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Making Health Spending Work

Fred McMahon & Martin Zelder

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Executive summary

Medical Savings Accounts (MSAs) are usually promoted as a demand-management tool that gives consumers incentives to economize on medical expenses. *Making Health Spending Work* takes the concept one step further and shows how MSAs can be used to design a *publicly funded* system that incorporates market dynamics. MSAs can bring efficiency-enhancing incentives to the supply side, creating consumer choice and empowerment with a public system that meets Medicare's key principles.

Over the last few months, Canada's political leaders have begun to break away from the reform-stalling tactics of special interest groups—which profit mightily from the current system—and to examine sensible reforms that could benefit all Canadians. By breaking free of old dogmas, Canada can turn myth into reality: we can have the best Medicare system in the world, one that expands choice and creates efficiency-enhancing dynamics.

Medicare's perverse economics

Making Health Spending Work contrasts the structure and incentives in an MSA system with the structure and incentives of the current Medicare system. It uses standard economic tools to explain why today's Medicare system produces so many perverse outcomes:

- why family doctors in Canada earn less than auto-workers on a hourly basis;
- why a painter, baker, or booking clerk working in a hospital earns a third more than a painter, baker, or booking clerk employed in the private sector;
- why Medicare consistently underpays trained medical workers, such as doctors and nurses;
- why Medicare consistently overpays non-medical workers;

- why the large and distant bureaucracies that run the system are unable to improve efficiency by fiat;
- why new monies devoted to medicare are siphoned off by special interests and provide little benefit to the public
- why medical services and technology are poorly distributed, creating queues throughout the system.

Creating choice in Medicare

Canadians believe that medical care should be available to all regardless of income but that does not mean Canadians should be required to forego the dramatic improvements and new choices markets have brought to virtually all sectors of our lives. Compared to 25 years ago, Canadians drive better, cleaner cars, watch crystal clear televisions that consume less electricity than older models, travel further and at less expense, enjoy spectacular new technologies—the list could go on for pages—yet the health-care system continues to falter. Canadians do not even receive the full benefit of new medical technology, usually invented elsewhere, because Medicare continuously fails to provide treatment in a timely manner.

Canadians would never permit nationalization of the automotive sector. Who would trade in a Ford or Volvo or Toyota for a Lada or a Yugo? While it is easy to understand the folly of a public-sector automobile monopoly, a public-sector monopoly in much of the medical sector is vociferously defended in the face of startling evidence that it threatens the health of individual Canadians, who have to queue up far too long for often inadequate services.

If anything, the medical care system is more complex than auto-making, yet special interest

groups continue to claim it must be publicly run. There often seems to be a deliberate attempt to confuse the idea of private provision of services with private pay for medical services. Yet, a consumer of medical services wants the best possible treatment, and it does not matter to the consumer whether it is provided by a government-managed facility or a private facility, so long as government pays the bill.

The MSA system

This paper shows how MSAs can create market dynamics within a public system. Each Canadian would be provided a government-funded MSA and then would be able to choose among private and public providers to obtain the treatment that best suited his or her needs. The consumer becomes the bill-payer. Consumer and provider incentives are aligned as providers seek to meet consumer demands for the most effective and efficient services. (Considerably greater detail on these dynamics is provided in the main body of this publication.)

This is much different from the current system, where neither the provider nor the consumer have any incentive to avoid waste—and can often benefit from it—while the distant bill-paying bureaucracy simply does not have the tools or information to enforce efficiency. And, it is not just the bill-paying bureaucracy that suffers: choice and market dynamics are absent from the system. Patients have to take what they can get, when they can get it, regardless of the wait or the quality.

The power of special interests

Canada ranks fifth among OECD members in the amount it spends on medical services yet ranks well down the list in most quality categories (OECD 2001). The low ranking of Canada's health-care system on the OECD's quality scale is consis-

tent with the rank of 30th assigned to Canada by the World Health Organization—virtually at the bottom of the list of affluent nations (WHO 2000). Yet, Medicare's supporters claim the system is fine as it is or just needs a little bit more money, despite the huge gap between spending and quality international studies have found.

It is important to understand from a policy perspective why Medicare retains its dogmatic defenders while its performance plummets in international assessments and while the anxieties of Canadians about their own health care are on the rise. The explanation begins with the structure of Medicare. Canada's system is virtually unique in the advanced world, not merely in its bottom-of-the-barrel score for a developed nation, but also in its insistence that the system be a public monopoly. In virtually all other nations, including social democratic nations like Sweden, the government funds private services as well as public services. Yet, it is government's monopoly of many medical services that the defenders of the status quo are most vociferous in protecting. Despite evidence from other advanced nations, the defenders claim that this monopoly is the heart of Medicare and oppose giving Canadians medical choices people elsewhere in developed nations enjoy.

Why would Medicare's supporters focus so much effort on defending government's monopoly? A little bit of economics helps with the explanation. Monopolies, whether in the public or the private sector, create huge advantages for those who control them. Medicare benefits two special-interest groups in Canada: public administrators, who are at least indirectly responsible to the voters though they have proved resistant to reform until it is forced upon them by a change in government, and powerful public-sector unions, who face no control until they finally exhaust the public's patience with their disruptions of the health-care system. With a public-sector monopoly mandated by law, public-sector union leaders enjoy enhanced power and a large, steady income from Medicare's dues-paying union members. This would

be threatened by any attempt to give Canadians the choices that people in other nations enjoy. It is easy to understand, on a purely human basis, why unions and their leaders react so powerfully to any threat to these privileges.

Thus, public-sector unions fund and lead protests and lobbying efforts across the nation in an attempt to convince Canadians that a government health monopoly, and lack of choice for individual Canadians, is actually a good thing. Political power, not health considerations, determines outcomes.

Making Health Spending Work explores the dynamics of the current system to show how it provides extraordinary advantages for special interests while short-changing less politically powerful providers of medical services—such as doctors and nurses—to the detriment of health services for Canadians. Since a monopoly system is freed of normal market constraints, rates of pay become a matter of power. Doctors and nurses, at least until recently, have been reluctant to strike and damage the health of their patients in order to obtain increased pay. Public-sector unions have shown no such restraint in labour action and have managed to hold the taxpayer hostage to their demands.

The unions themselves recognize the privileges they gain from this public monopoly. For example, the British Columbia Hospital Employees' Union recently tried to defend the exorbitant pay rates it has been able to coerce out of the province's health-care system by arguing that inflated rates of pay for hospital workers are justified because these workers face increased health risks (Cohen 2001). However, it is difficult to understand why a hospital payroll clerk deserves to be paid 39% more than a payroll clerk in the private sector; why a hospital painter deserves 31% more; why a hospital booking clerk deserves 32% more—the list could go on (Esmail 2002).

Special interests have also proved adept at capturing new monies put into Medicare. They have successfully limited health-care expenditures they cannot capture for their own advantage, regardless of the medical benefits they could bring to Cana-

dians. For example, though there is evidence that pharmaceutical and capital expenditures improve medical treatment for Canadians more than other types of expenditure, neither can be captured by rent-seekers within the system. So, of each new dollar entering the Medicare system, only 1 cent goes to pharmaceuticals and only 2 cents go to capital spending.

One often reads of special interests obstructing essential reforms elsewhere on the planet. From a distance, it is hard to figure out how reform can be derailed by special pleading that betrays the public interest. Anyone outside Canada would likely be stunned that special interests have been able to block policies that other nations successfully employ to improve health care. In a recent interview with reporter Mark Kennedy (2002), Senator Michael Kirby succinctly summed up the emptiness of Canada's false debate, inspired by special interests, on private versus public provision of medical services:

We're the only country in the world that does this public-private debate. Every European country would never get into this debate. There's a role for the public sector. There's a role for the private sector. I'm far more worried about the lady who says "I can't get a prescription drug" than I am ... about who actually carries out [an] operation.

The case for MSAs

Special interests will object loudly to MSAs. They will not be able to capture funding from MSAs unless they are able to provide Canadians with the quality, timely health-care Canadians would demand if given choice. The government health monopoly would be broken though public funding would be maintained.

Fortunately, the log jam that has long frustrated attempts to reform Medicare is beginning to

break. The Mazankowski report (Mazankowski 2001) in Alberta has suggested a number of sensible reforms, including further exploration of the MSA concept. Michael Kirby's Senate committee has examined a number of worthwhile reforms and includes a sound, empirically based discussion of MSAs (Kirby 2002). MSAs have a proven track record, with easily accessible research, which is discussed at length in *Making Health Spending Work*. Most of the references cited there and in this *Introduction* are available on the Internet. (See the website of the Toronto-based Consumer Policy Institute as well.)

Canadians can have a superior, publicly funded medical system. We can move beyond sterile debates and blow up the log-jam holding back reform. Instead of today's inefficient inequitable system—marked by life-threatening queues, rich Canadians fleeing the system for foreign treatment, political and military leaders with their own "no-wait" facilities, low- and middle-income Canadians trapped without choice, unequal levels of treatment depending on social status even within Medicare—Canadians can build a new public system marked by consumer choice and empowerment combined with the efficiency enhancing dynamics and innovation of a market structure.

Fred McMahon

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About this paper

Making Health Spending Work is a chapter from *Better Medicine: Reforming Canadian Health Care*, to be published in Spring 2002 by ECW Press, Toronto and Montreal. *Better Medicine* is edited by Dr. David Gratzer, the award-winning author of *Code Blue*, and contains essays by some of today's leading thinkers on health care, including economist William Watson, *Globe & Mail* columnist Margaret Wenthe, and historian Michael Bliss.

Making Health Spending Work

Introduction

The debate over Canadian health policy is curiously limited. Rather than applying the rich lessons derived from economic analysis,¹ most of those who debate health policy reform ignore market-based ideas, and instead focus almost exclusively on proposals that maintain the status quo, with only a few minor changes at the fringes of the system. In particular, the focus of debate is on supply, but through a command-and-control lens. Thus, debate centres on how to limit supply, or on the importance of devoting more tax dollars to increase supply, or on how to manage and administer better within the public system. What these narrow approaches share is an assumption that reform is best achieved through more extensive government control.

This essay contrasts the flaws and destructive incentives in medicare's current command-and-control structure with innovative ideas for the creation of a dramatically new and innovative system—a system with the potential to bring the benefits of market dynamics to the medical sector while maintaining the publicly funded nature of the system.

By ignoring market-based reforms and concentrating on centralized solutions, the present debate deprives Canadian citizens of the quality-of-life improvements they have realized in market-driven sectors—such as consumer goods, communications, entertainment, and so on—which dominate the rest of the economy. In those markets, the dynamic interaction of value-seeking consumers and competitive producers has led to huge gains for ordinary citizens. Hence, it is mind-boggling that we continue to view health policy reform in such a narrow and bureaucratic fashion.

This predisposition to seek governmental solutions to health policy problems was undoubtedly a by-product, originally, of Canadian compassion: low-income individuals should not be denied crucial medical care because of inability to pay. Unfortunately, this compassionate intent has not been well served by the institution of medicare. Preferential access to cardiovascular surgery on the basis of “nonclinical factors,” such as personal prominence or political connections, is common.² As well, residents of suburban Toronto and Vancouver have longer waiting times than do their urban counterparts,³ and residents of northern Ontario receive substantially lower travel reimbursement from the provincial government than do southern Ontarians when travelling for radiation treatment.⁴ Finally, low-income Canadians are less likely to visit medical specialists,⁵ including cardiac specialists, and have lower cardiac and cancer survival rates.⁶

The failure of this egalitarian dream is not medicare's only shortcoming. It is also, of course, grossly inefficient. This inefficiency is evidenced by prolonged and growing waiting times for care, discussed later in this essay. Moreover, the extent of the inefficiency is demonstrated by shocking new findings regarding the impact on health spending.

In this essay, we first examine the impact of medicare's current structure and the perverse incentives that arise from that structure. Then we explore a policy solution that creates market mechanisms even within a publicly funded system. We then turn to the impact of this policy solution on the health system's incentive structure and what this would mean for costs, productivity, allocative efficiency, demand patterns, and individual choice. We conclude with a brief discussion of some political considerations.

A house divided

Medicare is a house divided against itself. Incentives facing the players in the system clash. Consumers consume all the medical care they wish without regard for cost. Providers have incentives to boost their remuneration as much as possible without regard for either cost or quality of service. Only the bill-paying bureaucracy has incentives to limit costs and create new efficiencies, but the distant bureaucracy can hardly match the inventiveness and on-the-spot knowledge of consumers and producers, who have no incentives to create new efficiencies and savings and who can often gain from waste and inefficiency.

Compare this scenario with a market system and how it aligns incentives. Consumers, because they are paying their own bills, have incentives to seek the most cost-efficient, quality services available. Providers' incentives are suddenly aligned with consumers' incentives. To gain customers, providers must compete to provide what consumers want: the most cost-efficient, high-quality services possible. The price signal moves resources to their most efficient allocation.

These dynamics create a stark contrast with Medicare's command-and-control system. This system lacks mechanisms to balance supply with demand. Queues and shortages become tools to control demand to fit the government-managed level of inadequate supply. The system has no mechanisms to promote cost-efficient and high-quality services other than through bureaucratic fiat. Allocation is also determined by bureaucratic fiat, but without the information created by the price signal or with the knowledge of on-the-spot participants.

In a market, allocation of scarce resources is determined through the interaction of consumers and providers, which creates the price signal and a considerable amount of information. For instance, in a market-oriented system, a hospital would decide to buy an MRI machine based on whether

usage justified the cost, rather than waiting for the decision of a health bureaucratic on allocation.

Let's consider in more depth the incentives facing consumers. While publicly insured medical services are, of course, not "free," but are financed by taxation, they are "free" in the important sense that they require no out-of-pocket payment by consumers at the time of use.⁷ It is well known by economists everywhere that "free" services will be overused. Specifically, Newhouse and associates at the RAND Corporation, in their pioneering and celebrated RAND Health Insurance Experiment, discovered that an insurance plan with modest out-of-pocket payments (compared with a plan with "free" care like Canada's) significantly reduced use of health care without impairing the health of participants, except for a small subgroup, poor participants with a serious medical condition like high blood pressure.⁸ In other words, despite the paternalistic approach of Canada's Medicare system, consumers are able to make their own choices. Only a small minority in special circumstances faces constraints that prevent this power to choose. Our proposal for a market-based medical system will have mechanisms to address this problem.

Now, contemplate the incentives for providers. They face prices for their publicly insured services that are centrally determined, via bargaining for doctors, nurses, and other health care workers. Because these prices are not the result of a market mechanism, it is unlikely that they correspond to the value to society of the underlying services. As a result, the level of services provided will not correspond to the level that society prefers. Additionally, hospitals are constrained by their government-determined budgets, mandates as to the numbers of treatments they can provide, and by their inability to receive financial rewards for serving consumers better.

Consequently, the outcome we observe in Canadian health care is one in which neither consumers nor providers are motivated to make desirable decisions. Consumers' lack of out-of-pocket

responsibility leads them to demand some services with very low medical value. Doctors, nurses, and other health care professionals are not appropriately rewarded for what they do, and thus, justifiably, do not provide as many services as the public desires. Hospitals do not effectively compete because they are not rewarded for doing so. The taxpayers cover the costs of this misaligned system, relying on their agent—the government—to generate better results.

How well does the government do on our behalf? The traditional idealized view of the public-spirited bureaucrat has, in the last forty years, given way to a more realistic conception of government officials as self-interested creatures. As such, their decisions, like anybody else's, are aimed at achieving their own individual goals. But unlike Adam Smith's invisible hand, where the interaction of self-interested parties frequently leads to mutual benefit, the visible hand guiding government decision-makers often leads to an inefficient outcome. In such a state of affairs, the gains from reform exceed the costs, but reform still does not occur.

The reason that desirable reforms are not realized is because they are blocked by interest groups who can deliver a more appealing package of votes and financial support than the diffuse citizenry of taxpayers. For instance, public sector unions fight to maintain their virtual monopoly on staffing health facilities and the inflated wages that result from this monopoly situation. Their battle against privately managed clinics has nothing to do with promoting the health of Canadians and everything to do with politics and protecting union power. But surely superior health care should be the goal of medicare.

The inefficiency generated by political self-interest is manifested on a daily basis. Imagine that some set of hospital services could be best provided by private contractors, who use the government's fee schedule and bill the government so that service remains "free" to the consumer. This approach would make sense. Various forms of con-

tracting out and privatization, usually introduced only after intense opposition from the bureaucracy, have brought great efficiencies to government.⁹ Yet bureaucrats and politicians—along with public sector unions—have incentives to oppose private providers because private providers jeopardize their current arrangements and the privileges, power, and financial rewards associated with these arrangements. In short, the system creates incentives for small groups to frustrate attempts to improve the system for the benefit of average Canadians who need health care. Such conflicts are prevalent in matters small and large in the medicare system.

Of course, the incentive for self-interest runs through all human dealings. A for-profit hospital has every incentive to promote its services. But in a marketplace where choices are available, a hospital only attracts patients if it offers superior service or price, or both. However, in a public health care monopoly, consumers are left with no choice and must accept service where they can get it, regardless of quality.

Thus, consumer choices, distorted by medicare's insurance coverage and thwarted by a lack of serious options, combined with the decisions of self-interested politicians, lead to the systemic outcomes we observe. Crucial medical treatments are either denied consumers or—equally unfortunate—are not provided in a timely manner. Indeed, the most prominent evidence of the Canadian system's dysfunction is the prolonged and growing waiting time for treatment. Between 1993 and 1999, waiting time between a general practitioner's referral and treatment by a specialist rose from 9.3 to 14 weeks, a growth of 51 percent. Waiting times also rose dramatically for many critical types of care over this period, including medical oncology (114 percent), radiation oncology (65 percent), neurosurgery (43 percent), and orthopedic surgery (26 percent).¹⁰

Furthermore, Canada's record regarding waiting time is dismal when compared with other developed countries. In one study, Canadians waited

longer than Americans for cranial MRI (5 months vs. 3 days), screening colonoscopy (4 weeks vs. 2 weeks), and total knee replacement (5.5 months vs. 3.5 weeks).¹¹ In another, Canadians waited longer than Germans and Americans respectively for cardiac catheterization (2.2 months vs. 1.7 months vs. 0 months), angioplasty (11 weeks vs. 7 weeks vs. 0 weeks), and bypass surgery (5.5 months vs. 4.4 months vs. 0 months).¹² A third study found that Canadians waited longer than Swedes and Americans for elective bypass surgery and urgent bypass surgery.¹³

The question then arises whether these waits are caused by flaws in the command-and-control system or by simple lack of resources. It is impossible to completely disentangle these two possibilities, but the evidence strongly points to the type of system flaws discussed in this essay. Public choice theory suggests that resources put into a public system will be disproportionately diverted to interest groups and administration.

Once again, consider incentives. Medical consumers are not allowed meaningful choices outside the government system. Thus, those working within the system—unlike those who work in a market-oriented sector—face no threat to their job or income if consumers are unsatisfied, since consumers can't take their business elsewhere. In fact, consumer dissatisfaction provides a rationale for demanding more money. Similarly, those working in the medicare system don't gain additional job security or pay raises if consumers are satisfied.

This means that those running the public health system have little incentive to actually improve services, but they do have immense incentives to build administrative structures and reward themselves as new resources enter the stream. The data is entirely consistent with this hypothesis. A comprehensive review of the relationship between spending and services discovered some startling relationships.¹⁴

Untargeted increases in health spending fail to reduce waiting times, except in Quebec. In fact, increases in spending are related to *increases* in wait-

ing times for medical oncology, radiation oncology, and cardiovascular surgery. Additional spending also has no impact on the number of treatments offered by the medicare system. In a number of areas, higher spending is actually related to a *reduced* number of treatments. Such areas include total surgeries and radiology procedures.

These findings are consistent with public choice theory, which would predict that in a system like medicare, monies targeted to improve health care leak out to special interests. The theory would also predict that these special interests would devote much effort to capturing new monies, effort diverted from the actual provision of health care services. The system loses twice, once through the capture of new income streams for special interests and again through the efforts expended to capture the income. Compare this system again with a market system where providers are penalized when they divert resources to inefficient uses, as this action inhibits their ability to meet demand from customers for cost-efficient, quality services.

The distribution of new dollars injected into the medicare system nicely illustrates these points. Zelder found that expenditures on prescription drugs reduced waiting times.¹⁵ Capital spending also had positive benefits. Zelder found it increased the number of procedures that health providers are able to supply. Thus, in any rational system, one would expect new spending to be heavily weighted to prescription drugs and capital spending. Public choice theory, however, would predict that little money would go to drugs and capital spending since these expenditures go to outside providers—pharmaceutical companies, pharmaceutical distributors and retailers, building contractors, and equipment suppliers. Public choice theory proves right: only 1¢ of each new dollar entering the medicare system went to pharmaceuticals; capital spending received only 2¢.

Public choice theory would also predict that “insiders” would capture most of the new money, even if that meant directing it to areas that pro-

vide little improvement in health care. This also proves to be correct. Out of each dollar of new money, hospitals received 29¢, the catch-all category “other” received 25¢, and “other institutions” received 23¢. This diversion of resources almost certainly explains why increased spending is so ineffective in improving medical services. Medicare promotes rent seeking that diverts resources from medical care into the pockets of powerful special interest groups, such as public sector unions.

Moreover, even administrators with the best of all intentions would face an impossible task in running medicare. A distant bill-paying bureaucracy simply does not have the tools or the information to control each medicare transaction to promote efficiencies and savings. By contrast, in competitive market transactions, a party greatly interested in cost and quality—the consumer—is present at every transaction. Providers compete to offer the best service at the lowest cost.

Bureaucratic responses

The bureaucratic response to medicare’s problems is perverse. Rather than opening up the system, empowering frontline providers, and expanding choice, the bureaucracy has striven to tighten its control. Central bureaucracies decide which populations hospitals service, where hospitals are built, what treatments they provide and in what quantity, what equipment they buy, how much they can pay in salaries, what job descriptions are, and so on. As Canadian governments attempted to control the growth of medical care costs, they typically put a centralized bureaucracy or special planning commission in charge of making the difficult decisions about retrenchment.

For example, the Ontario Health Care Restructuring Commission, in its report on hospitals, made recommendations from the large-scale (which hospitals would be closed and which left open) to the small-scale (which wards in individu-

al hospitals would be shut down, how many beds would be closed, and which services individual hospitals would no longer provide). The government of Ontario then acted on the bulk of the recommendations.

Government is now laying siege to the remaining outposts of independence: federal Health Minister Allan Rock has declared he likes the proposal from Ontario’s Restructuring Commission to force all family physicians into group practices, where the bureaucracy would have the power to micromanage down to the last receptionist’s salary. Fierce opposition from doctors forced the Ontario government to back away from the most coercive measures recommended by the commission, but governments across Canada—including the federal government—continue to discuss ways to increase government control over doctors’ practices and the provision of medical services.

Similar perversities are found on the demand side. Demand is matched to supply not by the price signal—the most efficient system of allocation and production in human history—but rather through queues, rules, and rationing. Each can produce absurd, and sometimes tragic, results.

Internal dysfunction

A particularly severe area of dysfunction in the system is the human resource sector. While markets match staffing demands with labour supply through the price signal—whether at the level of vice-president or janitor—in the medicare system, pay structures are determined by centralized processes, which are sensitive to politics and the power of various groups. With rare exceptions, individuals are not permitted to form contracts at mutually agreed upon prices, so groups must bargain collectively, which inevitably serves Canada’s unions.

The health care bureaucracies have been careful to protect their monopoly employment power within each province by, among other things,

effectively limiting consumer choices in the provision of medical services to providers within the medicare system. This protection has been accomplished by laws that place restrictive conditions on physicians wishing to opt out of the public system, and require provincial licensing of private hospitals. Of course, the expanded choice provided by opted-out doctors and private hospitals would undermine the system's monopoly if consumers decided the private providers offered better services. Hence, political pressure by interest groups (e.g., public sector unions) has discouraged such private sector developments.

Moreover, political competition among provincial medical associations, nurses' unions, and other health sector unions has created a system in which pay is not clearly linked to social value. This politicized, government-bargained process leads to perverse salary decisions within the system. Power, and more importantly, the willingness to use it, drives remuneration levels. All of this adds up to a bizarre health care system in which medical workers are underpaid and nonmedical staff is overpaid. One indication of this imbalance is the relative compensation of physicians, nurses, and other medical workers. Although a direct determination of occupational value is difficult, one can gain a sense of the appropriateness of compensation by comparing data from the Organisation for Economic Co-Operation and Development (OECD) on Canadian and U.S. incomes. This comparison reveals that while Canadian physicians earn only 50 percent of what U.S. physicians do, Canadian nurses earn 85 percent of their American counterparts' average, and "all medical workers" on average earn 93 percent, in Canada, of the U.S. average.¹⁶ Because doctors and nurses are included in the "medical workers" calculation, this means that those medical workers who are neither doctors nor nurses (i.e., technicians, plus those in nonmedical jobs such as hospital janitors) earn more than 93 percent of their U.S. counterparts, perhaps 100 percent, perhaps more!

Political power is a likely explanation of this perverse salary structure. Doctors may be reluctant to strike. Many entered the health care profession because of a strong commitment to caring and medicine. Thus, doctors may hesitate to withhold services. In a publicly administered compensation system, where power largely determines pay levels, government can play hardball with doctors because their resolve to strike is weak. This tendency is reflected in a comment by New Brunswick Premier Bernard Lord during the New Brunswick doctors' strike in early 2001: "Do they want to take the patients of New Brunswick hostage? Is that their objective?" Because of such rhetoric, and because of the weakness of physicians' bargaining tactics, their strikes are often short-lived. In their recent dispute, New Brunswick doctors gave up their strike after three days, without any settlement or even much movement on the government's side, despite the fact that their fees are 30 percent less, on average, than those of doctors in neighbouring Nova Scotia.¹⁷

This kind of situation has enabled government's health care bureaucracy to shift much of the burden of the financial squeeze medicare has suffered in recent years onto the backs of doctors and nurses. That both professions are being underpaid is evident in the shortages of doctors and nurses that have developed from coast to coast. It is also evident in the permanent immigration flows between Canada and the U.S. Over the 1980–97 period, about fifteen nurses left Canada for the U.S. for every one who entered. Over the same period, about nineteen doctors left Canada for the U.S. for every one who entered.¹⁸ However, Canada suffers no shortage of well-paid, unionized nonmedical workers in the medical system. Demonstrating the perversity of the current system, medicare promotes underpay for and shortages of health workers in the health system, while at the same time promoting overpay for nonmedical workers.

The press loves to trumpet the stories about doctors who earn an obscene amount of money,

and some do abuse the system. As of 1995, the average GP (general practitioner), after the considerable expenses of running an office, earns just under \$100,000 in annual income.¹⁹ But Statistics Canada reports that doctors, on average, work 40 percent more hours than a typical Canadian. So if a doctor worked an average number of hours, that pay packet is reduced to just over \$70,000 a year.

Moreover, family doctors in private practice do not receive fringe benefits. They fund their own pensions, provide their own disability insurance, insure their spouses and children, etc. The cost of benefit packages varies considerably, but a conservative estimate is that they are worth about 20 percent of the base salary. This means that a doctor who worked about as many hours as the average Canadian would pull in a pay rate equivalent of about \$56,000 a year. That's less than an experienced teacher or autoworker earns. It is far less than the earnings of many people who hold skilled or semiskilled jobs, which don't require a university education and years of lost earning power.

However, nonmedical workers in the health care system receive a golden harvest. For example, while New Brunswick doctors returned to work without a settlement, the government of New Brunswick broke its own wage guidelines in its offer to hospital workers, represented by the Canadian Union of Public Employees (CUPE). Even so, the government had to threaten to legislate CUPE back to work. That action outraged militant unionists, who had been prepared to use their strike power regardless of the health care consequences. CUPE gave in to the legislative threat, but not without warnings of revenge from CUPE president Judy Darcy. The government, she said, would be "confronted by the full force of the labour movement."²⁰

This kind of threat gets the attention of politicians and bureaucrats. One study of hospital pay levels in British Columbia found that unionized nonmedical hospital workers (e.g., janitors), depending on their job type, receive 25 to 63 per-

cent more in pay than those doing the same job in the private sector.²¹ It is not surprising, then, that CUPE has funded and organized the fight against allowing private providers in the public system.

Yet in Canada's often bizarre medicare debate, even supposedly expert commentators frequently mangle reality. For example, Financial Post columnist Linda McQuaig writes that "doctors enjoy enormous political clout. Politicians who seem to welcome a good fight with public sector janitors and clerical staff tend to shy away from getting into fights with people they're likely to run into later at the golf club."²² But why would Canada be suffering shortages of doctors if governments so quickly caved in to their demands? Why would CUPE be able to fight so successfully against any reform to allow private providers if government was so willing to beat up on "janitors and clerical staff," as McQuaig has it? Surely, these workers would be the first to demand a liberalization of the medicare system if their government pay was suffering in comparison with pay in the private sector.

By contrast, in early 2001, when Alberta gave its doctors a significant fee increase, health officials across Canada reacted with public condemnation.²³ There should be no competition for doctors, the officials appeared to be saying. Of course, without effective competition to pay doctors what they are worth in Canada, capable doctors will increasingly migrate to the United States, and other qualified young people will pass on the prospect of medical school. At this rate, hospitals may soon be full of well-paid janitors and cooks, but devoid of doctors and nurses.

Introducing market dynamics to publicly funded health care

Markets eliminate the twisted incentives of a bureaucratic system. The consumer becomes the bill payer, pursuing the very simple objective of getting the best possible result at the least possible

cost. To succeed, providers must meet the consumer demand for cost-efficient service. The incentives of all the players in the system now lead to the same goal: improved efficiencies and reduced costs. The price signal balances supply with demand.

Yet in Canada's current medicare debate, it's usually assumed that market dynamics cannot be grafted onto publicly funded medicare, even though policy innovations have successfully used market mechanisms to achieve public ends in other areas—charter schools and school vouchers, tradable pollution rights, and property rights to promote conservation in the fishery, for example.

Medical savings accounts (MSAs) have the potential to bring market dynamics to a publicly funded medicare system. Under an MSA scheme, the government funds an MSA for each family or individual. The family or individual then draws on the MSA to pay for medical services. This empowers the consumer by providing choice.²⁴ MSAs can be structured in a number of different ways. Consider one possible scheme: Each year the government funds a personalized MSA for every Canadian. Projected medical expenses, based on factors such as age, sex, and medical condition, determine the amount paid into the MSA. The MSA can only be spent on a designated list of health services, which could include not only currently insured services, but items not currently insured, such as dental care, vision care, and alternative medicine. Those who spend less than their allotted amount during the year may retain some or all of the balance.

Those who exceed their allowance would be covered by an "overcharge" fund, roughly equivalent to catastrophic health insurance, but designed to cover medical expenses which, for whatever reason, exceed the individual's MSA. Affluent Canadians could be made responsible for paying some costs on their own before accessing the fund. The fund would kick in immediately for poorer Canadians, so they would never be charged for

medical services. This would remedy the problem the RAND study, discussed earlier, found for some groups of poor patients.

MSAs are usually thought of as a demand management tool. MSAs give consumers a strong financial incentive to economize on their medicare consumption, a much better outcome than bureaucratically imposed queues, rules, and rationing, which cannot account for differing situations or preferences. A great deal of evidence has recently been accumulated regarding the desirable effects of MSAs. A 1996 RAND Corporation study found that if all insured nonelderly Americans switched to MSAs, their health spending would decline by at least 6 and as much as 13 percent.²⁵ But although MSAs are not widespread in the U.S., due to severe regulatory restrictions on their structure,²⁶ they are the type of insurance held by 50 percent of South Africans.²⁷ In that setting, they have dramatically reduced health spending, including a reduction in outpatient spending by approximately 50 percent, as well as a reduction in inpatient spending.²⁸ Besides these cost savings, MSAs would individually benefit a substantial majority of the population, including those most prone to illness, according to a recent study from the Urban Institute.²⁹ The application of MSAs in the Canadian context has been described in Ramsay, Litow and Muller, and Gratzner.³⁰

MSAs could also liberate the supply side of the medicare system. For example, centralized fee schedules bargained by governments should be abolished; as well, the provision of hospital services should be opened to all qualified providers, whether for-profit, not-for-profit, or public sector. Consumers should be able to choose among them based on normal consumer preferences such as cost, quality, and convenience.

With consumers paying their own health bills through their MSAs, along with these other supply-side reforms, health providers' incomes would be determined by revenue from MSAs rather than by bureaucratic fiat. This would allow the price

signal to emerge and carry information through the system. Consumers would have an incentive to seek the most cost-effective care possible. Providers would be unleashed from bureaucratic control to meet this demand, and incentives would consequently be realigned to boost productivity and effective allocation of resources.

For example, central planning authorities previously have proved unable to provide enough MRI machines to the right hospitals, as is evidenced by long waits for MRIs in much of Canada. However, if a hospital were autonomous and able to buy its own MRI machines based on usage and a market-based fee schedule, it would be rewarded for providing the level of service demanded. In other words, each institute would have the incentive and the ability to provide the services needed in its community. A number of private clinics are now trying to meet the demand for MRIs that central planning has failed to fulfill, but the federal government says even this incentive violates the “spirit” of medicare.

Under the MSA system, efficiency occurs naturally, as part of the system dynamics. For instance, the Ontario Health Care Restructuring Commission’s proposal to force all family doctors into group practices open twenty-four hours a day, seven days a week, was largely designed to reduce the use of emergency wards in off hours. But if consumers had been given an MSA-style incentive to minimize their health bill, and providers were able to receive rewards for providing demanded services, off-hour alternatives to emergency visits would undoubtedly now be commonplace.

The MSA concept is flexible and could fit into any number of structures. For instance, an MSA system could maintain a “one-tiered” health care system. Except for the buffer area between MSA coverage and “overcharge” coverage, which could be implemented for higher-income Canadians, health care providers could be prohibited from accepting private, non-MSA payment for health services, except for providers who opt out of the

public system altogether and thus may not receive MSA payments. This scenario would be similar to the current system under which, for example, doctors may only bill the government for approved services.³¹

Political dynamics

Public sector unions and the most dogmatic elements of Canada’s left wing will oppose MSAs, as will those who believe individuals are not capable of making their own choices. Nonetheless, MSAs could have surprising political appeal for much of the Canadian political spectrum, in part because the Canadian public has been quicker than Canadian politicians to realize that the system needs reform. It is also in part because MSAs can be viewed favourably from both left-wing and right-wing positions.

Although many in the Canadian left, who remain attached to the idea of government management, will attack any reform, MSAs are in fact both a health policy and an income redistribution policy, something that should appeal to left-wing thinkers. General revenues will support MSAs, while an individual’s MSA will be based on medical need, regardless of income. In fact, the idea behind MSAs might well be described as, “From each according to ability, to each according to need.” According to surveys, it is low-income people who are most attracted by MSAs.³²

As for the right, MSAs can be presented as similar to tax breaks, in that each individual receives an allowance he or she controls, although an MSA must be spent on health care and contains a redistributive aspect. Nonetheless, this situation is different from government absorbing the money, or spending it for you. It should also appeal because it employs market mechanisms.

Finally, MSAs are politically self-equilibrating. Individuals will directly know, from their MSA balances, when the system is being underfunded, cre-

ating pressure for governments to provide appropriate funding while generating support for such funding, particularly since people will see the funds flowing directly into their personal MSAs.

Conclusion

No Canadian should be deprived of standard medical care because of inability to pay. But Canada's health care sector need not remain a command-economy experiment. No civilized society should (or would) allow someone to die of an easily treat-

able medical condition because that person lacks the money to pay for care. Yet Canadians now die because they lack a properly structured health care system.

The answer is not more bureaucratic control. The answer is grafting the efficiency and dynamism of market economies onto our publicly funded system. An MSA system creates dynamics for gains in productivity, improved resource allocation, and sensible demand patterns. Even more importantly, it allows individuals to regain control of their own medical decisions and provides the choices needed for such control to become a reality.

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