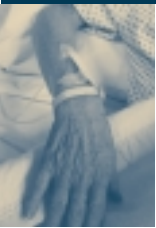


A series of essays giving the research evidence
behind Canadian healthcare debates



Myth: User fees would stop waste and ensure better use of the healthcare system.

There's an old idea that frequently sparks debate: that patients rampantly abuse the healthcare system. They indulge in unnecessary, expensive medical procedures all because they can get them for free. So why not teach Canadians to be more responsible by making them pay a charge for every health service used?

Because the idea just doesn't hold water. Research has long proven that user fees won't eliminate inappropriate care nor do much to reduce costs, and even the claim that patients waste healthcare resources is faulty.

Patients abusing health services? The true story

Robert Evans, a health economist at the University of British Columbia, explains: medical procedures are not hotcakes. People aren't going to line up eagerly demanding heart transplants just because someone else is paying.

What's more, patients can't really waste healthcare resources. Institutional and hospital care, physician visits, prescription drugs, and other medical services, make up most of total Canadian health spending.ⁱ But most of that spending is beyond a patient's control: many visits to doctors, all hospital care and prescription drugs, can only be given on a doctor's order.ⁱⁱ

That means patient-initiated abuse happens mostly during physician visits — which made up about 13.5 per cent of total health spending in 2000. But roughly half of physician services are referrals, or call-back visits to the same doctor, says Evans. So "first visits" initiated by patients probably made up about six to seven per cent of all spending. Since most of these visits are reasonable, Evans estimates patient-initiated abuse is



probably about one to two per cent of total spending — hardly rampant.

Tried, tested and quite untrue

In any case, user fees are unlikely to reduce costs. Researchers found that user charges — implemented in Saskatchewan in 1968 and abolished seven years later — reduced the annual use of physician services by about six per cent. But this happened mainly because the elderly and the poor saw about 18 per cent less of their doctors.ⁱⁱⁱ What's more, Saskatchewan's overall healthcare costs didn't shrink — thanks to physician fee increases and people with higher incomes, who saw their doctors more often.ⁱⁱ The fees also didn't affect the cost of hospital services, the most expensive form of care.

Another famous study on user fees is the U.S. Rand Health Insurance Experiment, which assigned individuals to insurance plans with different rates of user fees.^{iv} Researchers found people got less medical care in those plans with heavier charges. But the proportion of inappropriate antibiotic use, hospital stays and admissions was the same^{v vi} — with or without user fees — proving that the fees don't solve such problems.

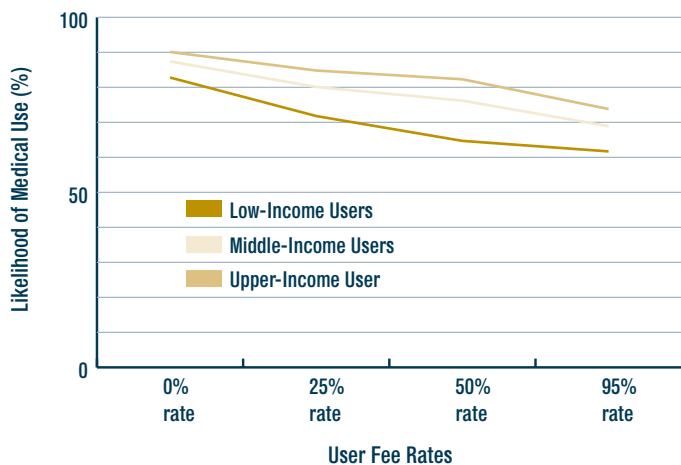


What changed was the way high-risk and low-income patients used medical services. Everyone used fewer medical services, but the decline was greater among poorer people. Sick people were also more likely to die when user charges were installed.^{vii}

However, Rand investigators found healthcare costs for people who paid user fees were lower than people with total health coverage. This seems to prove user charges at least lowered costs. But that disputes the findings in Saskatchewan, where costs didn't decrease. Why?

While the Saskatchewan experience affected all patients, Rand involved a dispersed group of 5,800 people, so each doctor only had a few patients enrolled in the study. That's not enough to provide evidence on the effect of user fees on the system. Therefore the Rand experiment, unlike the Saskatchewan experience, does not address the question of *overall* costs. We just can't conclude from Rand that healthcare costs would drop across the system; the evidence simply isn't there.^{viii}

Effect of User Fees on Medical Use, Rand Health Insurance Experiment



People *do* reduce their use of health services when user fees increase — but the poor, often the ones who need medical care most — are the hardest hit. In the Rand experiment, low-income users cut their likelihood of medical use from 82.8 per cent when they didn't have to pay, to 61.7 per cent when user charges were highest.

Data from Manning WG et al. 1987. "Health insurance and the demand for medical care: Evidence from a randomized experiment." *American Economic Review*, 77(3):251-277.

Penny wise, pound foolish?

But both studies do confirm it's mostly the poor who use less medical care when forced to pay extra charges. In the long run that would probably cost more, because the old and poor are less healthy than other groups.

In Quebec, for instance, when the elderly and people on welfare had to pay user fees for prescription drugs, they took less medicine. But that resulted in sicker patients and more visits to hospital emergency departments.^{ix} These findings echo earlier research, which showed that user fees helped reduce costs in the short term, but eventually led to more spending because more people would neglect to get early treatment.

Despite the rhetoric, user fees don't lead to a more affordable health system. Research has shown time after time that user fees inevitably create advantages for the rich and healthy while making matters worse for the sick and poor.

- i Canadian Institute for Health Information. 2000. *National Health Expenditure Trends, 1975-2000 Report*.
- ii Stoddart GL et al. 1993. *Why Not User Charges? The real issues*. Centre for Health Services and Policy Research, University of British Columbia. HPRU, 93:12D.
- iii Beck RG and JM Horne. 1980. "Utilization of publicly insured public health services in Saskatchewan before, during and after copayment." *Medical Care*; 18: 787-806.
- iv Manning WG et al. 1987. "Health insurance and the demand for medical care: Evidence from a randomized experiment." *American Economic Review*; 77: 251-277.
- v Siu AL et al. 1986. "Inappropriate use of hospitals in a randomized trial of health insurance plans." *New England Journal of Medicine*; 315: 1259-1266.
- vi Foxman B et al. 1987. "The effect of cost sharing on the use of antibiotics in ambulatory care: results from a population-based randomized controlled trial." *Journal of Chronic Disease*; 40: 429-437.
- vii Brook RH et al. 1983. "Does free care improve adults' health? Results from a randomized controlled trial." *New England Journal of Medicine*; 309: 1426-1434.
- viii Stoddart GL et al. 1993. *User Charges, Snares and Delusions: Another look at the literature*. Centre for Health Services and Policy Research, University of British Columbia. HPRU, 93:14D.
- ix Tamblin R et al. 2001. "Adverse events associated with prescription drug cost-sharing among poor and elderly persons." *Journal of the American Medical Association*; 285(4): 421-429.