ADAPTING TO ADVERSITY, PROTECTING THE PRINCIPLES, RESISTING REACTIONARY “REFORMS”:
CANADA’S HEALTH CARE SYSTEM IN THE 1990s

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Canada's Health Care System in the 1990s

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Financing and Delivering Health Care in Canada: A Micro-Summary

The description of "Reform" in the Canadian health care system could be made very short. There has not been any reform.

There has been no change in the fundamental principles and basic structural features of organization and finance of health care, since the system reached its modern form between 1968 and 1971. That system has evolved over subsequent decades, and has adapted more or less successfully both to significant changes in the external environment, and to changing needs and possibilities for health care services themselves. But it remains easily recognizable as the same system that was established a quarter-century ago.

Nor is this likely to change in the future (unless of course the Canadian federation itself breaks up, in which case anything might happen). Although there is a great deal of rhetoric about "crisis", and about the "bankruptcy" and imminent collapse of the Canadian health care system, this rhetoric has in fact been a continuing feature of health care debate in Canada throughout the history of the public program. Such claims become louder and more strident during periods of fiscal strain, but they turn out on examination to have little or no factual base.¹

A number of public investigative commissions have examined these programs, at the federal and provincial levels, over the past decade. The most recent, the National Forum on Health, chaired by the Prime Minister, delivered its Report in February 1997. All have reached similar conclusions; the current system is fundamentally sound, and contrary to widespread claims is also adequately funded. There are a number of ways in which the system should be adapted to yield greater "value for money" -- more effective care, more efficiently produced, for the same level of resource commitment as it now receives. But these can be achieved within the existing structure; they do not require "Reform" in any fundamental sense.

¹ The "disinformation" has become much more intense in the 1990s, as a side-effect of the abortive effort to achieve health care reform in the United States. Advocates of reform have pointed to the superiority of the Canadian approach, in virtually all respects, over American arrangements for organizing and particularly for financing health care. Opponents, especially private insurers and physicians, then launched massive attacks on what they claimed to be negative features of Canadian health care. These American publicity campaigns, though designed for internal consumption and with minimal relation to actual experience, inevitably spill over into the international, and particularly the Canadian, communications media.
structure; they do not require "Reform" in any fundamental sense.

In broad outline, health care in Canada is provided by private professional practitioners -- physicians, dentists, pharmacists, and members of a number of other, much less numerous professions -- and by not-for-profit hospitals each overseen by a Board of Trustees. Practitioners are predominantly self-employed in their own private practices -- solo or small group partnerships -- though some are employed full or part time in practices owned by other professionals. They are paid for their services on a fee-for-service basis. Hospitals, by contrast, receive an annual global budget from the Ministry of Health of the province in which they are located. Long-term institutional care is provided by facilities that may be part of an acute care hospital, or may be free-standing; but in either case they are reimbursed on a per diem basis. Some are for-profit, owned by individuals or corporations; others are run by various community groups.

The principal form of public insurance covers the services of physicians and acute care hospitals, these made up 34.2% and 14.4% respectively of the estimated total of $75.2 billion (CDN) spent on health care in 1996. Patterns of coverage for drugs, dentistry, and long-term care are much less uniform (from one province to another) and less complete. All residents are fully covered for "all medically necessary" hospital and medical care, without deductions or coinsurance. (Certain forms of elective cosmetic service are excluded.) Thus, a resident who feels a need for care will seek out a physician of his choice, and if accepted as a patient will then be cared for without any financial implications. The services provided will be paid for by the provincial government, according to a uniform fee schedule negotiated between the provincial government and the medical association of the province. (If a patient is cared for in another province, his "home" province will reimburse at the fees in effect in the province of service.)

Diagnostic tests ordered by the physician are also paid for by the province according to a fee schedule, as are referrals to specialists. Roughly half of all physicians in Canada are generalists or family practitioners, so the normal pattern of care-seeking is for the patient to go to "the family doctor" and, if necessary, to be referred on from there. Patients may "self-refer" to specialists, but this is discouraged. The specialist receives a larger fee for a formal referral; but perhaps more fundamentally the (deliberately) limited numbers of specialists permits them to concentrate on truly "specialized" work, rather than competing for patients with generalists. If hospitalization is indicated, the physician will arrange to have the patient admitted. Physicians are
Patients have free choice among general practitioners in the first instance, and if referral is indicated they can request referral to a particular specialist. (The physician also has a choice as to whether to accept the patient.) Similarly, a patient wishing to be admitted to a particular hospital might select a physician on the basis of his admitting privileges. In practice, however, in selecting a physician, the patient has usually also implicitly selected (if necessary) both the set of specialists with whom he has on-going referral relations, and the hospital at which he or they have admitting privileges. In any case financial considerations play no part because all hospitals, like all physicians, are included in the public insurance program.

There is no separate "private" system of care; what, after all, could it offer patients that is not already available in the public system? If physicians were permitted to practice both in and outside the public program, they would be able to manipulate access to public services so as to induce patients to pay them extra "private" fees for preferred access. And indeed physicians have long argued for this opportunity to generate extra income. But at present such behaviour, while not strictly forbidden (at least in federal legislation), is rendered virtually non-existent by a complex system of restraints.

This brief outline of the system from the patient's point of view has not changed since the late 1960s, although the services that might be offered have, of course, changed dramatically as medical technology has developed. The "complex system of restraints", however, refers to a totally different level of relationship, that between the federal and the provincial governments, at which major changes have taken place. The details of "federal-provincial fiscal arrangements" are arcane and highly specialized, and impinge little or not at all on either the individual patient or the individual provider in day-to-day practice. Over the long run, however, the survival or dissolution of the present system depends critically on decisions taken at this level.

For fundamental constitutional reasons, as well as good practical ones, the governments of the Canadian provinces have virtually all responsibility for both regulating and funding health care within their borders. They can in fact set up health care insurance programs any way they choose, or not at all. The federal government, however, sets the standards for "conforming" provincial
programs, and provides both cash payments and access to part of the income tax base for provinces operating such conforming plans. Effectively, then, the federal government can determine certain of the fundamental principles governing provincial plans – so long as it also contributes to their cost.

These principles are fundamental to all provincial programs – universal coverage, universal access “on equal terms and conditions”, comprehensiveness of benefits, portability of benefits across provinces, and public administration. In particular the access provision has been interpreted – by the federal government – as ruling out user charges, in whatever form. A province may choose to impose such charges – ultimate constitutional authority rests at the provincial level. But the federal grant to that province will then be reduced dollar for dollar by the total amount of all such payments made by covered individuals with respect to insured services. Accordingly provinces have moved, in various ways, to suppress such charges. [There is, however, and probably always will be, a small number of physicians looking for ways to extra-bill patients that will not be noticed or can somehow be represented as other than for insured services.]

Over time the nature of the federal contribution, as well as its relative size, has changed greatly. In the beginning the federal government shared a proportion (roughly half) of actual program costs; this was changed in 1977 to block grants independent of actual costs. In the 1980s and early 1990s the federal cash contribution was actually on a steady downward trend. If this cash contribution were to become too small, such that the federal government could no longer withhold significant amounts from provinces whose programs failed to conform to the fundamental principles above, then it is a virtual certainty that the present system would begin to crumble immediately. The road to an American-style system would lie open.

Certain of the more right-wing provincial governments have made their intentions clear -- they would move swiftly to introduce user fees, erode both comprehensiveness and universality of coverage, and permit the development of a private “second-tier” of services. Fiscally strained provincial governments face a powerful temptation to offload budgetary costs onto the private sector. In doing so they would have enthusiastic support from strong elements within the medical profession, and from private insurers who are at present largely shut out of a market that could otherwise be as lucrative (for its scale) as the United States.
investigative commission, and to the very strong public support for the present system, the federal government’s policy seems to be at least to maintain and perhaps even to strengthen the federal role. If so, then major structural change – which would in any case be “Reaction” back to the past, not “Reform” -- is unlikely.

**Funding Constraints in a Slow-Growth Economy**

That being said, however, there have in recent years been some very significant changes in the terms of the financial relationships between provincial governments and the providers of care. These have involved the more rigorous application of control mechanisms that have always been in place -- tighter controls over budgets, fees, and capacity. Until very recently, however, provincial governments have felt that they had much more limited public support in applying those measures over very vigorous political opposition from providers of care. But in the 1990s they sensed a stronger public mandate, and the consequences are shown in Figure 1.

For the first time in nearly half a century, the level of health spending per capita, adjusted for inflation, has actually stopped rising. Total spending has been flat for four years in a row. The agonized rhetoric of “savage cuts” emanating from some parts of the health care system reflects the fact that while the total has been stable, some sectors and regions have had their funding reduced while others have continued to expand. Thus it is not true that the Canadian health care system as a whole is undergoing funding cuts; the reductions that have occurred in total “real” per capita spending are too small to notice. But it is true that, for example, one particular provincial government (Alberta) reduced its own health spending by 8% in one year (1994). This works out to a cut of nearly 12% on a per capita, inflation-adjusted basis, across the board. It was small comfort to workers in the health sector that that government later (facing a provincial election) confesses that it had no idea what it was doing, and restored some of the funding.

2 Canadian readers, in particular, will note that I have ignored the regionalization initiatives that are underway in almost all provinces, and that might very well be described as significant “reforms”. But no province has included physician or pharmaceutical payment in these regional budgets. Moreover the newness of these initiatives, and their diversity across provinces, makes it difficult to describe them, let alone predict their effect. For the present they can be thought of, in the framework developed below, as primarily a rearrangement in the terms on which hospitals receive their budgets from provincial governments.
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The lower line in Figure 1 indicates that the control of costs has been tighter in the hospital and medical care sectors, where there is universal, first-dollar public coverage, than in the other sectors where coverage is neither universal nor comprehensive, and reimbursement of covered services is commonly incomplete. Real per capita expenditure in the two fully covered sectors has actually fallen, illustrating the general Canadian experience that, if cost control is the objective, it can only be achieved by putting all the payments through a single "pipe". Multiple funding sources, and "patient participation" in payment, are ways of preventing, not of achieving, cost control — that is why they are routinely advocated by those who draw their incomes from health care. The "hospital and physician" line also extends our historical experience back to the immediate post-war period; total health expenditure estimates were not compiled prior to 1960. The post-1992 "flat spot" can thus be seen as the first halt in a generation-long expansion.

But it is not the only period of restraint. This point emerges from Figure 2, which portrays spending on hospital and medical services — the same data as in the lower line of Figure 1 — but now as a share of Gross Domestic Product (GDP) rather than as real, per capita spending. The dates of introduction of the major programs of public insurance are also shown. It can be seen that while spending rose over the whole historical period prior to 1992 (Figure 1), its share of GDP actually topped out at the time of completion of universal coverage and then drifted downwards during the 1970s. Universal coverage was associated with the first clear period of global cost control.

This pattern broke in the 1980s, however, as the share of GDP spent on health care rose sharply in the recession of the early 1980s. Health spending retained this higher share throughout the rest of the decade, and then jumped even more sharply in the even more severe recession at the end of the decade. The trend in health care funding was unaffected by recession; when the overall GDP fell the health share rose.

The lower line at the right-hand side of the Figure indicates what the share of GDP might have been, if neither of these recessions had occurred. If one fits a (log) trend to real GDP per capita, over the period from 1947 to 1980, and projects this trend through to 1996, and if (which
is highly unlikely) one assumes that health care spending would have followed its actual path even if GDP had continued to rise on its previous trend line, then the share of GDP spent on hospitals and doctors would have drifted downwards during the 1980s, and fallen off markedly in the 1990s. But of course this did not happen.

The shift in economic performance after 1980 is also the key to understanding why there is such a contrast between the cost patterns of the 1980s and those of the 1990s. If the structure of the health care system was essentially unchanged over this period, and the administrative control mechanisms were “always there”, why were they not used before?

Figures 3 and 4 show the evolution of inflation-adjusted GDP per capita from 1947 to 1996, with the superimposed trend line fitted to 1980 and projected thereafter. Figure 4 takes the actual values from Figure 3, and expresses them as a ratio to the corresponding value of the trend line. What becomes obvious is that for the pre-1980 period, actual economic performance clusters quite closely around the trend, rarely departing by more than 5%. There was a substantial and quite prolonged recession in the mid-1950s, but it was followed by an equally pronounced recovery. What is notable about the 1980s is that there was no real recovery after the first recession. Despite the rhetoric at the time, and prosperous conditions in some parts of the country, the ground lost in the recession was never regained. Unemployment remained higher, fiscal deficits larger, and personal incomes lower. The next recession took us quite a lot further down, and as in the 1980s, the present “recovery” consists of stopping falling. There is no sign of a recovery in the sense of a return to our previous pattern of real income growth.

This then is the backdrop to the performance of the health care system. The degree of “tightness” of administrative control that was established in the 1970s, and that was quite successful, or at least adequate, in an environment of steady growth, was insufficient to deal with the post-1980s world. But providers of health care were accustomed to, and regarded as (their) right, ever growing resources. One had to be able to absorb all the new diagnostic and therapeutic possibilities that were constantly emerging; at the same time no one wanted to think about giving up anything. All quite understandable, but hard to maintain in a “no-growth” environment.

Winners and Losers: “Re-Priorizing” by Fiscal Default

But the post-1992 restraint, as emphasized above, has not been balanced in its effects.
Figures 5 to 8 illustrate the differential impacts across major sectors; the variations would of course be even more pronounced if data were disaggregated by province and by sub-sector. The general point, however, is that the overall containment has translated into quite substantial cuts in the hospital sector. A simple indicator of the relative severity of controls can be read off these figures by looking backwards in time, to find the years in which the share of GDP spent in a particular sector was about the same as it was in 1996.

The share of total health spending in GDP was about 9.4% in 1996. This was significantly below its 1992 peak, but still well above the level prior to the most recent recession. This observation supports arguments that the system, taken as a whole, is still well funded in terms of its share of the overall Canadian economy. On the other hand, if economic growth had continued at its pre-1980s levels, Figure 5 also shows that current spending levels would yield a percentage not seen for thirty years - just over 6%. So there has been considerable restraint, relative to past growth trends.

But hospital spending (Figure 6) now absorbs a share of GDP - not hypothetical but actual - roughly equal to its level at the beginning of Medicare in the early 1970s. That was of course a "local maximum" - there were downtrends in the 1970s and to a lesser extent in the 1980s, punctuated by the two recessions. And of course a good deal of the workload carried by hospitals in the 1960s is now in the (greatly expanded) long-term care sector. The current percentage is above that of most years of the 1970s, and not far below that of most of the 1980s. Nonetheless, Canadian hospitals could be said to have "lost" almost half a percentage point of GDP in the last four years alone, and this translates directly into lost jobs and/or lower incomes in that sector. Some expressions of distress are hardly surprising.

Physicians on the other hand (Figure 7) have maintained a share of GDP that is still well above its 1980s level. Their effective "insulation" from the recession that began in 1989 has largely been withdrawn, and perhaps painfully rapidly, since 1992. But their share is still high in historical perspective; and they have been affected much less than hospitals.

Finally drug expenditure, as shown in Figure 8, has been very little affected by the current period of restraint. Prescription and non-prescription drugs together now account for as large a share of GDP as does spending on physicians - a remarkable change from even ten years ago. As
noted above, the universal public health insurance programs in Canada do not cover drugs (outside hospitals and long-term care institutions). But every province provides some form of coverage for particular categories of people -- the elderly, those on welfare, people with unusually high drug bills -- and all have been struggling to control their shares of the steadily rising total.

Figures 5 to 8 make it clear that the Canadian health care system has been going through a shift in priorities, at least as expressed in spending patterns, with a redirection of substantial funding away from acute care hospitals and toward drugs. Physicians have suffered some short-term losses but seem, from a long-term perspective, to be holding their ground. There is, of course, no reason why global restraint of health should be reflected in balanced, across-the-board reductions. But in this case it is hard to avoid the sense that the relative burden of restraint has been determined by bargaining strength, and the specifics of payment arrangements, rather than health or other public priorities.

It is simply easier, both administratively and most importantly politically, to cut funds out of global hospital budgets than to negotiate and especially to enforce global limits on payments to physicians. And controlling fees alone, as is well known, is not sufficient to control total outlays. Physicians have other ways of adding to their billings, [The recent Canadian experience in attempting to control payments to physicians is described and analysed by Barer et al. (1996); but any published source is, by definition, somewhat out of date.]

Pharmaceuticals are, however, most problematic precisely because there is no universal public program of coverage. The combination of private, largely employer-based coverage with public programs for designated populations, and a substantial level of self-payment (co-payments or simply lack of coverage), is essentially similar to the American approach to health insurance (or the Canadian prior to universal Medicare). Accordingly it leads to exactly the same results. No one payer has enough leverage to control overall costs, and there is both temptation and opportunity to shift costs onto someone else – usually the patient – instead of controlling them. But shifted costs do not go away; they just come back later and larger.

The dynamics are well understood by all concerned. One of the reasons that the recent Report of the National Forum on Health gave for recommending the establishment of a universal public program of pharmaceutical insurance was that this would permit some control over the
costs of drugs. For exactly the same reason, the pharmaceutical manufacturers – especially the brand-name companies – are very suspicious of the idea. [The Forum were also responding to evidence of both inequity of access and cost burden, and inappropriate prescribing patterns.]

To this point, then, one could summarize the recent Canadian experience as not reform, but much more rigorous application of existing administrative control mechanisms, made necessary by a weak general economic performance, and made politically possible by a growing public awareness of the severity of the resulting public fiscal situation. But successful overall control has involved an unintended reallocation of spending, motivated less by conscious assignment of priority than by the differential abilities of provider groups to resist restraint.

Small Country, Large World: Related International Experience

Canada’s experience is not, however, unique. White (1995) observed that an “international standard” for health care finance had emerged in a number of industrialized countries, characterized by many of the same administrative control features -- global budgets, fee negotiation, limitations on capacity and manpower – that are found in Canada. And generally speaking, these administrative systems have been successful in containing costs in other countries as well – so long as the public are willing to support, or at least tolerate, the necessary measures.

Figure 9 shows, for the countries of the Organization for Economic Cooperation and Development (OECD), the (unweighted) average of the ratios of health spending to GDP. [Only those countries with continuous data series since 1960 are included.] The series for the United States and the United Kingdom are superimposed as representing high and low cost countries, and Canada is included to link with the previous figures. Figure 10 presents the data from Figure 9, but with the OECD average as a baseline of zero; the other three countries are shown relative to the overall average.

The most striking feature of Figures 9 and 10 is the change in aggregate performance in the mid- to late 1970s. Prior to that time, the all-OECD average moves up in parallel with the United States, though a couple of percentage points below. This was the period during which one might plausibly claim that “all countries” were experiencing similar patterns of cost expansion, though the U.K. was an obvious exception, as was Canada after 1970.
But that pattern changed roughly twenty years ago, and since the late 1970s the escalation of the OECD average has been much less rapid. American “uniqueness” is more and more evident. (One still sees the popular media -- and some analysts -- in the United States alleging that “all countries” have similar problems, but this is for domestic consumption.) The administrative mechanisms have had a substantial impact, at least relative to past performance, and relative to the one country where they could not be applied. In the earlier period, the U.K. cost experience dropped steadily below the rest of the OECD group, but for most of the last twenty years it has deviated much less, and most recently has moved back toward the average.

The last few years are of particular interest. The U.K. reforms, allegedly motivated by the objective of increased value for money, have been associated with a substantial acceleration in spending as compared with other industrialized countries. Maybe this is a temporary adjustment process; but for the moment it appears that managers, whatever else they do, cost money. The United States has actually seen a flattening of its share of GDP going to health care since 1992. There seem to be three schools of thought on this observation:

1. “Managed care” is finally working, and costs will now begin to fall;
2. This is a temporary phenomenon, and the upward march will soon resume;
3. Too soon to tell.

In any case the current American level is far above that in any other country (so that a mere flattening is not too impressive). And in other countries, such as Canada now but earlier in Denmark, Sweden, and Germany, costs have fallen as a share of GDP without a “managed care revolution” or even much in the way of reform. Indeed the overall OECD average now looks pretty flat; the recent U.S. performance is notable only relative to its own past.

But the international experience opens up some other interesting, and perhaps puzzling, perspectives on cost containment, and on reform more generally. Figure 11 presents survey data from several countries (about a thousand people in each country) compressed into a very crude measure of satisfaction with the country’s health care system (not satisfaction with one’s own health care, but with the system of organization and finance as a whole). These are then graphed against levels of per capita spending.

Apart from underlining American exceptionalism yet again -- so much spent, so little
satisfaction -- Figure 11 shows a clear relation between spending and satisfaction among the other countries surveyed. This is not good news for cost cutters or reformers; it suggests that any efforts at system containment should expect to meet public unhappiness that will readily be mobilized into political resistance. For Canada in particular, the very satisfying high ranking is from a time before the kink in the curve in Figure 1. The results might well be different now.

Figure 11 supports the argument that effective administrative controls on health care costs -- and indeed more detailed tools of management -- may exist but be politically too difficult to use. It leaves open the question of whether “reform” might change the situation. If there is in fact a generally close relation between spending and satisfaction, such that cost control equals political unpopularity, might there be ways of avoiding this trade-off through some form of restructuring? The data in Figure 11 show that it is possible to fall off the curve in the negative direction -- to spend a lot of money on a system that people do not like. But unfortunately no country leaps out as being well above the curve, with high levels of satisfaction and low health spending.

Yet the relationship expressed in Figure 11 does not appear to be as simple as (a public perception that) “more is better”. Spending and services are not the same thing; as every economist knows expenditure is the product of price and quantity. Only if health care prices were the same (relative to the prices of other commodities) in all the surveyed countries, would it be correct to infer that people receive more health services in the countries where more is spent on health care.

But these prices are not equal; in fact they appear to be very unequal across countries. Figure 12 presents, for the countries of the OECD, data on per capita health spending adjusted to U.S. dollar equivalents in two different ways. Both use exchange rates based on “purchasing power parities” (PPPs) that estimate the relative values of different national currencies, from the amounts they will purchase, in each country, of an identical “basket” of commodities. The first and most common form of comparison uses a PPP measure based on a commodity basket representative of the whole of the GDP, but the second includes only health care services in the hypothetical “basket”. As can be seen, the two different measures tell very different stories about international comparisons of health care spending.

The two bars for the United States in Figure 12 are identical, not affected by the choice of
PPP, since neither is adjusted. Per capita health spending in the United States is estimated and reported in $US. But for each other country the bars differ according to how the prices of health care commodities, relative to the general price level, compare with that same relationship in the United States. If health care is relatively cheaper (more expensive) in country X than in the United States, then the grey bar for that country will be higher (lower) than the black bar. This indicates that the per capita use of services is higher (lower) than would be reflected in a comparison of expenditure levels adjusted by GDP-based PPPs. A unit of the currency of country X actually buys more (less) health care in country X, relative to what a $US would buy in the U.S., than one would infer from exchange rates based on general PPPs – because health care is relatively cheaper (more expensive) in country X.

Taking Canada as an example, a comparison of the black bars shows that when Canadian health spending is converted into $US at general, GDP-based PPPs, we get the familiar result that Canadians spend much less than Americans. In 1985 the ratio was about three-quarters; it would be lower now. But health care prices are so much lower in Canada (relative to the prices of “other things”) that all of this difference disappears when one uses health sector PPPs for the comparison.

This implies that Americans and Canadians actually receive the same amount of health care services (although the mix could be different, and indeed we know that it is). Americans spend more, but do not get more; they just pay higher prices. As Figure 12 indicates, the grey bars exceed the black in every OECD country in the study. Some countries, such as Sweden, the U.K., and Japan, appear to enjoy particularly low prices for health care, and a correspondingly large increase in their relative position in terms of per capita service use. Others, such as Australia, New Zealand, and Germany, look more similar to the U.S. But everyone has some advantage.

Unfortunately the comparative price data are not nearly as good as one might wish, and in any case the study shown here is now a bit elderly. One should not make too much of the fine inter-country detail. But the general point remains valid; if one wishes to compare the relative availability of services, one must deflate expenditure data by prices specific to health care services themselves. And if one did this with the expenditure data in Figure 11, the comparatively regular relationship between spending and satisfaction would certainly break down. So why might
satisfaction be based, not on access to services (insofar as that is represented by use), but on spending levels?

One should not, perhaps, push the simple bivariate relationship in Figure 11 so hard. But there is a rather obvious connection between spending and public satisfaction that runs through the behaviour of providers of care. Total spending on health care is, always and by definition, equal to the total incomes earned by those who work in or otherwise provide resources to the health care sector. That is just basic national income accounting. When expenditures stop growing, or fall, so do total incomes. Someone gets hurt, economically. Their distress, in turn, is communicated to patients.

In Canada we have “medical terrorism” – deliberate (and occasionally confessed) scare-mongering by physicians – to try to convince citizens that their health will be at risk if more money is not made available. [The “crises” are always described in terms of shortages of resources – people, beds, equipment – but the solution is always more money.] In France, actual strikes by doctors seem to be fairly common, and always directly or indirectly about money. In the United States, efforts to establish some form of national health insurance have been defeated by very sophisticated and well-funded dis-information campaigns by physicians and private insurers. These have spread fear about the consequences of adopting any specific alternative to the current system, so paralysing attempts to change it. The British, from long experience with the National Health Service, have coined the expression “shroud-waving”: “Give us more money, or you or your loved ones will die!”

The general point is that doctors, nurses, drug companies, and other providers of health care (or related private services) use public fear as one of their principal weapons in contests over resources with governments, or whoever else is paying the bills. Thus public satisfaction or unhappiness with health care systems is based on some mix of personal experience, and “second-hand” satisfaction (or more accurately dissatisfaction) transmitted from providers.

Provider unhappiness in response to efforts at cost control then translates into pressure for “reform”, but it is “reform” with very different objectives from those motivating reformers seeking greater value for money. Indeed they are diametrically opposed; providers’ ideas of “reform” seem rather to focus on greater money for value. People with different objectives, however, often
employ the same rhetoric, not least because an open and explicit admission of what the real objectives are might make it much more difficult to secure broader political support.

The different objectives and corresponding arguments that have arisen in recent debates over health care reform in Canada turn out to be the same as those that have emerged throughout the life of our system, and indeed over the decades preceding its establishment. Efforts are made to present these arguments as “new thinking”, but in fact the same interests consistently put forward the same policies to achieve the same objectives, year after year, decade after decade. Nor is this situation peculiar to Canada. The interest groups involved are universal, and so are the arguments.

At risk of substantial oversimplification, however, one might say that there are, not just in Canada but universally, two major and distinct sources of pressure for reform, in the sense of significant changes in system organization. One source arises from the observation that attempts by governments, as payers for care, to control system costs and more generally to increase their management role so as to increase “value for money” are politically difficult and dangerous as well as technically demanding. The experience in Canada, as elsewhere, is that control is clearly possible, and better management may be possible, within existing structures. But there are indeed political costs. Some sort of structural “reform” might ease this trade-off.

The second source of pressure for reform, however, is providers themselves. Their objective, as a very crude simplification, is to restructure payment systems so as to make difficult or impossible the forms of administrative control now being applied, and thus to increase overall costs. They offer payers a “solution” to their difficult political trade-off in the form of cost-shifting, rather than cost-control. Simply pass the problem on to someone else – patients, private employers, anyone – and control your own outlays while letting the overall system (and its costs, and out r incomes) go where it will.

This is a very tempting siren song for fiscally pressed or ideologically conservative governments. It is also a very short-sighted strategy, short-term relief for long-term and possibly irreversible damage, as the American experience shows. But the danger is that “reform” strategies that start with the objective of improved management and control may become diverted into the path of (short-term) least resistance and perverted into simple cost-shifting exercises.
Certainly there will be a great deal of interested pressure exerted to bring this about.

**Distributional Effects of Alternative Funding Sources**

Nor are providers the only interested sources of pressure for “reform” in the sense of cost-shifting rather than system management. Figure 13 makes a point that should be obvious a priori, but that tends to be lost in discussions among economists in particular. Public health insurance programs are funded by contributions that are largely or wholly unrelated to either use of care, or risk of illness. These could be equal contributions per capita, but in practice they generally bear some relation to income. Systems funded from general taxation, like Canada’s, require people to contribute more or less in proportion to their incomes, regardless of their illness experience or risk status. Private insurers, by contrast, charge premiums that are based on estimated risk; when premiums are experience-rated they become used-based for the insured group as a whole. Direct charges are of course based on use.

It follows that the larger the proportion of system costs that are drawn from public funds, the greater the proportion that will be paid by people with higher incomes. Conversely the greater the proportion financed privately, whether by insurance or by self-payment, the smaller the proportion that will be contributed by the healthy and wealthy, and the greater the share that will fall on the unhealthy and unhealthy.

As noted above, this should be obvious a priori. Figure 13 presents data from the United States, showing the proportion of family income spent on health care through taxes, private insurance premiums, and self-payment, by income class and age of family head. As one would expect, both forms of private payment take a much larger share of family income at lower incomes, while taxation to support public programs for health care takes a larger share of the incomes of upper income people. It follows that, for a given level of total health care expenditure, increasing (decreasing) the proportion funded through private channels will decrease (increase) the share borne by people at the upper end of the income distribution, and increase (decrease) the share borne at the lower end.

It is also worth noting that the distributional pattern in Figure 13 holds for households with a head aged over 65, as well as younger ones. The United States does have a universal health insurance program for those over 65, but its benefits are diluted by substantial user charges
-- deductibles and coinsurance -- ostensibly to control costs and discourage inappropriate use. The record on cost control is what it is; but it is also true that most elderly Americans purchase (if they can afford it) some form of private insurance to cover (a part of) these charges. But the cost of this private insurance is not, of course, related to their incomes, so it takes up a larger share of the incomes of the lower-income elderly. The user charges in the American version of Medicare may or may not have any effect on overall use and costs, but they very clearly act to redistribute the overall economic burden of paying for care from higher to lower income people.

Are such redistribuional effects good or bad? That is a political question, and economists have no more (or less) ability to answer it than anyone else. Where you stand rather depends upon where you sit. But what one can predict with some confidence is that arguments for “reform” that emphasize “more personal responsibility” in health care finance are much more likely to come from, and be supported by, those toward the upper end of the income distribution. They have a clear economic interest in shifting more of the costs onto individual patients or private insurers. Moreover, when wealthier people do become ill, a system with a substantial amount of private payment will provide them with preferred access to services. Any “shortages” will be borne by those who cannot pay. Moreover, what the wealthy and unhealthy may have to pay for their own care can be offset against the taxes saved by not having to support a similar standard for everyone else.

The National Accounting Framework: Inevitable Constraints in Every System

All this discussion may seem rather cynical, the sort of thing that one would expect from an economist who knows the price of everything and the value of nothing. And clearly people’s motivations do go far beyond personal economic interest; otherwise most discussion would be pointless and no real society would exist. But the discussion of health care reform is often confused by claims and understandings that simply make no sense in terms of the underlying accounting relationships that, unfortunately, must and do hold, regardless of what we may claim to the contrary. An attempt at clarifying these relationships, so as to provide the basis for the discussion above, is offered in Figure 14, with a subsequent discussion laid out in Figures 15 to 18.

Figure 14 represents an adaptation of the standard national income accounting framework applied to the health care system alone rather than to the whole economy. For simplicity it has
only three sectors – households, producing firms, and government – suppressing the usual fourth or foreign sector. Figure 14 also abstracts from the accumulation and decumulation of assets and has no explicit time dimension. Everything happens within one country, and within a “year”.

A certain sub-set of all the goods and services produced and consumed in this economy are designated as “health care”, presumably because they are perceived as bearing some special relationship to health. These commodities are produced by “providers”, that are NOT people, but economic organizations – professional practices, hospitals, public clinics, drug and equipment manufacturers, etc. Real, physical people, including doctors, nurses, pharmacists, etc., are all members of the household sector. The importance of this distinction, standard in national income accounting, should emerge below.

Households own resources, including the very important resources of professional skills, time, and energy, but also various forms of capital and raw materials, that they supply to provider firms. Firms then convert these resources into commodities – the whole range of goods and services that have been identified as constituting “health care” – and these commodities are supplied to and consumed by members of households. These “real” flows, of real, physical resources flowing from households to firms, and real goods and services flowing back the other way, are represented by dotted arrows in Figure 14.

But households do not supply their resources for free. Firms pay for them, in the form of wages and salaries, but also “rent, interest, and dividends” in the national accounting phrase, and (of particular importance for health care) net incomes of unincorporated business. These payments then make up part of the incomes of those households that supply resources for health care production. For some, physicians and nurses, for example, this may be most or all of their income. But the holder of shares in a mutual fund, that has in turn bought shares in a drug company, is receiving dividend income from the health care sector. So is the owner of a building who rents out part of the ground floor to a pharmacy, and these amounts are also included in the total dollar value of incomes paid by providers back to the household sector. These financial flows are represented by a solid arrow.

Providers must also be paid for their products, either explicitly as prices or fees, or implicitly through some form of budgetary process. These receipts must exactly equal their
expenditures; no assets or debts are accumulated. (This is not as unrealistic as it may appear. Profits and losses in the firm sector are flowed through the income arrow to some of those in the household sector—usually the firm's owners but sometimes, as in the case of bankruptcy, its suppliers. Firms always break even because all discrepancies are moved, conceptually, to the books of the household sector.) Total expenditure on health care thus equals total incomes earned by households from its production.

So far, so good, and this framework can be applied in any country. The simplifying assumptions can be relaxed without conceptual difficulty, but at considerable graphic cost. The variations come in when we consider how revenues are assembled, and providers are paid. (There are also a great many different ways of organizing the processes inside the provider box; these are important but will not be considered here.) In “normal” markets, members of households pay providers directly for their services, exchanging currency for commodities at some explicit price. The same is true for some health care commodities. But there are two other major channels through which revenues are assembled for payment to health care providers, taxes, and private insurance.

In all developed countries (including the United States but with the possible exception of Switzerland) by far the largest proportion of funding for health care flows either directly through governments, or through highly regulated “quasi-autonomous non-governmental organizations” that are, in effect, public bodies. There are significant differences between systems that fund from general taxation, and those that collect social insurance premiums, but at this level of generality we follow the practice of the national income accountants and treat them all as taxes. Social insurance premiums are, after all, both compulsory and (largely or wholly) unrelated to one’s risk status. The significance of truly private health insurance, on the other hand, varies from one country to another. In some countries it is very small; in the United States it accounts for about one-third of all health care expenditure. (This falls to about one quarter, however, if government subsidies are netted off.)

These three sources of revenue are indicated by the three solid arrows flowing out of the household box. (We ignore minor items such as charitable contributions.) They add up to the total value of expenditures on health care, and these in turn equal the total incomes earned from health care production. Because these relationships are derived from an accounting model, they
are identities arising from the underlying conceptual structure. They cannot not be equal – except by arithmetic error.

Figure 15 reminds us, however, that both the expenditure and the income components of this three-part relationship have a price and a quantity component. The resulting equation is shown at the top of Figure 16. For expenditures this product is obvious; total expenditures are a (vector) product of the (average) prices per unit of each of the different types of commodities included under the label of health care, multiplied by the respective quantities provided. Health care expenditures may vary over time or across countries, either because of differences in service use, or because of differences in relative prices. This is the point that emerged so strongly from the cross-country comparisons in Figure 13, health care is in fact much more expensive, in relative terms, in some countries than in others.

The same is true of the resource inputs. These are factored into $Z$, for the (vector of) amounts of each of the different kinds of resource inputs used in health care production (e.g. person-hours of a particular professional or skill type) and $W$ for their average rate of payment (e.g. wages per hour). Variations in health expenditures may be traced either to varying quantities of resources used in health care, or to variations in relative incomes. A country with high levels of expenditure may be providing its population with a high level of services ($Q$); or it may simply be paying relatively high incomes to those who provide inputs to health care ($W$). These will then be carried forward in higher prices ($P$). Relatively high prices may also reflect technical inefficiency, in the form of a relatively high level of resource input ($Z$) per unit of output ($Q$).

The lower half of Figure 16 “unpackages” the aggregate equation, to remind us that the totals represent sums over all the different individuals, different types of health care services, and different types of resource inputs used in their production. While the aggregate equation is an identity, and must balance, it need not and probably will not balance for any one individual (or household). The same person can be at once a user of, a payer for, and an income earner from health services. But the amounts will be very different.


A healthy cardiac surgeon will receive a very high level of income from health care, but will account for only a small or zero level of expense. His level of contribution will be greater or
less depending upon whether he lives in a country where health care is primarily tax-financed, or one in which there is a high level of user-pay and private insurance. The former will cost him a lot; the latter, much less. A successful business executive will draw little or no income from health care (unless he is in, or owns stock in, a health-related business) but is otherwise similar to the surgeon. On the other hand an elderly widow with a chronic illness, living on a public pension, will earn little or nothing from health care, but will account for a substantial amount of expenditure, and again will contribute more or less depending upon the financing system. A tax-financed system will cost her little; but one that relies heavily on user charges and private insurance will take a relatively large proportion of her income. Compared with the surgeon or the businessman she both uses many more services, and has a much smaller income. In a strictly user-pay system, of course, she will probably be simply unable to afford the care she needs, and will be unable to purchase insurance. That is why all developed countries finance most of their health care through the public or quasi-public sector.

In general, as shown in Figure 17, we can divide the population into three groups. First, we can identify those for whom WxZ, their earnings from the provision of health care, exceed both their contributions and the proportion of costs that they account for. These we label “providers”; the rest of the population are primarily users of and payers for care. In general, providers have an economic interest in measures or policies that increase the total flow of funds into health care. Cost control, and more generally “value for money”, are the concern of payers. As (actual or potential) users, we all have an interest in access to appropriate and effective care. But as payers we want to see it efficiently provided at reasonable cost. Providers share this language; but their views on “reasonableness” and “appropriateness” tend to differ from those of payers. The conflict of (economic) interest is unavoidable.

But payers/users, the rest of the population, can also be divided according to whether they account for more of total expense than they contribute in revenue, or less. Those who contribute a lot and use little, we may call the healthy and/or wealthy; those who use a lot and contribute little are the unhealthy and/or unwealthy. The dividing line can be derived from the equation at the bottom of Figure 16, by holding total expenditure constant and shifting revenue sources between taxes and direct charges. This involves making exactly off-setting changes in tax and coinsurance rates for the system as a whole, and then identifying the characteristics of those individuals whose total contributions rise or fall (Evans et al. 1994). Those whose share of total
income exceeds their share of total health expenditure, will gain (lose) if direct charges are increased (decreased) and tax financed is reduced ((increased).

"Reform" proposals in any country, can be represented in terms of rearrangements of the boxes and arrows in Figure 14, with corresponding changes in the sizes of the different components of the equation at the top of Figure 16. But the equation reminds us that it is impossible to do only one thing. Any change in one component must be matched with either offsetting or balancing changes in other components. But the disaggregation at the bottom of Figure 16 further reminds us that any "reform" will have distributional implications, helping some economically and hurting others. And the classification in Figure 17 shows that groups of potential gainers and losers are well-defined — and can be readily identified, by themselves as well as others — in terms of the relationships in that equation.

From Cost Control to Cost Shifting: The Universal Provider Strategy

Thus, when governments limit their expenditure (as in Canada), the value of T falls, at least relative to what it would otherwise have been. (This may be in the form of reduced future taxes for health care, i.e. less current borrowing; asset changes are not explicitly represented.) This must correspond to a reduction in both P x Q and W x Z, lower relative incomes for people working in health care, and/or fewer jobs and shrinking markets. This could be avoided, however, if C and/or R, direct charges to patients or private insurance, could be increased. And indeed, as noted above we are seeing increased pressure from provider representatives in Canada for "two-tier" medicine, permitting doctors to bill their patients directly for real or imagined benefits of preferred access to services. Whatever other effects this would have, it would at least maintain provider incomes.

On the other hand the European advocates of "separation of purchaser from provider" focus their attention on the relation between payers, particularly governments, and providers, while (in some cases at least) leaving the assembly of revenues largely within the public sector. Traditional public health services, as in Sweden or the pre-reform United Kingdom, consolidated the actual provision of services within government, thus combining the blocks that are shown as separate in Figure 14. Their separation is intended to increase both the efficiency and the effectiveness of health services.
But increased efficiency implies that fewer resources are required to produce a given level of output—lower Z for given Q. Unless output is also expanded, total incomes will fall along with costs. Jobs, or sales, are lost. Similarly, if increased effectiveness is achieved by reducing or eliminating some services as ineffective in improving health, then the resources previously employed in producing those services are now no longer needed—again, unless activity can be increased somewhere else in the health care sector.

Thus there has been a continuing tension in the health care reform process, between those who are trying to maintain or expand output at lower cost, and those who are trying to maintain or expand costs—incomes—whatever the level or pattern of output. The latter may be willing to offer higher output in return for higher cost—as appears to be the case so far with the British reforms to the National Health Service. But they will resist bitterly—as appears to have been the fate of the Plan Juppe in France—reforms that are quite explicitly designed to make overall cost reduction more acceptable to the general public by assuring or expanding levels of output.

And always in the background is the fundamental division of interest among payers/users, between the healthy and wealthy and the unhealthy and unwealthy. When providers strive to divert “reform” efforts from cost-containment to cost-shifting, the healthy and wealthy (and the unhealthy, if they are wealthy enough) can usually be counted on as their allies. Even if no progress is made on system management—even if overall costs go up and efficiency (and public satisfaction) go down, the wealthy and healthy may still benefit if funding sources are shifted from public ro private.

Figure 18 lists several policies that have been suggested or applied in the management of health care systems; their distributional effects can be worked through the framework developed above. User charges, frequently advocated by economists fascinated with the theoretical properties of markets as a way to control costs, have already been demonstrated to be regressive in their distributional effects. The only other point to note is that such charges are consistently advocated, in all countries, by physicians and other providers. It can readily be seen, from the equation in Figure 16, that if a rise in C (direct charges) did in fact lower Q while leaving P unaffected, then either W or Z—or both—must fall. Physicians would be advocating a cut in their own incomes.
But of course physicians are not naive — though economists may be. They advocate user charges to increase the flow of private funds into health care, confident that aggregate effects on Q, if any, will be small, and can be offset by increases in P if physicians can regain direct control over their prices. Governments are relatively effective at cost control, private individuals or insurers are not, so the more private money that can be brought in, the higher will be overall costs. So long as public contributions (T) do not fall in response to the increases in C, then total costs and incomes will be increased, however that increase may be split between P and Q. Meanwhile, the market economists simply confuse the public and the politicians as to what is really at stake.

Technical efficiency, as partly discussed above, is more interesting. An increase in Q for given Z can be captured in several ways. If P and Z can be held constant, then Q and W go up together. This appears to have been the case with the dramatic improvements in efficiency in cataract surgery, and earlier in cardiac by-pass grafts, in the United States. (And also in Canada, despite the very different processes of fee-setting.) In a genuinely competitive market, increased efficiency, lower unit cost, and higher output are associated with falling prices. But this did not happen in the United States surgical market; instead surgeons captured all the gains. Only when the U.S. Congress began the direct regulation of fees through the Resource-Based Relative Value Scale (RBRVS) were surgical fees adjusted downward.

The U.S. experience with surgery was, at least prior to the RBRVS, providers' "best case" scenario for technical change. The "worst case" would have Q (and W) held constant, so that Z falls as efficiency increases. Unit prices (P) thus go down, and payers reap all the benefits of the change while some providers have to leave the industry. An example might be pharmaceutical dispensing; individual pharmacists can do little to increase the overall volume of prescriptions written — fortunately for them that is rising anyway — so cost-reducing innovations such as dispensing assistants or mail-order dispensing are a direct threat to their employment. Such innovations have accordingly been bitterly resisted over years or decades — unlike the changes in surgical technique.

The intermediate case, redeployment, involves holding both Z and W constant — protecting jobs — and increasing the overall level of health services output. The mix of services may change. Thus, acute care hospital use falls, but ambulatory services, home care and long-
term care expand. New “needs” are met. In effect, P has fallen but Q has risen to compensate, and those who hoped for a reduction in overall costs from improvements in technical efficiency have been disappointed. They have more services instead, whether they wanted them or not, and if providers have not benefited from improved efficiency, they have at least pulled its teeth.

Efforts to define “core services” that should be funded through public insurance programs play a similar role in pulling the teeth of the health care evaluation movement. The guiding idea behind the evaluation of health services is that many services now being provided are of little or no benefit, either at all or for many of those to whom they are offered. If such ineffective services could be identified, through reliable scientific analysis, then providers should stop offering them. In any case no one, public or private, should pay for them.

But efforts to identify and weed out ineffective services will, if successful, reduce (some elements of) Q. Unless compensating increases can be made elsewhere (or prices somehow increased) total costs and total incomes will fall. The elements of Z previously used to produce the ineffective services will no longer be reimbursed. It may be the case – will be, if the evaluators have done their jobs properly – that the health of patients will be unchanged or even increased as a result of the elimination of these services. But that is a separate issue. Whatever the health effects, someone’s income is threatened.

Enter the advocates of “core services”, or “basic benefits”, who would refocus attention on the sub-set of health services that should be covered by public programs. Rather than identifying and eliminating ineffective services from the total bundle, this approach would divide the vector Q into “core” and “non-core” services and transfer the latter from public coverage into the private marketplace. Private payment for these services will increase C, and so long as public payers do not reduce T in response, the total flow of funds will be increased. Even if public payers do reduce their contribution, private funding can now make up the difference. Furthermore, when sellers can set their own prices rather than having to negotiate with public payers, they can and typically do charge higher prices. And all the embarrassing questions about whether the services actually do any good for patients can be avoided. In the private marketplace, if consumers want to buy it, that is sufficient justification for its sale. A program intended to reduce costs and increase the effectiveness of care is thus diverted into cost-shifting, with the expectation of higher overall costs and lower effectiveness.
In general, however, attempts to define and de-insure “non-core” services have run up against the problem that very few services are clearly of no value to anyone, in any circumstances, at any time. A great deal of effort can be put into identifying trivial sums of money. The really large issues are services that are sometimes effective, but are used far more often than they should be, and these cannot be dealt with by a yes/no, in or out decision.

But we may be seeing, in North America, the beginning of a very large-scale shift from covered to uncovered services in the pharmaceutical sector. Manufacturers in the United States are increasingly marketing prescription drugs directly to the public, and are clearly very interested in removing the legal barriers to doing so in Canada. At the same time, they are applying to have drugs that were previously available only on prescription approved for “over-the-counter” sale. This strategy may be in response to greater efforts at pharmaceutical management and cost control by managed care organizations in the United States, and public payers in Canada.

Over the next decade, then, we could see an increasing proportion of drug costs moving out from insurance coverage – public or private – into the general marketplace. One might have questions as to the implications for the health of the population served, if increasingly powerful drugs are marketed directly to consumers. But this process does appear to be an example of a de facto redefinition of insurance benefit coverage, driven by providers, and quite explicitly intended to maintain or expand their own sales.

Finally “two-tier” services, I take to mean a system funded from public sources, with a parallel “private” system in which people can pay for preferred access to superior services, perceived or actual. Private insurance may or may not be permitted; in Canada for example it is illegal to offer private insurance coverage for services that are already covered by the public programs. (Private insurance for out-of-country services is, of course, perfectly legal.) A standard argument for two-tier systems is that they relieve the pressure on chronically under-resourced public systems. (And anyway what is wrong with people spending their own money if they so choose?) It should be noted, however, that the argument about supplementation of under-funded public systems is used regardless of the actual level of funding. It is heard both in Canada, still near the top in financing, and in the United Kingdom, still near the bottom.
What seems most clear about “two-tier” systems, actual or proposed, is that prices are higher in the upper tier. The “more resources” drawn in through private payment are reflected in increases in P and W, as much as or more than in Z and Q. Moreover, to the extent that a private tier really does bring in increased resources for health care, rather than just more money for providers, these may go to enhancing the image of the private tier – the plush carpets, the high-tech apparatus of dubious value – rather than meeting real health needs. Nor is this surprising, because the central problem of providers serving the upper tier is: “How do you convince people to pay more money?”

An obvious answer is to focus ones’ marketing on the healthy and wealthy, who can afford to pay extra for whatever services they might need. But this may be a small market. To expand, one must convince a large number of people who really need services that there is a significant difference between the private and the public tiers, in both ease of access, and probability of a good outcome. This, in turn, is most easily achieved if physicians can work both in the public and in the private systems, “streaming” patients and marketing private services to those with money.

The classic behaviour is for the physician with a private practice to promote the build-up of a long waiting list in the public system, and offer rapid access, for a price, to his private facilities. This seems to be a form of behaviour that generalizes across countries, though the specific ways it is done vary depending upon the local organization. Where physicians paid salaries or sessional fees in a public systems, they may simply fail to put in the contracted time, working in their private practices instead. In effect they sabotage the public system, pushing patients into the private tier.

But if the public system itself reimburses by fee for service, limiting its output will be more difficult. Especially in a system as well-funded as Canada’s, where the “long waiting lists” are largely an American myth, some sort of misrepresentation or outright interference with access would be necessary to convince people to pay out of pocket. (The waiting lists are largely, but not entirely mythical; there do appear to be some significant problems in orthopaedics, and transplant surgery depends upon the supply of suitable organs. But the key issues are managerial; there is no overall scarcity of resources.)
But the really serious effects are unlikely to emerge unless private insurance can be bought to cover private costs. And international experience suggests that that, in turn, probably requires some form of public subsidy, either directly or via tax concessions or regulation. Under such circumstances, there may be a substantial increase in the real resources absorbed by the health care system—the Z. But these would include all the underwriting, marketing, and administrative costs in the insurance process itself, as well as the extra administrative costs imposed on providers in order to comply with the requirements of private insurers.

These costs, in a full-blown private insurance system, can be quite staggering. The extra costs associated with “paper-pushing”, compared with those in an efficient system like that of Canada, have been estimated at over $100 billion a year in the United States, or over ten percent of total health care costs, and the discrepancy seems to be growing (Woolhandler and Himmelstein, 1991, 1997). Figure 19 shows the trend, since 1960, in the share of GDP devoted to costs for pre-payment and administration in Canada and in the United States. It should be noted that these data do not include the (very large) costs incurred in hospitals, physicians’ offices and clinics, and by individual patients in dealing with the very complex American payment system.

These administrative costs can be handled two different ways in our equation. The extra time and effort of all the financial, marketing, legal, and other personnel, the buildings and equipment, etc., all go into increased Z, with their corresponding rates of reimbursement W. But they do not produce any more health care services, as most of us would recognize them. So Q does not rise, and therefore P must. Recall that in Figure 13, relative prices of health care goods and services were higher in the United States than in any other OECD country. The net effect of private insurance is thus to increase R, P, and W and Z, lowering technical efficiency. If there are public subsidies as well—as in practice there usually are—then T also rises and R goes up less than it would otherwise have to.

Alternatively, however, it has been argued that because more resources have gone into the health care sector, the health services that emerge are somehow of higher quality—reflecting the better management or greater consumer choice among insurance plans. Costs are higher, but users are getting “more” services, higher quality if not higher quantity, because more has been spent, directly and indirectly, to produce them. In this case Q is in fact increasing, even if the increase must be seen with the eye of economic faith. Since the “increase” in Q has had no
detectable effect on anyone's health status, however, we would then have to conclude that the additional service “quality” was ineffective. Private insurance, on this interpretation, leads to more, but less effective, output. In any case, it leads to higher costs.

Risks of “Reform”. Advantages of Adaptation: The Current Situation in Canada

The analysis of Figures 14 to 18 is illustrative of the general point made previously. Health expenditures, by definition, equal health incomes; and it follows that any effort to limit the escalation of costs will be resisted, in a number of different ways, by those whose incomes are threatened. To the extent that efforts to “reform” the organization, delivery, and funding of health care services are expected to influence their overall costs, powerful pressures will be brought to bear in order to direct reforms toward cost shifting rather than cost control.

In this process, the public rhetoric will tend to be focused on expenditures (PxQ) and particularly on allegations as to the inadequacy of the quantities of services provided. But the real driving force behind efforts to capture the “reform” process comes from the income side (WxZ). And the critical policies have to do with the sources of funding (T+C+R). The consistency with which those who make their livings from the health care sector advocate increases in C and R, more private funding, is not coincidental; but rather a perfectly understandable focus on the only way of maintaining and increasing WxZ if T is capped reduced. If reformers can be persuaded to spend their time debating abstract economic claims about the putative efficiency of various market structures, they may “take their eyes off the ball” of how much total revenue is being collected, and from whom. There is then a good chance that reforms can be structured so as to permit cost expansion, or at least prevent reduction. If in the process the burden distribution becomes somewhat more regressive, so much the better.

Viewed from this perspective, the Canadian experience of tighter administrative control without structural reform may represent a less risky, if less exciting, path to system control. In effect, public policy has focused on the revenue side by maintaining the virtual bans on user

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3 One might then argue -- some have -- that the higher “quality” shows up in increased patient satisfaction, rather than in health outcomes. Indeed it must -- otherwise “consumers” would not have paid for it. But by this point the argument becomes completely circular. The reality test is to ask American patients how much “satisfaction” they derive from dealing with the ever-changing maze of “choices”, constraints and charges in that system. Consumers’ Union has in fact done so, and the results, not surprisingly, do not confirm the claims of public relations
charges and private insurance, at least for hospital and medical services. Whatever else happens, then, controlling \( T \) will control overall costs. And, again despite much rhetoric to the contrary, most of the limitation in expenditure seems to have taken the form of reductions in \( P \), not in \( Q \) – outputs have risen, not fallen, in both the hospital and the physicians’ services sectors. Under fiscal pressure, the system has become more efficient.

But the balancing equation is relentless, both provider incomes and levels of employment, \( W \) and \( Z \), have been reduced. Moreover the uneven distribution of the financial pressure does appear to have led to genuine problems in some areas. Not all of the claims of inadequate care are economically motivated. And the opponents of cost control understandably strive to give the highest public prominence ny problem areas. Figure 20 indicates that while Canadians still place the highest importance on equal access to care, there is also a very substantial concern for the quality of that care. If they came to believe that access or quality were being compromised in the name of “efficiency” or cost control, the present solid support for the public system might begin to crumble. The rhetorical fear-mongers accordingly use individual anecdotes of inadequate care to allege system collapse: “It will not be there when you need it!”.

But overall, though the adjustment may take some time, the Canadian system seems to be adapting to a somewhat less rich financial diet. And so far, public confidence in the system seems to be holding, as indicated in Figures 21 to 23. No major structural reform has occurred, and none seems necessary.

**SOURCES AND REFERENCES**

Estimates of national health expenditures, total and components, as reported in Figures 1, 2, and 5-8 are prepared periodically by staff at Health Canada, and now distributed by the Canadian Institute for Health Information. The latest estimates were included in “Drug Costs in Canada”, a paper prepared by Health Canada and submitted to the House of Commons Standing Committee on Industry for the review of the Patent Act Amendments Act, 1992, (March, 1997). The methodology for the current series that have been revised back to 1975 is given in Canada, Health Canada (1996) National Health Expenditures in Canada, 1975-1994 Full Report Ottawa: HC Policy and Consultation Branch (January). Data back to the late 1940s have been pieced together from earlier publications; the sources are given in the data appendix to M.L.Barer and R.G. Evans (1986) “Riding North on a South-Bound Horse? Expenditures, Prices, Utilization, and Incomes in the Canadian Health Care System”, in R.G.Evans and G.L. Stoddart (1986) Medicare at maturity: Achievements, lessons & challenges Calgary: University of Calgary Press for the Banff Centre, pp. 53-163.
Expenditures are deflated by the All-items Consumer Price Index, population estimates are for July 1 of each year, and GDP estimates are from the National Accounts, all generated by Statistics Canada (Figures 2-8). Data used are most recent estimates available at time of preparation.


Figures 14 –18 were prepared by the author. Figure 19 combines national health expenditure data for Canada and for the United States; the revised Canadian series subsequent to 1975 are not published but are available from the Canadian Institute for Health Information. The American data are from the OECD HealthData 96; the GDP concept differs slightly from that reported in American sources.

Figures 20-22 are from an EKOS survey supported in part by the National Forum on Health in 1995; Figure 23a,b is from surveys conducted by the Canada Health Monitor, 1995.

Other works referenced (without any pretense of a complete bibliography) are:


Figure 1

Canada Real Health Spending per Capita
$1986, 1947 - 1996

$2,000
$1,800
$1,600
$1,400
$1,200
$1,000
$800
$600
$400
$200
$0

year

Total

Hospital and MD
Figure 3

Canada Real GDP per Capita
$1986, 1947-1996

YEAR

GDP

Time Trend (47-80)
Figure 4

Canada Real GDP per Cap. over Trend
$1986, 1947 - 1996
Figure 5

Canada Health Expenditure over GDP
1960 - 1996

Actual

Trend GDP Projected
Figure 6

Canada Hospital Cost over GDP
1947 - 1996
Figure 7

Canada Physician Cost over GDP
1947 - 1996
Figure 8

Hospital, Physician and Drug Costs
As Percent of GDP, Canada, 1960-1996

- Hospitals
- Physicians
- Drugs (60-75)
- Drugs (75-96)
Figure 9

Health Care Spending over GDP
Selected Countries, 1960-1994

Figure 10

Health Care Spending over GDP
Deviation from OECD Average, 1960-1994

Canada  U.S.A.  U.K.
Figure 11

Satisfaction with Health Care
Selected OECD Countries

Proportion "System Works Well"

Per Capita Spending, in $US, 1989
Figure 12

Health Care Spending per Capita, 1985
As % of US, in Purchasing Power Parity

[Bar chart showing health care spending per capita for various countries, comparing GDP PPPs and Health Sector PPPs.]
Figure 13

Family Expenditures for Health Care
By Income Decile and Age of Head

Percent of Family Income

Out of Pocket  Total Premiums  Public Sector
Figure 14

ALTERNATIVE WAYS OF PAYING FOR HEALTH CARE

NET TAXES

[FOR HEALTH]

GOVERNMENT

OTHER INSURERS

PREMIUMS

CHARGES

HOUSEHOLDS

HEALTH CARE PROVIDERS

HEALTH CARE

RESOURCES

INCOMES

Total Revenues equal Total Expenditures equal Total Incomes
REVENUES ASSEMBLED

From taxes, user charges, and private insurance premiums

\[ T + C + R \]

must equal

EXPENDITURE ON HEALTH CARE

Quantities provided multiplied by prices

\[ P \times Q \]

must equal

INCOMES EARNED FROM HEALTH CARE

Factor inputs multiplied by input prices

\[ W \times Z \]
SO THE BALANCING IDENTITY:

\[ T + C + R = P \times Q = W \times Z \]

BUT THESE ARE AGGREGATED ACROSS PERSONS (i), COMMODITIES (j), AND FACTOR INPUTS (k).

RE-LABELLING:

\[
\sum_i \{tY_i + \sum_j (C_j \times q_{ij}) + R_i \} = \\
\sum_{ij} [P_j \times q_{ij}] = \\
\sum_{ik} \{W_k \times z_{ik}\}
\]
THE IDENTITY HOLDS ONLY IN AGGREGATE.

HOUSEHOLDS FALL INTO TWO CLASSES:

(1) PROVIDERS:

\[ W \times Z \text{ EXCEEDS BOTH} \ T + C + R \text{ AND} \ P \times Q \]

(2) USERS/PAYERS:

\[ T + C + R \text{ AND} \ P \times Q \text{ EACH EXCEED} \ W \times Z \]

USERS/PAYERS IN TURN DIVIDE:

(2A) HEALTHY AND/OR WEALTHY

\[ T + C + R \text{ EXCEEDS} \ P \times Q \]

(2B) UNHEALTHY AND/OR UNWEALTHY

\[ P \times Q \text{ EXCEEDS} \ T + C + R \]
WHO GAINS AND WHO LOSES?

USER CHARGES VERSUS TAX FINANCE:

IMPROVED TECHNICAL EFFICIENCY:

- INCREASED EARNINGS?
- REDEPLOYMENT?
- COST CONTROL?

"CORE SERVICES" VERSUS EVALUATION:

"TWO-TIER" SERVICES:

- WITHOUT PRIVATE INSURANCE
- WITH PRIVATE INSURANCE
  - WITHOUT PUBLIC SUBSIDY
  - WITH PUBLIC SUBSIDY
Figure 19

Prepayment and Administration Costs
Share of GDP, U.S. and Canada, 1960-94
Importance of Various Aspects of Health Care

"Which one of the following aspects of health care is of greatest importance to you?"

- Equal access to health care for all Canadians, 53%
- Quality of health care service, 31%
- Health of Canadian population, 9%
- Costs of health care system to country, 8%

Ekos Research Associates Inc.
Les Associates de recherche Ekos inc.
n=3,021
Figure 21

Satisfaction with Current System

"Overall, in the area of ... how would you rate the performance of the current system?"

Health Care: 61%
- Consumer protection: 42%
- Crime: 42%
- Education: 35%
- Environment: 34%
- Privacy: 33%
- Cultural life: 31%
- Information highway: 29%
- Housing: 28%
- Economic climate: 26%
- Job training: 21%
- Unemployment: 19%
- Job creation: 18%

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n=3,021
Preferred Responsibility for Various Activities

Health Care

- Government: 71%
- Federal: 32%
- Provincial: 34%
- Local: 4%
- Citizens: 11%
- Business: 6%
- Other NGOs: 11%

n=4,020 responses

All Other Priorities

- Government: 58%
- Federal: 27%
- Provincial: 24%
- Local: 7%
- Citizens: 13%
- Business: 14%
- Other NGOs: 13%

n=50,035 responses
Support for Canada Health Act Principles

Universality: 89% 85% 93%
Accessibility: 82% 77% 85%
Portability: 81% 78% 89%

Source: Canada Health Monitor, 1995
Support for Canada Health Act Principles

Comprehensiveness

Public Administration

% rating "very important"

Source: Canada Health Monitor, 1995
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