, and poorer people sicker. The healthy rich thus stand to gain the most from the introduction of user charges and the sick poor stand to lose the most [5,Figure1]. Viewed this way, well-intentioned advocates of user charges seem more like the Sheriff of Nottingham than Robin Hood.

In another paper in this series we analyze in detail how different types of user charges distribute the costs of financing the health care system across particular groups of people [4]. There is another issue of distribution, however, that is hidden from discussion in the affordability argument, and which deserves to be mentioned here. That is the issue of the distribution of benefits rather than costs.

In moving from a primarily income-tax financed system of paying for health care to a system with user charges, there is also a change in the criteria for obtaining access to health care. In the current system, access to health care services is intended to be based solely on the need for care, which in turn depends on whether people get sick or injured (or perceive themselves to be sick or injured) and the judgement of their physicians as to whether using services will help to make them better. In a system with user charges, access to care depends in part on ability (and willingness) to pay the charge. People with higher incomes will thus on average not only pay a smaller share of the costs of health care; they will receive a larger share of its benefits. Whether there is anything "wrong" with this change in criteria is not for analysts -- be they economists or physicians -- to judge. But it is important for analysts to point it out in the popular debate, and for advocates of user charges to acknowledge that it is the case. It represents a change in the fundamental values which Canadian society has chosen to guide the provision of health care. It seems too important to be left hidden.

Not everyone hides it. When discussions of the affordability argument reach this point, the response of some (though by no means all) supporters of user charges is quite direct. They say, "people should be able to pay extra to get better service." But what does "better" mean? Usually, it means that those able and willing to pay should be able to "jump the queue" if there is one, and get faster care than those unable or unwilling to pay the charge, regardless of need. A remark attributed to Mr. Steve West, the Municipal Affairs Minister of Alberta, vividly illustrates this point: "I don't want to retire with a half a million dollars in the bank, be 92nd on the list for heart surgery, and die with all that money in there" [30]. Again, although this is
not the way Canadians have chosen to determine access to care in the past, there is nothing intrinsically or analytically "right" or "wrong" about this position. It is a legitimate statement of personal values and deserves consideration as such. It is important to be clear about what the values are in Mr. West's statement, however. He is explicitly saying that there should be public subsidy of privileged access for those able to pay extra.

Although Mr. West's remark seems to be a plea for preferential treatment of the rich - better access to publicly-funded services for those who are able to "ante up" - this is not its only possible interpretation. He, and others like him, may be implying the creation of a separate, private health care system, available to those able and willing to pay for it. In principle, the existence of a truly separate private system, which did not distort the public system and in which patients were entirely responsible for the full cost of their care, without public subsidies of any type, sounds like a solution to Mr. West's problem. In practice, however, such a "two-tier" system is impossible to implement. At least nobody (including the United States) has done it yet. And in places where private systems co-exist with public ones (especially where physicians are allowed to work in both systems) there are always distortions and/or public subsidies. So, even in this scenario, the public will end up subsidizing preferential access to care for those who can afford it. Again, there is nothing inherently 'wrong' with this. But again, it would represent a dramatic departure from the values on which Canadian Medicare has rested for almost three decades.

The Real Issues

Our examination of the debate over user charges has shown that although the most popular arguments seem to be clear, simple common sense, they are not. Key parts of the arguments, and key concepts and words, are very fuzzy. The same words are used at different times by different groups for different (often inconsistent) purposes, without (perhaps deliberately [5]) spelling out their true meaning. The factors that must be considered are not simple; on the contrary, they are quite complicated. And what seems like common sense may at some times be incomplete and at others downright misleading.

When the arguments are broken down into their pieces, and the camera "zooms" in on each piece, a different picture of what is apparently the same debate emerges. When the claims that are often made are examined carefully, and compared to what is actually known about the effects of user charges, it looks like charges will do only a very few of the things that their advocates claim.

At the bottom of the user charge controversy, somewhere in the underbrush of claims and counter-claims, and deep in the forest of media stories about the health care "crisis", there are two real issues that need to be resolved. One involves our values as a society. The other involves our willingness to accept the difficult and often uncomfortable work of restructuring the health care delivery system to be more effective and efficient. Neither is easy.

Both the responsibility argument and the affordability argument ultimately require
Canadians to re-examine the fundamental social values on which the current health care system is based and either to reaffirm or change those values. The creation of a universal hospital and medical insurance system offering first-dollar coverage for Canadians was based on the philosophy that the benefits of a health care system should be distributed on the basis of need alone and the costs of the system should be distributed on the basis of ability-to-pay alone. User charges reverse this, at least in part, by distributing some of the costs on the basis of need (to the extent that use reflects need) and some of the benefits on the basis of ability-to-pay. Supporters and opponents of user charges can argue about how big or small the effects of charges will be, and about whether many or few people will be affected, but these are not the issue. A fundamental change in values and philosophy is. You can't be a little bit pregnant.

Whatever role the so-called "experts" - economists, physicians, nurses, hospital administrators, clinical researchers, other health care professionals, government bureaucrats, politicians and even philosophers and ethicists - have played in the debate so far, it is questionable whether they have much more to contribute on this issue once they have produced their evidence and clarified the points of debate. For the question of values is one which must finally be decided by ordinary Canadians. The experts will each have one vote - like everyone else.

The responsibility and affordability arguments have another characteristic in common. Each ignores the second real issue and what is perhaps the most important source of financial pressure in the current system, namely our failure to manage the system as well as we could. There are many opportunities for reforms that would improve the organization, financing, regulation, administration and delivery of health care and increase the effectiveness of taxpayers' money that is currently spent, but they are seldom acted upon. There is a reason for this. They involve hard work.

They involve risky political choices, and sustained commitment to reform over a long period. They require negotiations between governments and providers about levels of spending and methods of payment. They require changes in the types of facilities and the types of professionals that make up the system. They require explanation and communication to the general public, and new ways for the public to be involved in decision-making, including decisions about who is to get what benefits and why. But perhaps most important, they threaten powerful interests by requiring changes to the distribution of both the power and the incomes of those associated with the health care system, much closer scrutiny of whether what is currently done is achieving its purpose of improving health, and cooperation between many groups with competing agendas.

Compared to the prospect of a steady and sometimes painful, even if thoughtful, restructuring of what economists call "the supply side" of the health care system, the idea that it might be possible to avoid all this by going through "the demand side" of the system and charging patients to raise more money is very tempting. And this is one of the things that user charges will do - at least in the short run. By papering over the structural cracks in the health care house with more money, the incentive to make repairs that are overdue will be taken away.
"If money's not a problem, why should we change the way we do things. Who needs the hassle?" is not an unreasonable reaction for people working in the system. We all might say the same, if we were in their shoes.

But user charges are still a "cop-out", say their critics. Not only does a user charge policy fail to address the need for structural and management reforms, the debate about the policy deflects attention even further away from the central issue of reform. It lets those who should be accountable for the effectiveness and efficiency of the health care system - whether politician or health care provider - "off the hook". This assessment seems accurate to us, but it is still incomplete. For what seems like a "magic bullet" to solve today's problem of health care costs will not solve tomorrow's. And tomorrow will come. The basic forces which drive expenditure up are unlikely to change, nor is the inability of the economy to support ever higher expenditures. Responses like "user charges will buy time to work on the big problems" or "tomorrow's problems have tomorrow's solutions" are therefore either naive hopes or shrewd strategies for protecting established interests.

They may also be dangerous, rather than helpful, to Medicare. Once user charges are introduced, and reform postponed (thus leaving the upward pressures on costs unchanged), it is very likely that provincial governments will sooner or later find continuing increases in the charges too tempting to resist. If the resulting out-of-pocket costs to patients become significant, then it will be difficult to prevent private insurance from re-emerging. Although this "slippery-slope to the U.S.-style health care system" scenario is by no means a certainty, the road to a U.S.-style system may be both smoother and less reversible than it appears [31]. Even a small probability of such an outcome should be cause for concern; Americans themselves admit that theirs is the most costly and least effective model for providing access to needed health care and protecting people against the financial burden of sickness.

It is important to recognize, therefore, that the question "why not user charges?" is not just a choice about values. There are, or will be, real effects on Canadians in both the short and long runs that come along as part of the package, with varying degrees of certainty depending on the effect. Values are not like ice cream ("will that be chocolate or vanilla?"); choices about social values determine paths that lead to important differences in societies.

The effects of user charges, both real and imagined, have been examined in detail throughout this paper. User charges will generate revenue, and make more money available to health care providers. Those who represent doctors and hospitals know this, and it is why claims of underfunding and proposals for user charges frequently come from them [1,5]. At the same time, however, user charges will almost certainly increase, not decrease, the total cost of the health care system. They are unlikely either to reduce the use of health services significantly, or to discourage unnecessary use and only unnecessary use, or to encourage people to act responsibly, although they will symbolically remind everyone (especially the poor) that Canadian health care is not "free". In the process they will remove an important part of the motivation for reform of the system to improve its effectiveness and efficiency.
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