

## CHAPTER 14

# DESIGN OR ACCIDENT IN HEALTH CARE POLICY: THE CHESHIRE CAT

### ECONOMIC ANALYSIS TO WHAT (OR WHOSE) ENDS?

Economists analysing the health care industry usually adopt a clearly defined subject-object relationship. The health care system of a particular society is a social system, resource using and commodity producing, which while rather complex and displaying a number of unusual features can nevertheless be studied and evaluated at arm's length (intellectually at least), much as one would any other sector of the economy. The economist is at the eye-piece, the physician, nurse, hospital, reimbursement agency, is on the slide.

Yet it is obvious that the participants in the process view the relationship very differently. Individuals or institutions providing health care regard economic analysis (if at all) as a means to their own ends, a discipline or body of techniques akin to (though generally somewhat less useful than) biochemistry or physiology, which can be used to promote personal or collective objectives defined within the health care system itself.<sup>1</sup> Freidson's (1970) distinction between medical sociology and the sociology of medicine has application to economics as well.

This inversion of perspective has significant implications for economic analysis itself. The peculiar institutional features of health care delivery, if taken as a serious social response to genuine organizational problems rather than a series of accidents or nefarious plots by providers, force one back to a questioning of the usefulness of many of the standard tools and concepts of economic analysis, and a re-thinking of their underlying methodology. More generally, this process exposes the significance of certain fundamental, but rather arbitrary and crude, assumptions about individual and group behaviour which are so basic to economic analysis that it is easy to forget that they were ever made. Having worked so long with one particular map, one may need to be reminded that it is not the territory.

Indeed, this re-thinking of basic assumptions may serve as a road out of the "Pangloss-trap" (Culyer 1984) of "neo-Austrian" analysis. If we believe that all behaviour *and all institutional environments* represent the outcome of optimal responses by individuals and groups to the opportunities and constraints which *they* (not external observers) perceive, then it follows that no improvement is possible on whatever situation now exists -- in the private *or public* sectors -- whatever is, is right.<sup>2</sup>

The case for amelioration, from left or right, then falls to the ground, as does the very possibility of a contribution from economic analysis. And this appears to include the first of Culyer's suggested escapes from the Pangloss-trap, the "entrepreneurial" role of the economist as educator and mobilizer of public opinion -- moulder of perceptions -- with respect to particular policies (see also Hartle and Trebilcock 1983). Since the economist is just as much inside the Pangloss-process as anyone else, his activities in this regard are equally subject to "optimizing" determinism and have no greater standing than those of a hired PR firm or habitu  of Spouter's Corner.<sup>3</sup>

Culyer's second alternative, which is very much in the spirit of this text, is to apply analysis to proximal objectives defined external to the analysis itself. Of course those objectives may require further justification in terms of general political or social acceptability.<sup>4</sup> But the worst criticism he finds for this approach is that it is looked down upon by economists. Accordingly, this terminal chapter will postulate certain general classes of social objectives which might be sought through public intervention in the health care financing and delivery system.<sup>5</sup> It will then attempt (very roughly) to evaluate the current (early 1980s) experience with public health insurance in Canada and its possible future developments. Of course all forecasts will be falsified, just as all generalizations are false. But extrapolating the forces presently at work enables one to sketch alternative scenarios which appear internally consistent and plausible, and to rule out others as inconsistent or implausible.

## **OBJECTIVES OF HEALTH POLICY: A SUGGESTED AGENDA**

As the Cheshire Cat pointed out some time ago, if you don't much care where you get to, it doesn't matter which way you go. If you do, it does. And if we, by doing some considerable violence to the actual processes involved, think of public policy toward health care and particularly toward health care finance as making up a sort of very large scale public program or super-project, then we can discern several different types of objectives which may be thought of as the potential benefits from that intervention (Evans and Williamson 1978, Chapter 1; Barer *et al.* 1979).

The objectives which societies and their representative politicians, administrators, and professionals seek through public health care policy can be divided into two major groups, financial, and "real" or functional. The first class, financial objectives, refer to the patterns of claims over goods and services, of credits and debits, across the members of the society, which arise as a result of the incidence of illness and the response of the health care system. In principle (though not in practice) one could imagine financial policies reshuffling these claims, redistributing the burdens of illness and the costs of health care, quite independently of any impact on the health care delivery system itself. Indeed "idealized" insurance programs, free of problems of adverse selection or moral hazard and embodying no *ex ante* subsidies, would do just that. They would redistribute financial resources *ex post* from those who did not to those who did become ill and use care, without influencing levels or patterns of care utilization or production.

Functional objectives, on the other hand, relate to the actual patterns of care: What sorts of goods and services are produced, in what quantities, how, and for whom? In seeking such objectives, public policy intervenes directly in the process of care provision to modify the behaviour of the health care industry and/or of its customers, relative to that which would have been displayed in a competitive marketplace of (more or less) voluntary exchange.

The financial objectives are primarily, though not entirely, redistributive -- "spreading the burdens of care." The economic burdens of illness range from the costs of associated "needed" care, through lost income, to pure loss of life satisfactions (utility) -- or life. Most societies attempt to redistribute resources in favour of those with large care costs. Some include public systems of income replacement; none (for reasons discussed in chapter 2) appear to address pure welfare losses. However as chapter 2 also pointed out, *public* redistributive policy as expressed through public insurance programs, generally redistributes *ex ante*, from people with low risk of illness, or at least low expected health care cost, to those with high. Competitive private

insurance will handle *ex post* redistribution, if that is a social or private objective, but will tend to charge differential premiums (or build in self-selection mechanisms) according to expected loss or risk status. Public insurance transfers wealth across risk classes.

Of course private insurance systems are not perfect, and market failures may develop in private risk-bearing markets. It is quite possible that persons may find themselves unable to purchase health insurance, even though they are willing and able to pay the actuarially fair premium plus a competitive load factor. This failure can arise either because adverse selection makes it impossible for such persons to identify themselves to policy-sellers -- being lost in a crowd of higher risk people -- or because scale economies, market size, and selling expense lead to an over-diversified or monopolized supply of policies and correspondingly excessive load factors. In this case, compulsory public insurance can remedy failure in private insurance markets -- an efficiency objective -- quite independently of any impact on either wealth redistribution or patterns of care delivery.

Further, public policy can and does have a significant impact on patterns of income and wealth distribution between providers and users of health care. If all care were provided by for-profit firms operating under exogenous demand curve constraints in perfectly competitive markets with free entry and no specialized irreproducible inputs, then of course all factor inputs would earn their opportunity costs regardless of how public policy affected the overall size or shape of the industry. But this textbook picture bears no resemblance to any actual health care system. And the incomes of health care workers, relative to the rest of society, are quite sensitive to public policies toward occupational regulation, organization, and payment. The dramatic swings in (relative) Canadian physician incomes under private and public insurance, and the contrasting experience of United States physicians, and of Canadian dentists, under mixed private insurance and self-pay regimes, serve as examples; but so do relative wage patterns in hospitals, or profit rates from pharmaceutical sales. A significant part of public health care policy, particularly as it affects "costs," is in fact a form of industry- or sub-industry-specific income policy serving to advance or to contain the income aspirations of particular groups.

Moving from the financial to the functional side, public policy has historically been divided into regulatory policies -- principally delegated to professional groups -- intended to affect the pattern or mix of services provided, and financial policies -- from subsidies to universal insurance -- intended to affect the overall level of provision. The initial emphasis of public insurance was on expanding overall utilization -- "reducing the barriers to care" -- in whatever way providers thought appropriate. More recent emphasis on cost containment uses the payment system to try to restrict overall levels of utilization -- capacity and budget restraints in hospitals, controls on physician immigration and (to some extent) domestic supply -- while still relying on providers to determine mix. But it is clear that public policy objectives encompass mix of services -- maintenance of quality, suppression of quackery, linkage of provision to "needs" -- as well as overall volume. Otherwise the whole apparatus of direct and delegated regulatory authority lacks justification.

These functional objectives of public policy, relating to the volume and the mix of care provided, and the particular recipients, are yet another way of expressing the idea from chapter 1 that the resource/health status relationship of Figure 1-3 is the proper concern of public policy. If the ultimate objective of policy is the attainment of a satisfactory relationship between resources used and health status attained, then it follows that policy must be concerned with amounts and patterns of care use.

But it also follows that the technical efficiency of care provision also is, or should be, a policy issue. And while that theme has emerged frequently in the discussion above, it does not appear to have been a major concern of Canadian providers or users of, or payers for, health care.

Somehow efficiency was expected to be achieved spontaneously, as a by-product of the professional process. The initial pressure for public insurance was to provide a means of both increasing utilization by some segments of the population, and redistributing financial resources between low and high users -- reducing barriers and spreading burdens. Later it was viewed as a means of containing provider incomes and rationing overall utilization. But the perception that regulatory and payment policies have a major impact, for good or ill, on the actual resource costs of whatever care is provided has had relatively little influence on public debate -- except among economists.<sup>6</sup>

## **COMPETING SOURCES OF LEGITIMACY: POLITICAL, PROFESSIONAL, AND MARKET**

With this set of fairly general objectives in hand, and noting that the particular expression of those objectives varies over time and persons,<sup>7</sup> we can consider where the Canadian health care system is now, and how it may unfold. In the process we may distinguish three different sources of legitimacy or processes of control -- political, professional, and market -- which confront each other with competing claims to define and govern the pursuit of these objectives. They represent deeply rooted ideological patterns as well as coalitions of particular interests. Each proposes a set of institutions which will give rise to patterns of incentives and information flows and which in turn will generate outcomes in terms of patterns of resource use and wealth distribution. Each postulates an ideal form (more or less unrealistic) of the health care system organized through its preferred institutions, yet suffers from characteristic vices which are all too apparent to its competitors (Culyer 1982). Public policy (or its absence) emerges from the tension among these three.

At present, Canadian hospital and medical care policy is in a state of tension between political and professional ideologies and sources of legitimacy, with a comparatively small role for market forces.<sup>8</sup> Advocates of the professional view sometimes use the rhetoric of the market -- "free enterprise" -- in their attempts to influence the political process, but this should not be confused with support for an unregulated delivery system. This tension was built into the public health insurance system *ab initio*, as a result of failure to question the assumptions of the "Medico-Technical" model of health care utilization outlined in chapter 1.

Professional ideology holds that the practice of medicine is the preserve of physicians, or more generally, that professional activities are properly controlled by professionals. Making health a "political issue" is an improper development both in itself and because it leads to poorer health care. There may be some bitter debate from time to time as to *which* particular group of professionals has responsibility for which activities, but it is a breach of professional decorum if this debate should unfortunately spill into the public arena. (Public disagreements also weaken the political position of professions, by undercutting claims of collective expertise.)

Within this ideological framework, professionals not only claim exclusive jurisdiction over *how* medicine is practiced, or health care provided, but also over *how much* care is appropriate. They allege the right, on the basis of superior expertise, to determine not only where the curve in Figure 1-3 is located, but how far along it a given society should move. Moreover, though somewhat less confidently, professional ideology holds that professionals should determine their own incomes, relative to the rest of society. This is expressed, not in the form of claims to specific entitlements, but in assertion of the right of the individual practitioner to set her own fees, in a "market" reserved for and closely regulated by the profession itself.

Public policy in Canada has not explicitly challenged these professional claims, but has put in place a financing system which is directly in conflict with them. By centralizing the reimbursement of both hospitals and physicians through budget- and fee-setting negotiations, the state has indirectly entered both the "practice of medicine" and the income-determination process in a major way. While leaving professionals in primary control of how available resources will be used, and (by setting the internal structure of fee schedules for self-employed practitioners) of the relative remuneration of different specialties or patterns of activity, the state in setting overall limits is implicitly (and sometimes explicitly) determining what facilities shall not be available, what services shall be discouraged or not provided at all, and (more roughly) what limits shall apply to practitioner or hospital workers' incomes. Its justification for such intervention can be found in overwhelming public support for the Medicare program, whatever the public may think of the particular governments which administer it.

This conflict of competing legitimacies, expertise versus collective choice, is encapsulated in the "underfunding" versus "cost-explosion" arguments of the early 1980s. "Underfunding" means that the state, or society more generally, is not providing sufficient resources to the health care system, either to provide the level of health care servicing which professionals judge appropriate, or to pay the incomes to which they aspire. For obvious political reasons the former shortfall is more openly alleged, although as noted in chapter 7, the availability of hospital facilities affects provider incomes as well.

"Cost explosions," by contrast, imply the converse, too much servicing, of minimal or no benefit at the margin, and/or provided by people who are overpaid or working inefficiently. If none of these implications is accepted, then an increase in costs is a social gain, not a policy problem.

## **CONSTRUCTIVE INCONSISTENCY: PAPERING OVER THE CRACKS CAN WORK**

The outcome of this tension between ideologies has, so far, been a quite constructive inconsistency. The Canadian health care system scores comparatively well on both financial and functional dimensions. Most of the economic burden of health care expense (though not, obviously, the burden of illness) is distributed across society in relation to taxable capacity generally, as indicated by income and expenditure, and is not related to the actual or anticipated illness or expenditure experience of the individual.<sup>9</sup> Universal coverage ensures that no one will be dropped out of the insurance system as a result of adverse selection.<sup>10</sup> And the direct bargaining between state and providers has placed some limits on the process of wealth transfer from the rest of society to providers, a process which during the 1950s and 1960s was proceeding apparently unchecked. Of these effects, only the public assumption of risk-bearing can be interpreted as an efficiency gain, but the other pattern of wealth transfer -- healthy to sick, low risk to high risk, and provider to citizen/taxpayer (at least relative to what might otherwise have occurred) -- seems to be in line with general social priorities.

On the functional side the picture is somewhat less clear. A substantial amount of literature (Boulet and Henderson 1979; Siemiatycki *et al.* 1980; Broyles *et al.* 1983) suggests that the public insurance system does serve to redistribute health care in favour of "sicker" as well as lower income users. Its influence on overall use is much more difficult to disentangle from that of the general expansion in hospital facilities during the 1950s and 1960s, and in physician supply during the 1960s and 1970s. On balance, however, it appears that the combination of public control over total resources plus professional control over specific applications -- priority

setting -- has led to a more effective use of those resources than would have resulted either from an attempt at direct public control of utilization patterns (which would probably have been politically, if not administratively, impossible), or from a continuation of pre-Medicare policies which amounted to almost a blank cheque for providers. That is not to say that the present health care delivery system is optimized with respect to effectiveness, but only that the compromise has worked relatively well up to now, especially considering the alternatives displayed in other countries.

Where it has functioned less well is in the area of technical efficiency. As emphasized above, cost-reducing innovations, such as manpower substitution or ambulatory alternatives to inpatient care, threaten jobs which in an environment of budgetary constraint may not be made up elsewhere. United States critics of the Canadian system as "public utility" medicine *do* have a point. Innovation has been blocked, not so much in the cost-expanding technologies, which generate their own constituencies rapidly enough, but in the cost-reducing ones for which no constituency exists. And natural experiments do not occur in a uniform public system. The Canadian financing system has tended to freeze in place organizational structures and modes of care provision and delivery, and so to maintain higher than necessary costs of care.<sup>11</sup>

### **IF THE CRACKS WIDEN, CAN MORE MONEY FILL THEM?**

So far so good, but can the compromise, the unresolved conflict between professional and political ideologies, be maintained? Should it be? If so, how? If not, what are the alternatives and what are their likely effects?

The principal source of concern about the viability of the present structure stems from the level of political conflict which it generates, a conflict which is being only partly moderated by the short-run expedient of allowing the health care share of GNP to increase a bit, and releasing much of the pressure on physician fees.<sup>12</sup> Lying behind this conflict is the longer run problem of manpower oversupply (or at least escalation) noted in chapter 13, and the shifts in demography and technology which exacerbate perceived "needs." Just as provincial governments find themselves under increasingly acute resource pressures, providers perceive a dramatic expansion in their ability to provide effective therapy -- if only resources were available. If both sides grow weary of the endless conflict, the result could be changes which could lead to quite a different system.

The simplest response to the "underfunding" claim would be to expand public funding for health care, either by raising taxes or by cutting other public programs. As commentators on the "politics of restraint" have pointed out (Dobell 1983), Canadian provincial governments are struggling with the balancing of priorities, not with an absolute lack of resources. Many, indeed most, other developed countries spend a higher proportion of their national resources on health; why shouldn't we?

The answer is that quite apart from the question of the efficacy of the additional services which these resources would buy, the conflict situation would not in fact be mitigated. As pointed out in chapter 1, only the "finite needs" model of Figure 1-3a, combined with bounded relative income aspirations, is consistent with a stable upper bound on health care spending generated within the health care system itself. In the more realistic case of Figure 1-3b, or adaptive income expectations (or entry of personnel in response to incomes), the health system has *no* self-limiting mechanism. Ten percent of GNP, once established as a norm, would soon become "under-funding," as would twelve. The experience of other countries, not just the United

States, is that upward pressures on costs, and political conflict, do not abate at higher levels of spending. They are only moderated by continuing relative increases.<sup>13</sup> Thus expansion of public spending on health care, while it would undoubtedly lead to increased provider satisfaction for a time, because it would transfer wealth from taxpayers or beneficiaries of other public programs to health providers, and expand health care service output, would eventually lead back to the same situation we now face.

### **PRIVATE VERSUS PUBLIC MONEY: USER CHARGES, EXTRA-BILLING, OR "PATIENT PARTICIPATION"**

In any case, federal and provincial governments appear very reluctant to move in this direction. Accordingly, an alternative proposed by some provider representatives is "diversification of funding sources" -- direct charges to patients over and above public reimbursement rates, eventually supported by the reintroduction of private insurance. This evolution, building on a combination of open-ended extra-billing by physicians and direct charges by hospitals, appears to offer both relief for provincial treasurers, by holding down public expenditures for health care, and the opportunity for health care providers to increase their incomes and the level of services they provide.

Direct charges to patients, euphemistically described as "patient participation," are ironically advocated both as a means of increasing health expenditures (by Canadian medical associations and some hospital people) and of controlling or reducing health costs (principally by American economists but also by some private health insurance people, working with an assumption of exogenous demand curves; see chapter 2). They are unlikely to do both, for mathematical reasons which are not very complex. There are many different ways of structuring and administering direct charge systems, but on balance it seems most probable that if such charges are administered by providers at their own discretion, individually or collectively, they will have the cost-expansion effects predicted and sought by their Canadian advocates. The American arguments for cost-control effects rest on rather special assumptions which are difficult to justify (Barer *et al.* 1979).<sup>14</sup>

The short-run effects of a shift toward more "private" financing, patient payment with or without private insurance, can be extrapolated from current experience with physician opting out and extra-billing in Ontario and Alberta, and from pre-Medicare experience in Canada and United States experience in the 1970s. But the long-run picture is much less clear, and could involve quite dramatic changes in the whole framework of health care organization. The key question is the extent to which the regulatory framework evolves to permit competitive market forces to influence the process of supply.

These short-run effects would be primarily a wealth transfer from patients to providers -- higher incomes for physicians -- and perhaps to some extent to taxpayers as well if public reimbursement rates escalated less rapidly in consequence. Moreover these transfers would be quite uneven. Alberta data on extra-billing (Plain 1982) show a very small proportion of physicians making very large earnings from extra-billing, while a much larger number earn small amounts (relative to their reimbursement by the public plan) and serve as political and ideological "spear carriers" for the principal beneficiaries. Wolfson and Tuohy (1980) similarly find the principal effect of opting out of Medicare in Ontario to be elevated physician prices and incomes, with concentration of opting out in particular specialties and regions. Thus the wealth transfers are drawn, not from patients in general, but from patients in particular regions and with

particular types of problems. Hospital user charges similarly fall most heavily on a relatively small proportion of the population, as hospital use tends to be highly concentrated among the aged and chronically ill.

In addition to these health-related wealth redistribution effects, direct charges appear to have some impact on patterns of care use. Stoddart and Woodward (1980) found evidence of a negative effect of opting out on use by lower income patients, and the studies reviewed by Beck and Home (1978) and Boulet and Henderson (1979) clearly support the proposition that direct charges inhibit use by the poorer members of the population. But as noted in chapter 7 (see also Barer *et al.* 1979) it does not follow that overall use falls. The principal effect of charges may be to redistribute care from more to less price-sensitive individuals.<sup>15</sup>

Apart from these wealth redistributions, it is difficult to see any clear-cut effects on use of care. It is sometimes suggested that hospital user charges might lower overall utilization rates; but the empirical evidence does not support this hypothesis. As noted above, all analyses of hospital utilization show it as, in total, primarily capacity-driven, at least in a fee-for-service context. If, as some of their advocates suggest, user fees were to *increase* total resources available for care, they might support greater servicing intensity, and perhaps higher physician billings.

The impact of extra-billing or user fees on medical service supply is ambiguous. Their presence or absence is unlikely to affect rates of domestic physician training. If the prohibition of extra-billing led to physician out-migration, this would tend to lower utilization and costs. If on the other hand extra-billing should spread, and fee levels per procedure correspondingly rose, the present physician stock might supply less effort at higher income levels (the income/leisure trade-off). The resulting lower level of servicing could then masquerade as a demand response. But overall, effects on care use are likely to be small.

A Medicare system characterized by a relatively low level of direct charges, as those in several provinces have been *ab initio*, thus appears to score somewhat less well than a comprehensive one on both our financial criteria -- risk reduction and equity of burden -- and perhaps slightly worse, but not very different, on the functional ones. But precisely because it is *not* very different, such a system does not resolve the conflict between political and professional objectives and authority over the health care system.<sup>16</sup> Direct charges on a limited scale may be ideologically offensive or satisfying, and may create specific cases of hardship and affluence, but they preserve the fundamental tension between political responsibility for global funding (95 percent, if not 100 percent) and professional responsibility for what is to be done. The third or market criterion -- individual willingness and ability to pay -- is suppressed through the continued agreement by both professionals and politicians that needs should govern use, and that supply should be closely regulated.

## **DISMANTLING MEDICARE: PRIVATE FUNDING, PRIVATE INSURANCE, AND PRIVATE DELIVERY**

If neither increased public funding nor small-scale direct charges significantly modify the existing confrontation, what other alternatives exist? One possibility is a withdrawal or scaling down of the political role in funding, with or without a major change in regulation, and a reversion to a major role for private insurance carriers. This could come about, for example, if provincial governments deliberately held fee schedule and hospital budget escalation well below the growth of the general economy, and permitted or encouraged physicians and hospitals to bill

patients for additional amounts.<sup>17</sup> In this case, the proportion of bills paid out-of-pocket would escalate, and the political feasibility of (and justification for) the ban on private insurance would vanish. Private coverage would, like United States "wraparound" coverage for their incomplete form of Medicare, arise to fill in gaps in public coverage, and depending on premium levels for public coverage (in those provinces levying premiums), some groups of the population could find it preferable to move out of the public program altogether. The dismantling of the "Medibank" program in Australia (Deeble 1982) is an example of such a process, where public program premiums and benefit schedules were deliberately manipulated to encourage middle- and upper-income people to buy private coverage.<sup>18</sup>

Canadian past and United States present experience with multiple funding sources, mixed public and private insurance and self-pay, suggests that such a shift would significantly redistribute wealth from ill to well, high-risk to low-risk people, and patients to providers. It would probably expand the volume of services provided, while making access more dependent on income. The key thing it would *not* do, however, is constrain expenditure. It would not answer the question of how much to spend, other than by the professionals' answer -- more.

Thus the professionals' recommendation of diversified funding sources and less government interference appears to be dynamically unstable, and to lead towards the present American situation. There, governments are hard-pressed to meet even their limited share of a rapidly expanding total health bill and, in a fragmented funding system, lack the administrative mechanisms as well as the political will and mandate to establish control. But the cost explosion also places great strains on the business firms and unions funding private insurance. From these, along with government, comes the political pressure to "do something." The response so far has been to increase reliance on market-type institutions, on "competition," in the real sense, not as the words are used by professionals. From insurance markets, privatization spreads (inevitably?) to health care markets themselves.

## WHAT HAPPENS NEXT? THE UNITED STATES ALTERNATIVES

But for the reasons analysed in chapter 10, for-profit firms in a health care environment -- hospitals, laboratories, pharmaceutical firms, medical clinics -- make their profits from sales, not cost containment. The incredibly fuzzy United States thinking which, presumably muddled by ideological symbols, equated private for-profit enterprise with cost control, has begun to undergo reality therapy. The future directions offered seem to be threefold.

One, arising from the "welfare burden" arguments of chapter 2, traces the problem back to excessive insurance stimulated by public subsidy, and offers the hope that the "magic bullet" of taxing employer-paid health insurance premiums in the hands of the employee will lead to reduced insurance coverage and an increase in the numbers of cost-conscious shopper-patients who will impose market constraints on provider behaviour. Since it rests ultimately on the hypothesis of an exogenous demand curve for care, this approach of relying on *individual* self-paying consumers to exercise the ultimate control over how much of what sorts of care should be provided essentially folds back into provider control, for reasons discussed in chapter 4. Reductions in insurance coverage would, however, transfer wealth from ill to well, and perhaps to taxpayers, and make access to care more dependent on ability to pay.

The second, and much more interesting "market" approach has been under discussion for a number of years but was brought up high on the political and intellectual agenda by Enthoven (1980). This plan envisions large numbers of private organizations, Health Maintenance

Organizations (HMOs) in the United States jargon, selling contracts to groups of patients at a fixed price per time period which bind them to supply (or pay for) all "needed" hospital and medical services (and drug and dental, if in the contract). Of course the organization, or its contracted physicians, determine "need." The key strength of this approach, in terms of long-run stability of the health care sector, is that competition for contracts among such organizations tends to encourage both technical efficiency and concern for efficacy. As we have noted above, it is already amply demonstrated that such groups do make less use of hospital space and high technology interventions, and more use of intermediate-level personnel substituting for physicians. But these are merely examples of *what* they do. The critical difference is *why* they do it; such organizations differ from every other "player" in the health care system in that they operate under economic incentives (in a competitive environment) to hold down the total cost of the care they provide, not to push it up.

They also, obviously, have incentives for both underservicing and careful selection of clients. To date, most experience has been with large, long-established, and non-profit versions of such organizations, motivated by some combination of public service, professional commitment, and economic survival. And they have been operating in a non-competitive environment where outperforming the fee-for-service "competition" in the cost dimension was not terribly demanding. It may thus be dangerous to extrapolate from past performance how large numbers of highly competitive for-profit HMOs would behave. In any case, a substantial regulatory framework appears necessary for this "competitive" solution to prevent "cream-skimming" and dumping of all the high-risk patients on some insurer of last resort, or diluting quality of care, particularly for the few patients *in extremis* who generate very high costs.<sup>19</sup>

The competitive HMO approach to health care is expanding steadily in the United States, but still covers under 10 percent of the population and has yet to demonstrate a global impact. The "magic bullet" of taxation of employer-paid premiums, if it were politically feasible, should significantly enhance HMO attractiveness. HMOs can typically offer lower premiums and/or more comprehensive services than can insurers reimbursing free choice of fee-for-service physician and hospital.<sup>20</sup>

Much more rapid, however, has been the expansion of the third alternative, "de-regulation" and for-profit supply (Gray 1983). United States corporations appear to be rapidly finding ways around legislative and regulatory restrictions on their activity, with the approval of many in the public sector. And professionals, who have in the United States so long used the "free enterprise" rhetoric to mobilize support against the political system, now find resistance to the market rather difficult ideologically as well as practically.<sup>21</sup> The result may be, indeed on some accounts already is, a loss of professional control over the content of medical practice. Not only the NFP hospital, but also the NOFP medical practice, is sliding toward larger scale and FP motivation, and the professionals who work *in* it will be required to work *for* it. If patients' interests happen to coincide with profits, well and good. If not, unfortunate.

But the unbridled competitive market appears to share with the professionally controlled, mixed funding system the problem of long-run instability. Since for-profit ("investor-owned") hospitals expand their markets and earn their profits by expanding costs, they create ever greater problems for the private insurance industry as well as for the more limited public reimbursement programs which, so far, even the United States right wing has not been able to shed. Their growth may be expected to induce protective responses by reimbursers -- California's Preferred Provider Organizations (Trauner 1983) being one example, employer as well as union-sponsored HMOs being another.

Thus the longer term result may well be to speed up the development of organizations standing between providers, for-profit or otherwise, and patients, whether publicly or privately

insured. However sponsored, these organizations will offer patients access only to "needed" care, as determined by their providers or representatives, and from a limited range of providers -- no more free choice of doctor. In return they guarantee a fixed cost per time period to the patient or those responsible for her costs. They will then exercise controls over provider behaviour, to limit costs, in return for granting providers access to "their" patients. In a situation of general oversupply, and rapid expansion, of health personnel, plus shrinking public budgets for health, the residual traditional fee-for-service market may get quite tough.

But what, if anything, do the remarkable, entertaining, and expensive thrashings of the United States health care system have to do with Canada? Not too much, it is to be hoped. They do, however, dramatically point up both certain dangers and certain opportunities which may confront us as well.<sup>22</sup>

First, it appears that any attempt to mitigate the professional/political conflict by diversifying funding sources and breaking down the centralized political control leads into a dilemma. Either it merely grafts a small and rather inequitable quasi-market, under professional control, onto a system which remains predominantly public, in which case the confrontation remains, or it moves to an environment in which public control over and responsibility for funding are significantly reduced, at least in proportion, in which case costs escalate uncontrollably and eventually the system fragments and "de-regulates" on United States lines. This scenario suggests that having fought off political control, professionals would-in due course find themselves confronting the private, for-profit corporations which are at present held off by the public regulatory system. The competitive FP system which follows scores relatively badly on all our above criteria, except perhaps technical efficiency, but even that is unclear given the overhead costs of competitive marketing (note the experience of private insurance, chapter 2 and the minimal evidence of lower costs, as opposed to higher revenues, in FP hospitals, chapter 10). And it generates a high rate of technical change, again a distinctly mixed blessing.

Overall, a predominantly FP delivery system would probably display a proliferation of servicing, a linkage of access to willingness to pay rather than needs (for-profit institutions describe this as "moving up-market"), distribution of costs according to use (or expected use) rather than ability to pay, and substantial income gains for those providers least inhibited by professional ideology or scruples. If it sells, do it.

This FP system itself, however, also appears to be unstable, subject to uncontrolled cost escalation. But it is too early yet to tell whether it will in the United States evolve into a system dominated by public and private "HMO-type" organizations acting essentially as patients' purchasing agents to control providers, or whether it will attain stable expenditure and utilization levels by simply withdrawing entitlements entirely, dropping the poor, elderly, and chronically ill out of the health care system. After explosive growth in any industry comes the "shake-out" -- but in what form?

## **A PROFESSIONAL ALTERNATIVE: CONTROL BY CARTEL?**

The root problem faced by the advocates of professional control, then, is how to create institutions, other than centralized public budgetary control, which will lead to eventual stability of health sector expenditure. At present every participant, except government, faces incentive patterns which encourage more spending, whether to increase servicing or to raise incomes. Is there any conceivable set of professional persons or groups which could recognize *over-funding* (or at least sufficient funding) for longer than six months to a year, and could act to control

funding levels accordingly?<sup>23</sup> If the relationship between resource inputs and health outcomes is of the form of Figure 1-3b, we have argued above that determining "how much is enough" (globally, not in individual cases) is a political, not a professional function. But professionals may not only lack legitimacy in this sphere, they may be, probably are, simply incapable of making the decision. And understandably so.<sup>24</sup>

In the pre-Medicare days, physician-sponsored insurance plans, which were at one time more or less monopolies, did exercise such restraints, but only over physician fees, on a year-by-year basis. Their market position was eroding by the time Medicare was introduced, but it could conceivably have been legislatively sustained. The difficulty is that these insurers were presiding over a longer term dramatic expansion in physician relative incomes and service costs -- a controlled explosion, not control. They showed no sign of being able to impose long-run stability even for physician costs, let alone hospital care. And in the present environment of rapid technological advance and proliferation of profit or income opportunities, against the backdrop of an increasing supply of treatable aged, the prospect that a providers' cartel, even backed by a compliant public regulatory authority, could reach and enforce a consensus on anything but "more," seems remote indeed.

The long-run consequences of a scaling down of the public role in Canadian health care thus would appear to be an intermediate period of cost expansion and deterioration of both the financial equity and the overall effectiveness of the health care system, accompanied by a shift from professional to FP control and a United States-type situation. If this is not inevitable, it is hard to see what present or potential future institutional features of the professional system would prevent it. The consequences of a scaling down of the professional role in the conflict, however, could also be rather unattractive.

## **INCREASED PUBLIC CONTROL: HOW CIVIL A SERVICE?**

One could imagine a scenario in which provincial governments were able to maintain expenditure control over health care by essentially lock-step policies -- gearing manpower and capital equipment availability to population growth (possibly age-sex adjusted) and setting fee schedules and budgets such that provider incomes rose in line with the rest of the economy, but taking no further interest in the actual delivery process. It is often alleged, and with some plausibility, that such a "civil service" approach could have an enormously destructive impact on the morale and productivity of health care providers and on the quality of their work. Of course the converse proposition, that to be happy, productive, and constantly advancing quality, health care workers must be assured of a constantly growing share of national resources, is unsupported, as the trees cannot grow to the sky. But there *are* real dangers in what the Americans call the "public utility" model (with a gratuitous slur on some quite progressive public utilities). If the providers of care lose interest in or commitment to their professions, the quality deterioration could be serious indeed. If external limitations on the health care sector are inevitable, they must also be justifiable and acceptable.

Moreover, if the professional claim to represent the broader public interest is diluted by self-interest and lack of information, the political process is not exactly perfect either. We have already noted that shifting the relative income-determination process from the professionally controlled market to the political arena substitutes a downward for an upward bias (though the interests countervailing this bias are rather more organized and articulate). A public reimbursement authority has an equivalent incentive to keep down servicing levels, in both

quantity and sophistication, just as does a United States-style HMO. Whether or not "underservicing" now characterizes Canadian health care, it clearly could do so.

A slightly cynical model of the political process would suggest that public resources will be devoted only to those health care services which a majority of the population either feels that it "needs," either now or in the future, or is willing to support for others. Why waste resources on either invisible or unpopular sub-populations of little political significance, or on meeting "needs" which many people might have (or would sympathize with) but are unaware of? The political agency role is at least as subject to incompleteness as the professional one, and politicians and bureaucrats *have* occasionally been observed to be acting in their own interests and/or those of powerful sponsors, not those of the general public which they serve. Just as above we argued that political intervention was necessary to monitor the performance of the professional agency function, so there is a need for the professional monitor of the political agent. This would be substantially more difficult to achieve in a delivery system, whether a public service or merely a publicly funded one, in which providers had lost interest in their professional roles.<sup>25</sup>

### **BUT WHY CONFRONTATION OVER (ALLEGEDLY) COMMON OBJECTIVES?**

There may, however, be an acceptable middle ground between public and professional authority. Both ultimately derive their legitimacy from a claim to represent the interests of the population generally, either as citizens/taxpayers/voters or as patients. And each, as demonstrated above, bases its arguments -- underfunding or cost escalation -- on an implicit judgement about the resource input/health status relationship of Figure 1-3. Yet governments have done relatively little to substantiate the claim, implicit in their cost-control policies, that the curve is flat or declining. And professionals have thus far rejected any obligation to substantiate their claim of a positive slope or to confront contrary evidence, as if such substantiation (on scientific criteria, not merely assertion of professional experience, judgement or opinion) were inconsistent with professional status.<sup>26</sup>

The solution may lie in the development of more extensive interaction between government and professionals, using evaluation methodology and "technological assessment" to develop diagnostic and therapeutic protocols which can be based on the best evidence available as to effectiveness and efficiency. In this process both sides are at risk. If the evidence clearly shows that a proposed activity or program, new or expanded, is likely to have a significant impact on someone's health, this creates an obligation on government to provide resources. But if evidence of efficacy is lacking, for new or established programs, professionals would then be under obligation to assist, or at least not resist, modification or termination.

And if the process is to function, providers will have to accept that, if Figure 1-3b applies, not all "needs" are worth meeting. They cannot both participate in the allocation process at the expert, professional level, and seek to undermine it through the political or market processes (*e.g.*, by selling additional services on the side).

In this process the utilization data generated by the public insurance programs could be of great use, not only to assist in evaluating the effects of particular interventions, but also in identifying the nature of current practice and the impact of recommendations for change. Individual institutions or practitioners could be monitored to ensure that policies agreed on by government and profession as scientifically justified are indeed having the desired impact on

actual practice in the field. If not, corrective action can be taken through the payment process, or otherwise.<sup>27</sup>

In such a process, the results of United States experience with competitive HMOs, private FP hospitals and clinics, and alternative institutions generally could be of tremendous assistance in mapping out the range of the possible. While Canadians were among the pioneers of daycare surgery, for example, American ambulatory surgicenters have begun to do T. & A.s, and hernia repairs at all ages. And it is the United States HMOs which consistently show that 40 percent reductions in hospital use, from current Canadian rates, are possible without apparent injury to the health of the served population. Information on the therapeutically possible can come from many sources, and the wide range of different ways of providing care currently developing in the United States is likely to throw up a number of alternative possibilities for evaluation.

### **WHAT TO DO, OR HOW TO DO IT -- A ROLE FOR NEW PLAYERS?**

There is an important distinction, however, between how we learn what is possible and desirable, and how we create institutions which will bring such changes about. Proposals in Ontario for the development of a system of "public competition" (Stoddart and Seldon 1983) based on Health Services Organizations empanelling patients and reimbursed per capita by the provincial government represent an attempt to expand the role of new types of institutions like the American HMOs whose incentives and constraints will lead them to change current patterns of medical and hospital use in a direction already known to be possible -- less hospital use. The suggestion that government and professionals attempt to review the evidence for such possibilities, and modify practice patterns by administrative mechanisms, represents an alternative institutional means to the same end. What form such collaborative action would take, and whether it would succeed in the end, is at this point too early to tell.

The "public sector competition" approach has the important feature, however, that it introduces competitive forces and market institutions into what is presently a two-sided relationship, without replacing either the political or the professional roles. HSOs could be permitted to compete for patients in a variety of ways -- premium rebates, for example, or "free" dental or pharmaceutical services. In regions with significant numbers of opted out physicians, it is difficult to understand why (from a public interest, as opposed to professional monopoly, perspective) they should not openly advertise their opted in status. And if their public reimbursement includes not only a fixed dollar amount per patient enrolled, but a share of "saved" hospital costs, these extra resources can be used in competing for patients. In this setting, new, and anticipated more efficient, forms of delivery can expand their market shares, not by administrative or professional fiat, but by the choices of individual consumers. The regulatory environment might require some modification to permit such organizations to communicate with their potential customers, and to ensure that they were not frozen out of the public hospital system by their fee-for-service competitors. But in general such institutions seem compatible with continued public control over global funding, and professional regulation of the content of practice.<sup>28</sup>

Such developments have the feature that they introduce a new class of participant, with different incentives, into the political/professional relationship. In this respect they are paralleled by the experiments currently underway with for-profit management teams contracting to run public NFP hospitals. Again, a new player or transactor enters the system, whose economic incentives may be to control costs, not to escalate them.

The conditional statement is required, because much depends on how the contract is written. As noted above, FP contract management in the United States setting has every economic incentive to *raise* both utilization and prices, and any Canadian provincial government which contracted (or permitted a hospital's trustees to contract) on similar terms should collectively seek psychiatric care. But a contract which related the profits of the management team (inversely) to the hospital costs of a defined group of people -- essentially capitation reimbursement -- and provided for charging back of costs externalized to the rest of the health care system (or out of it) by management action, plus some monitoring of patient-care outcomes, could create the appropriate form of incentives by, in essence, turning the FP management team into a sort of HMO responsible specifically for hospital services. How, or whether, such an institution would work, is fitting matter for experiment and depends critically on the contract structure and the incentives it embodies. But such managements could conceivably encourage shorter patient stays, more use of hospital-based ambulatory or home care alternatives, and closer attention to both admission and servicing intensity patterns.<sup>29</sup>

## **INSTITUTIONS, INCENTIVES, AND INFORMATION**

At the end, we come back to the basic theme of chapter 1. Canada, like every other society, has evolved a set of institutions which govern the behaviour of transactors in the health care field, by the creation of patterns or flows of information and incentives. The resulting behaviour patterns lead to overall outcomes in terms of resources used up, types and amounts of goods and services produced, and distribution of services and resulting incomes and costs, among the members of society. These outcomes can be evaluated in terms of more general social objectives of equity, effectiveness, and efficiency, and the trick is to develop institutions which lead to satisfactory outcomes. We have argued in this chapter that behind the current sound and fury over underfunding or cost-escalation; user charges, extra-billing, professional freedom and patient protection; patients dying in corridors or overservicing lies the general problem which we share with all other developed countries. What set of institutions (subject to constraints of political feasibility and cultural continuity) will lead to patterns of transactor behaviour -- governments, providers, and users -- which yield the best available outcomes in terms of efficient and effective health service provision and fairness of the resulting patterns of economic burden and benefit?

## **WHAT'S WRONG WITH THE STATUS QUO?**

We have suggested that the present confrontation of professional control over the specifics of provision but public control over total resources used, and minimal use of market mechanisms such as direct charges, yields a remarkably good compromise -- in world terms -- but at the cost of what appears to be escalating political friction, and possibly the beginning of a slippage of cost control. And while relatively cost-effective compared with many other countries' systems, it is nevertheless a good deal less effective and more costly than it could be. The absolute cost amounts are very large.

Finally, the Canadian health care system embodies a number of forces which appear inconsistent with longer term stability. Most obvious is an implicit expansionary manpower policy, which leads inevitably to either higher costs or lower provider incomes. But there is also

concern over the potential for continuing conflict in growing provider frustration which, if not constructively channelled, could lead to demoralization as well as militancy. "Alienated" professionals mean poor overall system performance. At the same time the regulatory and payment structure makes unduly difficult, if not impossible, organizational changes which could lead to improved service efficiency. Changes in *what* is provided take place quite rapidly; in *how* it is provided, much more slowly.

Moreover, the Canadian health care system (like most others) has not developed a satisfactory way of dealing with the really fundamental question of life and death. The official political position is that all "needed" care is to be provided, without charge. And this text has emphasized the range of important and difficult allocation and efficiency questions which can be addressed within that framework. Yet technological change is steadily shifting the resource/health status relationship to increase the economic significance of the ethically much more difficult questions of the "pulling the plug" sort. And politicians find open confrontation of the life and death questions, the decisions not to invest resources in prolonging life, extremely dangerous to their political health. Maintenance of the important illusion that "all needed care" is provided may increasingly rely, as to some extent it does already, on a tacit professional agreement that at a certain stage, "heroic measures" are inappropriate. But a really disgruntled profession, armed with a technology encompassing large numbers of very expensive "life saving" or at least significantly life-prolonging interventions, and willing to go public, might well confront provincial governments with the choice between *real* cost explosions, and loss of public confidence in the whole Medicare program.

Thus far, professionals have played on public fears to try to achieve relatively small changes, a bit more income here, a program expansion there, but have not wished to risk the political fallout from an open attack on the system. Perhaps they never will. But as the reach of technology extends, either the political system must find ways to address overtly (or delegate) the problem of balancing specific lives and dollars, or it must be increasingly dependent on the health care system, physicians in particular, to perform this role on its behalf. And their willingness to do so may not be independent of the level of conflict.

Yet proposals for reassertion of professional control, with or without a vestigial market sector, offer no prospect of a satisfactory or stable alternative either. More extreme proposals for a major shift to competitive market institutions, either directly or after a period of professional control, private insurance, and cost escalation, appear at the moment even less attractive.<sup>30</sup>

Alternative possibilities, suggested above, include attempts to develop and expand avenues of communication between political and professional authorities, on the understanding that neither one is going to, or should, go away. A concern for the provision of services of demonstrated effectiveness, and (less apparently) efficiency, of meeting the most needs possible with the resources available, should provide a common ground. This is not a new idea; such co-operation on a limited scale has gone on constructively in Canada for years. But the inevitably confrontational processes of fee and budget negotiation seem to swamp these co-operative endeavours. And so long as professionals, officially at least, regard the content of care as no one else's business, while governments and administrators regard it as not their responsibility, confrontation seems inevitable. Health care is far too important to leave to professionals, and in any case we cannot afford to do so.<sup>31</sup>

The other possibilities above -- "public competition" through HSOs, or for-profit contract management -- represent different ways of mitigating the political/professional conflict by introducing forms of provider organization with some incentives to contain, rather than expand, spending. Of course limiting spending to any *particular* level is not an end in itself. But eventually stability has to be achieved through some institutional form.

If improved political/professional co-operation on system management cannot be achieved, and if support cannot be generated for alternative forms of provider organization, then continuation of the present tension may be the best available alternative. Canada's health system is said by some to be "in crisis," but most health systems are "in crisis" most of the time. A system *not* perceived to be "in crisis" might be cause for concern, suggesting that the balance of conflicting forces and interests had broken down. So long as both political and professional agencies maintain their confrontation, and neither side becomes tired of the role, the experience of the last decade suggests we may not do too badly. But we could do much better.

And eventually the balance may start to shift. The federal-provincial conflicts of the early 1980s suggest that it has begun to do so; behind the trumpeting and bellowing along the world's longest defended border (between the federal and provincial governments) the Medicare system may indeed be in real danger. The *Canada Health Act* should prevent, or at least inhibit, one form of erosion, (not a trivial contribution) but provides no positive directions. Yet whether Medicare survives in its present or modified form, or starts down the slippery slope of "Australification,"<sup>32</sup> the underlying policy issues will not go away. The considerable international variety of social "solutions" to the problems of health care delivery and finance do yield more and less equitable and efficient results -- though efficiency is rather difficult to prove conclusively. But each society continues to find itself struggling with the same issues of what to produce, for whom, and how, and how to modify its institutions to get a more satisfactory result. How you play the game matters, and matters quite a lot; but you cannot end the game, by "winning" or otherwise.

## **AND A LAST WORD ON ECONOMICS -- FOR GOOD OR ILL**

The role of economic analysis in this process is to try to clarify the implications of different institutional frameworks and policy choices. Logically it cannot, as the Cheshire Cat pointed out, serve as a source of social objectives or values -- though economists (including this one) frequently try to do so.<sup>33</sup> What it can do is to provide a framework for assembling and assessing the available evidence, so as to assist in predicting how particular health care systems, or the transactor of which they are made up, are likely to react to the information and incentives embodied in different policies. Further, it can be used to trace through, in a logical and consistent manner, the interactions among such behaviours and to predict the resulting outcomes in terms of social objectives. Economic analysis can also be used to obscure or misrepresent these processes, to yield results favourable to policies benefiting the analyst or her sponsor. Or, as a result of misreading of evidence or inappropriate choice of analytic framework, suppressing key relationships and responses, and highlighting unimportant ones, it may be irrelevant or simply wrong.<sup>34</sup>

But used with some care, with as many as possible of the cards on the table, and in conjunction with other disciplinary perspectives on the elephant, the economic framework yields a number of insights which seem to come with great difficulty, if at all, from other intellectual traditions. Occasionally some of these turn out to be useful. If this excursion through an economic interpretation of the Canadian health care system turns out to provide one or two such insights for readers responsible for actually making the system function, in whatever capacity (including paying for it), well, I suppose that was the purpose of the exercise.

## NOTES

<sup>1</sup> Readers of *The Hitchhiker's Guide to the Galaxy* may recall the mice.

<sup>2</sup> Of course the extension of rational optimizing behaviour from the economic sphere of human activity to all other forms of interaction and institutional design rests on either an unsupported (and unsupportable) quasi-empirical generalization or an empty tautology left over from first-year philosophy. But the difficulty is that economic analysis does not appear to contain within its own methodology any definition of its scope of application, of its appropriate boundaries. (Any resemblance to certain unpopular neoplasms is *surely* accidental.)

<sup>3</sup> It is most interesting that in Reder's (1982) analysis of the "Chicago School" of economists and its tendency to extend its methodology over the widest range of human activities -- social (the family, religion), political (law, public regulation), even genetic? -- only two areas are excluded. All other forms of behaviour become endogenous and "explained" in terms of economic forces. The exclusions are the preferences of transactors, which if endogenous would no longer support the normative propositions favoured by the Chicago school (as Galbraith makes clear time and again) -- and the activities of economists themselves.

<sup>4</sup> Or the willingness of a client to finance their pursuit ...

<sup>5</sup> It will not provide a detailed critique of economic methodology in the light of its successes and failures in the health care field (though some of this is implicit, and often explicit, in the chapters above). There are two good reasons for this. Such a critique would probably be of interest (at best) to a very few economists and almost no health care people, and anyway the task is beyond me. But it needs to be done, perhaps as part of a more general re-thinking of economic methodology.

<sup>6</sup> Everyone agrees, when pressed, that efficiency objectives are very important; but they seem to lack political appeal. People will fight for social justice, equity, liberty, rights to care -- but not, alas, for efficiency.

<sup>7</sup> Both medical associations and provincial reimbursement agencies, for example, accept relative provider incomes as a significant objective of public policy. They just attach different signs to its weight.

<sup>8</sup> One might suggest that dentistry is in tension (in most provinces) between professional and market ideologies, with a small role for the political process, and drugs and appliances lie between politics and the market, with some limited professional component. But this appealing symmetry is probably overstated.

<sup>9</sup> There are of course in some provinces exceptions to this generalization; extra-billing and user charges, and premiums. Premiums, being unrelated to the insured person's expectation of illness, and *de facto* compulsory for most people, are best thought of as a form of poll tax. They do not relate tax burden to ability to pay, and thus offend against a major principle of tax equity, but they do not link it to actual or anticipated care use either. (They may, however, create problems of access if vulnerable groups become uninsured by dropping out of the premium system, *e.g.*, as a result of unemployment.) User charges and extra-billing are difficult to reconcile with the central Medicare principles of universal, comprehensive, publicly administered coverage. As will be discussed below, they inject a foreign element which could represent a transition stage to a very different type of system. They may also, now that the *Canada Health Act* penalizes provincial governments which impose or permit them, be in the process of disappearing. But that is far from certain.

<sup>10</sup> It may lead to certain people being compelled to accept non-optimal "over-coverage," but this is by no means obvious a priori; see the discussion in Evans (1983).

<sup>11</sup> Of course, it is easy to confuse the shadow and the substance. The "blooming, buzzing confusion" of the entrepreneurial U.S. system generates a high volume of innovative ideas, but (thus far) remarkably little real progress in improved global efficiency, as opposed to technological virtuosity.

<sup>12</sup> The most obvious source of conflict is the process of relative income determination for providers. While the pre-Medicare environment of professional control of the "market" and private insurance appeared to place no limit on the escalation of provider relative incomes, the present monopoly/monopsony bargaining environment is believed by providers to place them in an unduly weak position. They can only protect themselves from progressively eroding relative incomes -- "exploitation" by government on behalf of the taxpayer -- by either strikes or threats to the integrity of the insurance system itself -- opting out and/or extra billing.

This "safety-valve" view of direct charges has two serious weaknesses. As a collective tactic it imposes no costs on the profession, unlike a strike which harms both striker and employer and thus creates incentives for settlement. Secondly, it places pressure on individual patients in a dispute between profession and government. In a sense, direct billing is a perfectly flexible strike weapon: refusal to serve if pay demands are not granted, on a case-by-case basis.

Yet it does respond to a real issue. The present funding system *does* represent a long-term "incomes policy" for health care workers, administered by a government which has a direct interest in holding their relative incomes down. Strike threats (or strikes) in hospitals have thus far maintained hospital incomes, but no satisfactory mechanism of arbitrating physician incomes has yet been developed. Physicians' principal negotiation tactic has been to threaten to wreck the payment system (and to try to gain public support for doing so), a threat which must become ever more strident to maintain credibility.

<sup>13</sup> Ironic confirmation of this was given by the Canadian Medical Association in its testimony before the Special Committee on the Federal-Provincial Fiscal Arrangements (Breau Committee) (Canadian Medical Association 1981). Working under the common handicap of out-of-date data, they argued that 7 percent of GNP spent on health was far too low, and that 8.2 percent (which looks rather like a half-way point between the then-available Canada and U.S. rates) should be a target to be reached over about five years. The very next year, 1982, a combination of recession plus increased health spending brought the actual figure to just under 8.5 percent -- but the system is still alleged to be "underfunded." The reply by CMA spokesmen that the CMA's target assumed increased health spending, not decreased GNP, is reasonable, except that it shifts smoothly from a relative to an absolute spending standard, and is inconsistent with the 1981 CMA position that as a country becomes richer (GNP rising) its share spent on health should also rise. Not to labour the point, the CMA objective was clearly, and quite understandably from their perspective, "More." The specific numbers were just means to that end.

<sup>14</sup> Indeed the argument sometimes put by advocates of direct charges, that provider discretion will ensure that no one who "cannot afford" to pay (in the provider's judgement) will be charged, and that no one will be denied services through inability to pay, can be translated into the framework of the price-discriminating monopolist of chapter 7, charging different prices to each buyer. Total revenue is thus maximized, while output need not change at all, and the entire effect of the policy is to increase prices and provider incomes. Of course providers have neither the ability nor the desire to discriminate so perfectly, and what someone else "can afford" is a very imprecise concept.

<sup>15</sup> How such redistribution would affect the matching of use to needs is difficult to determine conclusively. But the well-established correlations of age, illness, and poverty should certainly place the burden of proof on advocates of charges. Even if, *at the margin*, little or no connection is found between health care use and health, it does not follow that a policy which serves to redistribute care from the more to the less ill should be regarded with indifference, much less applauded.

<sup>16</sup> Alberta and Ontario, where physician opting out and extra-billing is most common, do not have noticeably more amicable negotiating processes.

<sup>17</sup> Alberta shows some signs of moving in this direction, but no province has openly adopted such a policy, and some have specifically rejected it.

<sup>18</sup> The federal government's attitude toward criteria for cost-sharing would become critical here. The passage of the *Canada Health Act* in early 1984 clearly indicates that, for the present at least, the federal government will *not* permit such an evolution, so this discussion is hypothetical. Whether the Act will lead to the prohibition of direct charges altogether, is more problematic.

<sup>19</sup> "Thou shalt not kill/But needst not strive/Officiously/To keep alive." The competitive market for group contracts is supposed to discipline this process. Representatives of employee groups are assumed to be informed buyers on

behalf of their members, and to withdraw from HMOs who cut corners. But this does not help the elderly widows or the chronically ill or unemployed. Competitive HMOs appear to offer great advantages for the non-old, the non-poor, and the non-sick. But integrating the people who really *need* care into this sort of system, especially in its for-profit form, is far from simple.

<sup>20</sup> Ironically, a change which the "exogenous demand" school argued would lead to less comprehensive coverage, may in fact lead to more. HMOs typically offer broader coverage with fewer self-pay components, but control costs on the supply side.

<sup>21</sup> The Singapore Syndrome: having one's guns pointed in the wrong direction.

<sup>22</sup> "Nothing is ever wasted, it can always serve as a horrible example." (G.L. Stoddart, personal communication).

<sup>23</sup> Of course Canadian advocates of "privatization" may take the view "Après moi, le deluge." Short-run gains would accrue, and to those late in career, that may be justification enough. The American physicians who successfully fought off national health insurance are home and dry with their investments; their successors face a very different world.

<sup>24</sup> Such a role requires individual professionals to act as agents for both individual patients and the collective society, to balance three (including their own) sets of conflicting interests, not two (Evans and Wolfson 1980). This may not be possible, and in any case has not been part of the traditional professional role. The concept of the "cost-conscious physician" suggests that it might become so, but so far the supporting evidence is absent.

<sup>25</sup> Whether the U.K. National Health Service refutes or confirms this concern about professional demoralization and/or imperfect political agency is rather difficult for an outsider to determine. So many images of the NHS have been created for both Internal and external political purposes (Culyer 1982) that assessing the reality would be a most complex task. Are or were NHS "refugees" in practice in Canada "demoralized," or did they simply see greener pastures? Is Mrs. Thatcher seeking "value for money," or destruction of the NHS?

<sup>26</sup> As Freidson (1970) argues that indeed it is.

<sup>27</sup> This would represent a departure from past Canadian efforts to evaluate medical practice -- cervical screening, for example, or periodic health examination -- in that the results of such studies would be used not merely to inform those practitioners who read journals, but to monitor and modify actual practice patterns with professional as well as political support. In U.S. terms, Professional Standards Review Organizations run jointly by the paying agency and the medical association, with financial and professional teeth.

<sup>28</sup> Of course professional regulation can be used punitively by a dominant group of providers to discipline or suppress potential competitors. A policy of encouraging competitive forms of delivery which pose a real threat to "mainstream" care markets must therefore include some monitoring and control of the professional self-regulatory process. Similarly, critics of such proposals have argued that they will fragment users by social and economic class, and enable provincial governments to spin off the more politically vulnerable into second-class care. Again the response must be monitoring and control through informed public opinion.

<sup>29</sup> Of course if reimbursed a fee based on service load, *e.g.*, patient days, or proportionate to overall costs, such managements would attempt to induce the reverse effects. But no provincial government would be so foolish as to write such a contract. Defense contracting experience with cost-plus-percentage-of-cost (CPPC), or even cost-plus-fixed-fee (CPFF), contracts is sufficiently well documented, and deplorable (Scherer 1964), and in any case common sense should guide.

<sup>30</sup> There may be, over the U.S. market rainbow, a world of private for-profit firms providing ever more efficacious care, at the lowest possible cost, to citizen/patients who have adequate personal resources, private insurance, or public subsidy sufficient to get the care they need. But it can be seen only with the eye of faith. The present situation appears to be predominantly wind and rain.

<sup>31</sup> In this context it is interesting to note that dual management, explicitly coordinated physician and administrator responsibilities at each level, is a fundamental policy of the largest U.S. HMO (Kaiser), while FP hospitals also appear to give physicians a large role on their boards. And in the U.K., "clinical budgeting" extends the managerial role -- and responsibilities -- of the clinician. The "two lines of authority" may be drawing together in a number of settings.

<sup>32</sup> Which turns out not to be permanent either.

<sup>33</sup> Reinhardt refers to playing politics in the guise of science as a favourite economists' pastime -- see also Evans (1982*b*) -- but as your doctor will tell you, there's a lot of it about.

<sup>34</sup> These are immoral and bad analyses, respectively, and are done by other people.