

User fees penalize the poor – A better way to raise health care funds would be to forgo tax cuts

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The Zombie of health policy debates is walking the streets again.

In 1994, a group of leading Canadian health economists labelled proposals for user fees as the "walking dead". They suggested that charging patients at the point they need health care decreases use only among those who need health care the most. Nevertheless, user fees will not stay where they belong, dead and buried.

Canadians have seen the latest resurrection in reports of Jean Chretien's visit to Sweden. Swedes are charged a small fee, equivalent to about \$17 for a doctors visit. Mr. Chretien wondered whether introducing such a user fee would be good medicine for Canada.

In this column two weeks ago, I noted that Swedes make fewer health care visits than Canadians, and that Sweden spends less per person on health care than Canada does. I suggested that lower poverty rates, greater public coverage of drug costs, and paying physicians by salary instead of fee-for-service explain the Swedish success.

Why is it so unlikely that user fees would help solve the ills of Canadian health care? To answer that question requires considering the possible effects of user fees.

One possible benefit is that user fees might save on health care costs. Indeed, some Swedish administrators believe that their fees have saved the system money by decreasing health care use.

That might be a good thing, but only if the health care visits patients avoid are for unnecessary care. If patients stay away when they need care, they will undergo unnecessary suffering in the short term. Their long term health may suffer as well.

Can patients distinguish between necessary and unnecessary doctors visits and avoid only the unnecessary ones? A major study conducted in

the United States found that user charges decreased both unnecessary and necessary services.

In the end, patients may actually need more care, and more expensive services, when they avoid seeking needed care. For instance, if user fees keep patients from visiting the doctor to have their blood pressure checked, the result over the long term may be a disabling stroke.

Both Canadian and American studies of the impact of user fees for prescription drugs have repeatedly shown exactly this effect. Short term gain of savings for reduced drug use leads to long term pain because of serious illness when patients don't take needed medication. The result is greater use of doctors and hospitals, and increased rather than decreased total costs.

This problem of bad outcomes from avoiding needed care gets worse when you consider who avoids visiting the doctor when faced with user fees. Naturally, those with lower incomes, the poor and the elderly, stay away.

Who faces the greatest need for health care? Older people have a much larger illness burden than younger individuals. Health status is also related to income. The poor are, as a group, sicker than those with higher incomes. Thus, those who reduce health care utilization because of user fees are the people who need that health care the most.

This is exactly what happened when, in 1968, the province of Saskatchewan introduced a user charge for physician visits. The charge, the equivalent of about \$10 in today's prices, led to a reduction in doctors visits by the poor of 18%.

The total decrease in physician use was, however, only 6–7%. Why was that?

The physician, rather than the patient, initiates many visits to the doctor. Doctors decide on when patients should make well-baby visits, have check-ups for chronic conditions like diabetes or high blood pressure, or return to the office to check their recovery from a short-term illness.

Saskatchewan's physicians, paid on a fee-for-service basis, saw a

potential income drop when poor people sought care less often. As a result, they increased the number of visits from those who could afford the user fee. They also used a more expensive mix of services. The results was, despite a substantial drop in use by the poor, almost no savings at all.

Given that user fees are unlikely to reduce health care spending significantly, user fee advocates suggest another possible benefit. User fees might generate money to pay for hospitals, home care, or drug benefits.

This would only be possible if the government, who funds the health care system, received the user fees. Up until 1986, Ontario allowed physicians to charge user fees. In that system, the money went to increase doctors incomes, and did not contribute to paying for other health services.

In Sweden, the government collects the user fees. Unfortunately, that involves administrative costs. Swedish authorities acknowledge that those costs eat up almost all the money that the user fees generate.

Consider that we wanted to generate an additional \$300 million in funding for health care in Ontario today. One way would be to charge patients user fees and \$300 million is what we might expect to generate by a modest user fee for physician services.

Another way to generate the money would be to forego tax reductions. For instance, the government could cancel the tax break for people who send their children to private schools. Or, they could reduce the planned tax cut for corporations from 2.1 billion to 1.8 billion.

If we chose user fees, they would come with an administrative cost, the burden would fall on those who need health care the most and can least afford it. User fees may well, in the long run, lead to an increased illness burden. Unless we changed our system, user fees would end up augmenting physicians incomes, and would not be available to improve hospital or home care.

The choice to forego tax cuts would be administratively efficient, would preserve equal access to care for all Canadians, and the money could go directly into funding for hospital and home care.

It isn't a difficult choice. The Romanow Commission is currently reviewing the Canadian health care system, and will soon be making recommendations. A wise decision by the Commission will put the user fees Zombie to rest.