

Shawn Whatley

The case for user fees in Canada

EQUITY AND EFFICIENCY

versus

OVERCONSUMPTION AND WASTE

July 2022



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Executive Summary

Medical therapies differ in value and impact. In Canada, patients assume they can ask for whatever care they desire, as many times as they want. Doctors can order whatever patients request or appear to need. Neither patients nor doctors have to worry about value or cost. Voters expect the state to pay for it all as “medically necessary” care. Currently Canadian medicare looks like the Wild West of health insurance. We can blame doctors, but we have no way of holding patients accountable for their decisions.

This is the crux of the issue. Overconsumption (“all-you-can-eat” care) decreases welfare in a system struggling to provide timely access for real needs such as cancer treatment, joint replacement, and emergency care. Aside from objective medical needs, medicare has no way to sort out patients who fall in the middle between obvious and frivolous. The system offers care to as many patients as possible and puts the rest on a waiting list, some of whom really do need care and come to harm through waiting.

At its heart, Canadian medicare was designed as an insurance system. Insurance pools risk. Imagine, for example, a disease costs \$100,000 to treat and carries a 1-in-1000 chance of getting it. A group of 1000 people should expect that one person in their group will get the disease and require the \$100,000 treatment. Insurance works by collecting \$100 from each person in the group to cover the cost of the one person who gets sick. This concept works well for objective disease. But no insurance system in the world funds all-you-can-eat care. Care is either rationed by the consumer, through a co-payment process, or it is cut behind the counter, through waiting lines and rationed resources.

At some point Canada will have to admit that rationing care is a necessary part of all health insurance. Either rationing is up front, where patients get a say, or it is hidden, and patients suffer the decisions that others make on their behalf. User fees give patients the opportunity to decide whether they can

go without service, instead of leaving the decision to a panel of experts who know nothing about a patient's symptoms.

Two arguments in support of user fees seem especially relevant for Canada now. First, user fees decrease the likelihood that patients who want low-impact care will show up in the first place. This leaves more capacity for those who need it and greater efficiency overall. Second, user fees enhance equity and promote the common good. Properly structured, user fees balance the burden, which helps sustain the welfare state.

Some see user fees as “dangerous, reckless, and ineffective” or as a tax on the poor and sick. Back in 1984, Canada essentially eliminated user fees with the enactment of the *Canada Health Act* (CHA). However, the decision in the CHA to eliminate user fees was made without good evidence. Within months of Canada closing down debate on user fees in 1984, the US-based RAND Corporation published the first randomized control trial on user fees, which showed that user fees do not have a negative effect on health. Newer studies show the same thing.

“ *Most countries use some form of patient cost-sharing: user fees, co-payment, co-insurance, or deductibles.* ”

Most countries use some form of patient cost-sharing: user fees, co-payment, co-insurance, or deductibles. Many countries use them all. The most frequent argument against user fees is that patients who cannot afford the fee will forego necessary care. Yet, for this reason, modern user-fee programs in Organisation for Economic Co-operation and Development (OECD) countries have robust exemptions for children, the elderly, the poor, and those with chronic illness.

Health insurance companies did not invent user fees to achieve wealth redistribution or to raise money. Insurance companies developed user fees to improve efficiency, decrease moral hazard, and improve horizontal equity. Depending on how user fees are designed, they can help achieve any number of broader social goals – including wealth redistribution. But if we conflate user fees with wealth redistribution, we will either avoid instituting user fees for fear of unfavourable redistributive ends, or we will pursue them to achieve those ends. Either way, we will miss the point of why user fees were invented in the first place.

The body of evidence around health insurance has transformed what we thought we knew when Canada abandoned user fees over 35 years ago. Other countries have addressed and solved the arguments against fees. Around the world, most countries now use fees as a better approach to curbing overconsumption than rationing alone. User fees work to improve efficiency and equity. It is time for the federal government to explore how provinces could employ user fees within the broader environment of the CHA.

Sommaire

Les thérapies médicales diffèrent quant à leur utilité et leur efficacité. Au Canada, les patients présumant qu'ils peuvent demander tous les soins qu'ils désirent, aussi souvent qu'il leur plaît. Les médecins peuvent prescrire tous les soins que les patients demandent ou semblent nécessiter. Et ni les patients ni les médecins n'ont à se soucier de la valeur ou du coût. Les électeurs, eux, s'attendent à ce que l'État paie pour tous les soins réputés être « médicalement essentiels ». À l'heure actuelle, le modèle canadien est un peu le « Far West » de l'assurance-maladie. On peut reprocher bien des choses aux médecins, mais n'empêche qu'il n'existe aucun moyen de tenir les patients responsables de leurs décisions.

Cette question est au cœur du problème. La surconsommation (les soins « à volonté ») diminue le bien-être au sein d'un régime qui peine à répondre en temps utile aux besoins réels, comme le traitement du cancer, le remplacement d'une articulation et les soins d'urgence. Mis à part les besoins médicaux objectifs, l'assurance-maladie ne dispose d'aucun outil pour identifier les patients à mi-chemin entre les besoins évidents et frivoles. Le régime offre des soins au plus grand nombre de patients possible et place sur une liste d'attente tous les autres – parmi lesquels ceux qui nécessitent réellement des soins sont ainsi mis en danger.

À la base, l'assurance-maladie canadienne a été conçue comme un régime d'assurance, l'assurance mutualisant les risques. Disons, par exemple, qu'une maladie coûte 100 000 \$ à traiter, avec une prévalence de 1 cas sur 1 000 : 1 000 personnes de tout groupe donné doivent donc s'attendre à ce que l'une d'entre elles contracte la maladie et ait besoin du traitement de 100 000 \$. L'assurance fonctionne en recueillant 100 dollars auprès de chacune de ces 1 000 personnes afin d'assumer le coût revenant à la seule qui contracte la maladie. Ce concept fonctionne bien pour les pathologies objectives. Toutefois, aucun régime d'assurance au monde ne finance les soins à volonté. Les soins sont soit rationnés par le consommateur – par le biais d'un copaiement – ou, encore, au guichet – au moyen de files d'attente et de contingents.

Le Canada devra forcément admettre que le rationnement des soins est un élément essentiel de tout régime d'assurance-maladie. Soit le rationnement se pratique ouvertement, ce qui signifie que les patients ont leur mot à dire; soit le rationnement est caché, les patients subissant alors les décisions que d'autres prennent en leur nom. Les frais d'utilisation permettent aux patients de décider eux-mêmes de se passer de certains services, plutôt que de s'en remettre à la décision d'un groupe d'experts qui ne savent rien de leur état.

Deux arguments à l'appui des frais d'utilisation semblent particulièrement pertinents pour le Canada en ce moment. Tout d'abord, les frais d'utilisation réduisent le risque de voir les demandeurs de soins à faible impact les requérir d'emblée, ce qui renforce la capacité offerte aux patients qui les nécessitent ainsi que l'efficacité globale. Ensuite, les frais d'utilisation améliorent l'équité et favorisent le bien commun. Adéquatement structurés, ils équilibrent la charge et contribuent à soutenir l'État-providence.

“ *La plupart des pays utilisent une forme ou l'autre de partage des coûts : frais d'utilisation, copaiement, coassurance ou franchise.* ”

Certains estiment que les frais d'utilisation sont « dommageables, malavisés et inefficaces » ou représentent une taxe sur les pauvres et les malades. Ces frais ont essentiellement été éliminés en 1984 lorsque la *Loi canadienne sur la santé* (LCS) a été promulguée. Or, cette décision prise dans le cadre de la LCS était exempte de preuves solides. Quelques mois après la fin du débat de 1984 sur les frais d'utilisation, la RAND Corporation, basée aux États-Unis, publiait les données du premier essai contrôlé aléatoire sur les frais d'utilisation, qui démontraient que ces derniers n'ont pas d'effet négatif sur la santé. Des études plus récentes sont allées dans le même sens.

La plupart des pays utilisent une forme ou l'autre de partage des coûts : frais d'utilisation, copaiement, coassurance ou franchise. De nombreux pays utilisent toutes ces formes. L'argument le plus commun contre les frais d'utilisation veut que les patients incapables de les payer renoncent à des soins essentiels. C'est pourtant pour cette raison que les programmes à frais d'utilisation modernes des pays de l'OCDE prévoient des dispenses majeures pour les enfants, les aînés, les pauvres et les malades chroniques.

Les sociétés d'assurance n'ont pas inventé les frais d'utilisation pour redistribuer les richesses ou recueillir des fonds. Elles l'ont fait pour augmenter l'efficacité, réduire le risque moral et améliorer l'équité horizontale. En fonction de leur conception, les frais d'utilisation peuvent contribuer à atteindre toutes sortes d'objectifs sociaux plus étendus, y compris la redistribution des richesses. Il reste qu'en associant les frais d'utilisation à la redistribution des richesses, soit on évite de les instituer par crainte de fins redistributives défavorables, soit on les adopte en vue d'atteindre ces fins. Dans un cas comme dans l'autre, nous passons à côté de la raison pour laquelle les frais d'utilisation sont établis en premier lieu.

Ce que nous pensions savoir lorsque le Canada a abandonné les frais d'utilisation il y a plus de 35 ans est mis en doute par l'ensemble des preuves dont on dispose sur l'assurance-maladie. Certains pays ont examiné et récusé les arguments avancés contre les frais d'utilisation. Partout sur la planète, on a maintenant recours aux frais d'utilisation : une approche plus efficace pour freiner la surconsommation que celle qui se fonde uniquement sur le rationnement. Les frais d'utilisation permettent d'améliorer l'efficacité et l'équité. Il est temps pour le gouvernement fédéral d'examiner comment les provinces pourraient intégrer les frais d'utilisation dans le cadre global de la LCS.

“The most basic point, often obscured in public discussions, is that the public must pay for care under any system of finance.”

-Fuchs 1974, 127

Introduction

Tommy Douglas, father of medicare, once said, “People appreciate something if they’ve paid for it. If you give people a card from Santa Claus entitling them to free hospital services, it is not good psychology” (Douglas 1984, 228). But by the 1980s, his “good psychology” came to be seen as bad, dangerous, and ineffective. Douglas changed his mind, and Parliament changed with him.

At a glance, Canadian medicare now looks like the Wild West of health insurance. We have no way to tame it. Patients can ask for whatever they desire, as many times as they want. Doctors can order whatever patients request or appear to need. Neither patients nor doctors have to worry about value or cost. The smallest benefit must always be considered. Any risk of (medical) inaction must never be ignored. Marginal value shrinks with each new medical discovery, while costs balloon. Voters expect the state to pay for it all as “medically necessary” care.

Government seems desperate to avoid recreating the same unstoppable stampede with its proposed national pharmacare program. Pharmaceuticals are not all created equal. Some offer more vital and valuable benefit than others. “Encouraging cost-conscious product selections” offers a way to focus funding on what offers the greatest value for a given cost (Yeung and Morgan 2019). Patient co-payment for pharmaceuticals can direct funding

towards high-value products. To be clear, the point is to *direct* funding, not to find ways to *increase* funding. Elimination of payment for low-cost pharmaceuticals shifts the emphasis to high-cost, high-value ones. This may in fact even increase the expense per service overall.

Medical therapies also differ in value and impact. Some care saves lives; other care calms the worried well. Patients ask doctors for absentee notes, second and third opinions, and advice about what they heard on TV or in the naturopath's office. We know that in Canada up to 30 percent of the services doctors perform are deemed "unnecessary care" (see CIHI 2017, 8), but we do not know whether the patients who received that unnecessary care should not have gone to see the doctor in the first place. We can blame doctors in retrospect, but we have no way of holding patients accountable for their decisions. Too often, the only way to know whether one needs to see the doctor is to go and see the doctor (Fuchs 1974). In the crowd that comes into a clinic, planners have no clear method for sorting out who really needs to be there.

If costs were our only concern, accountants and economists have all kinds of creative ways to control them: cuts, partnerships, off-loading, rationing, deferring, and a dozen other manoeuvres can make costs less obvious on provincial balance sheets. If we start focusing on costs, we will end with a plan to cut them. Frustrated voters might give the party that proposes a cost-cutting plan one election win. But simply cutting costs is not a long-term strategy. Canadians want something better; cost cutting is not the place to start.

Equity and need

Before we dig into the data or discuss options to improve efficiency, we need to unpack what happens in a clinical encounter. Let us begin with health insurance, which is a gigantic topic and one that requires a longer introduction than usual.

At the extremes, only two kinds of patients exist: those who need medical care and those who do not. One group of patients – for example, those with broken hips – need medical care. No amount of waiting, inconvenience, or patient co-payment will change their decision to seek care. They cannot function without help. Another group of patients – for example, those seeking a third opinion for anterior knee pain (the bane of orthopedic surgery) – do not need medical care. Waiting, inconvenience, and patient co-payment, or any other hurdle, can (sometimes) change their mind about seeking a third opinion. These patients can function without seeing another surgeon. Of course, subjective needs include patients without any symptoms, physical or mental, to report at all. They just want to talk to someone and a physician is a captive audience during an appointment, albeit an expensive one to the taxpayer.

Each extreme – broken hips and lonely patients – fuels one or the other pole of the user-fee debate. Those who oppose fees emphasize objective needs, which make fees seem irrelevant at best. Those who support fees emphasize the exorbitant waste of resources on subjective needs. If medical care divided neatly between broken hips and lonely patients, we would not need to discuss fees at all. We could de-list services that offer little to no benefit. In passing, we should note that although “coughs and sniffles” present fodder for impassioned speeches about people who abuse the system, minor complaints cost very little to see and often come attached to patients who do not know any better.

Our problem is more difficult. Most medical services come attached to complex patient concerns that cost a great deal more than a cough or sniffle. For example, imagine you were progressing towards hip replacement. It takes years for hips to wear out. How many visits should you need on your journey from normal hips to new? How much benefit must your doctor provide to qualify a particular visit as *not* frivolous? If you choose to ignore advice to lose weight and pursue physiotherapy, should you be able to see your doctor more frequently because your pain continues? If you do go to see your doctor, only to repeat all the same investigations, and hear all the same advice you received nine months ago, does that represent high-value care?

Most times, your physician cannot tell if you already had all the investigations done recently at another clinic. Did the repeat investigations change your life in any meaningful way, other than gaining the knowledge that your hip might look a tiny bit more worn out on X-ray? You spent nothing (directly) for the services rendered but also received nothing valuable in return. You suspected that you probably did not yet warrant a new hip before you repeated everything; you just needed confirmation.

So there is a spectrum of patient needs that ranges from the very obvious cases with clear treatment plans to procedures and visits that offer significantly less value to the patient, perhaps even none. But we can roughly group them into three categories:

- Group A needs care. They have an objective need, and medicine has concrete ways to meet the need; care will add objective value. Group A patients enter the clinic on crutches and walk out without them.
- Group B can live without care. Medicine makes no difference to their ability to function. In fact, a visit to the clinic might cause significant anger and frustration when the patient hears how long it will take to get another CT scan (especially if the doctor does not have the courage to refuse one outright). Group B patients enter the clinic on crutches and leave the clinic disappointed and still on crutches. Their problem cannot be fixed, or they do not like the fix on offer.

- Group C can be labelled, somewhat disparagingly, as frivolous. They enter the clinic on crutches to show their Christmas presents to the staff (one of many true stories). Group C patients leave the clinic happy, as long as staff spend some time with them.

To be clear, we have no way to know, for certain, which patient belongs in which category. Anecdotes about Group C patients' Christmas presents might be so rare that they do not warrant further mention. Furthermore, a visit without objective value might retain enormous subjective value, such as allaying a patient's anxiety, which can itself become a significant mental-health issue if unaddressed. Who are we to say the visit was frivolous? Furthermore, how can we say a visit for hip pain, in which we added no objective value, is not frivolous, but a visit for a runny nose most definitely is frivolous? Leaving these (unanswerable) questions aside, most clinics contain a mixture of Group A, B, and C patients.

“ *Federal blank cheques ... had lured the provinces to support the idea of universal medical care.* ”

If 10 Group A patients and 10 Group B patients seek care, everything works when the medical system can see all 20 plus a few Group C patients who also show up. This almost held true in the 1970s. Canada came to world-wide fame with first-dollar coverage (free care) and no state rationing. Doctors treated and governments paid; no questions asked. Doctors could see 10 Group A patients, 10 Group B patients, plus five frivolous Group C patients, and we still did not have wait times. Canada had more hospital beds than sick people to put in them, and patients used less than half the number of services they use today (Grant and Hurley 2013).

Everything changed five years after all the provinces joined medicare. Federal blank cheques – the promise to pay 50 percent of provincial spending on health care – had lured the provinces to support the idea of universal medical care. In essence, provincial politicians could promise voters medical services paid for with federal dollars without worrying about using provincial dollars to pay for the full cost of those services. Once provincial support was in hand, the federal *Established Programs Financing Act* (1977) switched federal funding to block payments. This meant that the provinces had to bear any growth in health spending. Having created an insatiable demand for health care from the provinces, the federal government backed away from

the escalating costs. This forced provinces to actively ration care to control spending (Whatley 2019, 2021, 2020). And indeed, governments rationed supply aggressively, but demand went untouched.

Today, the myth of all-you-can-eat care lives. Now medicare can see only 11 of the 20 patients who seek care. Some say we can only serve eight. Medicare offers care to as many patients as possible and puts the rest on a waiting list. We hope (fingers crossed) that the ones who were not seen all came from Groups B or C. But hope is not a plan, so some who really do need care come to harm through waiting.

This is the crux of the issue. Overconsumption decreases welfare (Feldstein 1973) in a system struggling to provide timely access for *real* needs such as cancer treatment, joint replacement, and emergency care. Aside from obvious, objective medical needs, medicare has no way to sort out patients who fall in the middle between obvious and frivolous. One person will put up with her hip pain and see her doctor once or twice about it over a span of several years before she finally needs surgery. Her sister with the same pain and level of function will see her doctor once every two to three months, with repeated investigations, multiple rounds of CT scanning, and extra consultations with orthopedic surgeons. After several years, she will get her hip replaced, possibly even a few weeks sooner than her sister.

Professor Kenneth J. Arrow, father of health economics, put it this way “But when you are sick, your diagnosis might turn out not to be what you thought it was... There are a lot of decisions that have to be made along the way, some of which are just questions of comfort, and some of which are really medically significant. The insurer is not in a good position to monitor what is going on” (Finkelstein 2015, 58).

Limited supply, unlimited demand

No insurance system in the world funds all-you-can-eat care. Care is either rationed by the consumer through a co-payment process, or it is cut behind the counter through waiting lines and rationed resources. At some point Canada will have to admit – as Britain did eventually with its National Health Service (Vertesi 2003) – that rationing care is a necessary part of all health insurance. Either rationing is up front, where patients get a say, or it is hidden, and patients suffer the decisions that others make on their behalf.

Most countries enlist patients’ help in the form of patient co-payment, such as user fees, to shift their systems away from the Wild West, all-you-can-eat approach. User fees give patients the opportunity to decide whether they can go without service, instead of leaving the decision to a panel of experts who know nothing about a patient’s symptoms.

Canadian medicare has no obvious way to address the demand side of the supply-and-demand equation in health care (Powell 1966). Medicare has few obvious brakes at the bedside, at least in theory. Medicare tries to encourage restraint from the supply side. For example, medical organizations promote programs such as Choosing Wisely to encourage doctors to stop offering useless or low-value care: Do not order low yield X-rays. Avoid useless consultations. However, those same organizations do not defend doctors who actually “choose wisely” if those choices elicit complaints or legal action.

The real brakes on health care lie behind the scenes, where the state rations the care patients demand and doctors order. Doctors grumble that the state gives too little, and the state grumbles that doctors offer too much. Brakes on the system show up at every bedside, but patients often wonder who is to blame. The brakes turn the all-you-can-eat approach into something more like a soup-kitchen (Laporte 2014).

Why Canada needs user fees now

Two arguments in support of fees seem especially relevant for Canada now (though saving money and raising revenue are not either of them).

First, fees enlist patients in the struggle to focus high-value care on the patients who need it most. User fees decrease the likelihood that patients who want low-impact care will show up in the first place. This leaves more capacity for those who need it and greater efficiency overall. Large, randomized studies show that when user fees are employed in health insurance there are no negative outcomes for health and the efficiency of the system improves.

To be clear, care that is concentrated on those who need it may *increase* the total cost of care for the system. We would hope that the savings from treating real disease, especially if we catch it earlier, outweigh the cost of frivolous care. Frivolous care is wasteful and limits the amount of treatment we can offer for real medical needs, but it is also relatively cheap to provide. Relatively frivolous, low-cost care displaces other high-value, high-cost services from the queue. Given limited capacity (doctors, nurses, beds, etc.), total spending for a given time period will decrease if some of the capacity is occupied with frivolous needs and high-value care is denied or deferred by forcing more serious concerns to wait in line.

Second, user fees enhance equity and promote the common good. Properly structured, user fees balance the burden, which helps sustain the welfare state. Should two equally healthy sisters with the same income pay the same for medicare if one works hard to preserve it while the other shows no regard? This raises the issue of “horizontal equity”: the notion that people in similar circumstances should be treated (or contribute) the same. Although no insurance system can completely eliminate inequity based on behaviour,

user fees improve the situation. They encourage everyone to focus on getting the most out of a shared resource.

Politicians from across the spectrum are irritated by discussions of user fees in Canada. Some see user fees as “dangerous, reckless, and ineffective” (Irvine and Gratzer 2002). Their reaction is based on valid arguments, ones that we need to address up front. Some Canadians view user fees as a tax on the poor and sick. Indeed, if the structure was clumsy, user fees could turn out to be just that. However, all developed countries that employ user fees also have a long list of exemptions for the poor, sick, old, and young. We will address other arguments both for and against fees below.

Finally, a discussion about user fees pulls us into some of the complex interconnections that bedevil the insurance industry. We’ll first tackle the basics (and misconceptions) about payment for care, health insurance, and user fees and then review Canadian and global experiences with user fees, which will guide us as we review arguments for and against fees. Our discussion will favour Canadian issues over academic completeness.

User fees have not been tried and found wanting in Canada. They have been outlawed, fumbled, and left untried for political reasons. It is time to take a second look at them (Picard 2017).

User fees versus payment for care

Canada essentially eliminated user fees in 1984 with the enactment of the *Canada Health Act* (CHA). Provinces now risk losing federal funding if they allow hospitals to impose user fees or physicians to bill patients for any extra amount that medicare does not cover (known as “extra billing”). The decision in the CHA to eliminate user fees was made without good evidence. Within months of Canada closing down debate on user fees in 1984, the US-based RAND Corporation published the first randomized control trial on user fees (Brook, Ware, and Rogers 1984). The landmark Health Insurance Experiment study showed that user fees do not have a negative effect on health. Newer studies show the same thing, as we will discuss below.

But first, we need to highlight an implicit assumption buried in the CHA. For Canadians, the CHA cemented the idea that user fees exist primarily to raise money for care by making sick people pay for it. We hear “user fees” and assume a negative impact on wealth redistribution. This is wrong for three reasons.

First, as mentioned above, most countries provide exemptions for those with chronic or major illnesses, those of lower socioeconomic status, the elderly, and the young. Second, no matter how we choose to pay for care, the public still pays for it all. The health economist Victor Fuchs offered a simple yet overlooked observation about health finance nearly 50 years ago:

The most basic point, often obscured in public discussions, is that the public must pay for care under any system of finance... That is, the ultimate cost falls on families and individuals even when the payment mechanism makes it appear that the bills are being sent elsewhere. Except during an economic depression, no magic wand of finance can divert labor, capital, and other resources to medical care without resulting in a reduction in resources available for food, housing, education, recreation, or other goods and services. Nor is there any secret formula that can transfer the cost of health care to “government” or “business” without the burden eventually being borne by the public through more taxes, higher prices, or lower wages. Granted, the choice of financing system can make a significant difference to families at the highest and lowest levels of income, but the average family will have to pay the same share under any system. (Fuchs 1974, 127-128)

In other words, all payment for care comes from the public. Different payment mechanisms offer different paths for payment to follow, but that is it. The source remains the same, whether we use tax-funded state insurance, private insurance, a universal basic income, or some combination of all three. Thus, cost-sharing is a misleading term in that the public pays for all costs no matter how payment is structured. In Canada, we seem intent on protecting the (false) impression that there is no payment for care. Canadians believe – indeed, political careers depend on maintaining the myth – that they will get the care they need, when they need it, and *it will be free*.

Finally, the debate about how best to pay for care too often becomes inextricably linked to wealth redistribution. We assume that our current first-dollar approach (i.e., that government will pay every dollar we consume in health care services from the first dollar onwards – in other words, free coverage) is the best way to achieve fairness and equity. And we assume that any change to how we pay for care will have an adverse impact on wealth redistribution. This creates a determinist fallacy that chains health policy to a single vision for payment. If Canadians want to link care *and* wealth redistribution, we can achieve these two goals in any number of ways, including first-dollar coverage, user fees, or other co-payment mechanisms. Even if we were to take the extreme opposite approach to payment and have each patient pay for care out of her own pocket, we could still achieve massive wealth redistribution from the rich to the poor if we put all the money required for care into each person’s pocket in the first place (e.g.

with a negative income tax (Powell 1966)). There are many ways to achieve wealth redistribution, and we must stop thinking that first-dollar care is the best or only way to do it.

We must be clear on this before we start. It makes little sense to talk about user fees if people view them as a way to raise more tax dollars, or a way to increase payment for care, or a way to undermine the approach to wealth redistribution currently in place in Canada. All payment for care comes from the public.

Health insurance companies did not invent user fees to achieve wealth redistribution or to raise money. Insurance companies developed user fees to improve efficiency, decrease moral hazard, and improve horizontal equity. Depending on how user fees are designed, they can help achieve any number of broader social goals – including wealth redistribution. But if we conflate user fees with wealth redistribution, we will either avoid instituting user fees for fear of unfavourable redistributive ends, or we will pursue them to achieve those ends. Either way, we will miss the point of why user fees were invented in the first place.

Health insurance

At its heart, Canadian medicare was designed as an insurance system. Insurance pools risk. Imagine, for example, a disease costs \$100,000 to treat and carries a 1-in-1000 chance of getting it. A group of 1000 people should expect that one person in their group will get the disease and require the \$100,000 treatment. Insurance works by collecting \$100 from each person in the group to cover the cost of the one person who gets sick. This concept works well for objective disease. Broken hips do not spark debate about whether or not they require medical attention. And we do not find lobby groups petitioning for broken-hip repair to be added to services funded by the state. An obviously broken hip leaves no room for medical or political indecision.

However, most disease hides itself and rarely reveals its true nature at the start (Nuland 2008). Furthermore, many people spend their lives worrying about disease and require continual proof of its absence. Patients often ask their doctors for information and insight into options around investigations, treatment, and risks of developing disease. Finally, each year brings new concerns and conditions that some earnest person or group seeks to medicalize and label medically necessary. This opens a discussion about medical necessity – something that each province defines differently – and represents another layer of fuzziness that falls under medical insurance but lands beyond the scope of this paper.

User fees defined

User fees are typically a small charge relative to the total cost of care – anywhere from a few dollars to as much as \$20 or \$30 depending on the point of access – collected at the point of service. For example, patients might pay \$5 to see their family doctor or pay \$20 to be attended to in a hospital emergency department. Fees change behaviour, but higher fees do not seem to cause more behavioural change (Brook, Ware, and Rogers 1984). Most countries have annual caps on fee payments as well as a long list of exemptions for specific patient groups.

Having said that, simple works best (Salampessy et al. 2018, 797). If fees are based on complex mathematical formulae, with exclusions for some procedures but not others, the fees do not achieve the desired outcomes. For instance, clinicians often cannot offer details about the fees associated with all the possible investigations and treatment options for a specific patient concern. This injects an order of complexity and a degree of cost uncertainty that most patients cannot understand and will not tolerate. Simple approaches to raise awareness about cost seem to support well-informed decision-making, whereas complexity causes confusion without change.

Most countries do not apply fees to public health and preventative services. Immunizations are discrete variables: people do not ask for more immunizations than schedules allow, nor do they seek second and third opinions on individual immunizations. Immunizations do not (usually) offer a continuous spectrum of demand. More generally, public health services have also been called “merit goods” – something people might not ask for otherwise. They are goods that offer a greater benefit to society than the benefit offered to any single individual. Notwithstanding all the furor over COVID vaccines, immunization programs still function as discrete variables.

User fees fall into a broader basket known as cost-sharing. Cost-sharing also includes co-insurance and deductibles. These other forms of co-payment seem less applicable to Canada at this time but warrant mention in passing. Patients find co-insurance especially irksome (Finkelstein 2014, 52). Having to pay 20 percent of an unknown total cost of treatment injects a level of uncertainty that is often too much to bear. And high-deductible insurance works in countries where patients have the opportunity to choose it in return for lower premiums when they might have had the chance to choose a lower deductible plan if they wanted. These decisions do not apply in Canada where citizens cannot choose anything because their only option is the single-payer, state-operated approach to medical insurance.

Canada's experience

User fees are not new in Canada. Saskatchewan experimented with a clumsy approach between 1968 and 1971 that applied the same fees to everyone. The fees decreased demand for physician services by 5.6 percent. Unsurprisingly, it had the biggest impact on the poor. And it did not decrease spending on health care overall (Beck and Horne 1980). Quebec tried its own blunt approach – in this case by imposing user fees for pharmaceuticals in 1996. It led to a drop in medication use by the elderly (by 9 percent) and by the poor (by 14 percent), which caused an adverse health impact and an increase in emergency department use (Tamblyn, Laprise, and Hanley 2001, 421). Again, no surprise here either.

In 2010, Quebec planned a \$25 user fee on medicare services based on apparent support for the idea that had been floated in the government's election campaign platform. But when it came time to implement the fees, large street demonstrations broke out. It seemed that “public outcry killed the policy” (Toronto Star 2010).” The 2010 Quebec attempt at implementing user fees focused on raising money – fees promised \$500 million in new revenue. Around the same time, an expert panel convened by the Canadian Medical Association (CMA) suggested exploring all possible options, including user fees, to avoid Canada being forced by the courts to allow the introduction of private care. It created a fracas at the 2011 meeting of the CMA General Council in Newfoundland (Vogel 2011a, Vogel 2011b, Vogel 2011c). In 2016, Quebec again tried the idea of levying user fees. The federal government threatened clawbacks of Canada Health Transfer payments, as per the CHA, so Quebec banned them once more (McKenna 2017).

All this led veteran health care journalist André Picard to write that “Medical user fees are back and it's time for honest debate” (2017). Picard noted (correctly) that “Canada is one of the few Western countries that does not have user fees.” Picard also noted (incorrectly) that “There is no good evidence that extra billing discourages unnecessary procedures... user fees are usually symbolic – to show patients are doing their part.” However, there happens to be plenty of powerful evidence about user fees to which we now turn.

Global experience

Most countries use some form of patient cost-sharing: user fees, co-payment, co-insurance, or deductibles. Many countries use them all. Nadeem Esmail and Michael Walker reviewed the pros and cons of first-dollar coverage in 2008 (Esmail and Walker 2008). The authors looked at how other countries including Australia, France, Germany, Italy, Japan, Netherlands, New Zealand, Norway, Sweden, and Switzerland approach payment for health care. Only Denmark, Canada, and England used a first-dollar approach. They noted that cost-sharing transfers some financial liability onto the insured, but most

countries limit this with a cap on payment. Most countries use co-payment, but no uniform rule applies.

Esmail and Walker note that all countries use limits, exemptions for poorer patients, families, those with chronic disease, etc. Australia funds 85 percent of services and patients pay for the rest up to a cap. France has co-insurance, co-pays, extra-billing, and a nominal user fee as part of its statutory health insurance approach. Germany employs cost-sharing up to 2 percent of household income (1 percent for the chronically ill). Italy employs co-payments on speciality care and procedures. Japan uses co-insurance.

We find the same thing in another paper focused on Asia, in which Japan, South Korea, and Taiwan each use co-payments (10 percent, 10-20 percent, and 5-10 percent, respectively) (Peng and Tiessen 2015). Asian countries report that user fees can improve equity and coverage using a system of subsidies and exemptions. Properly structured, none of these countries have found a negative impact on equity or health outcomes.

But do user fees work?

User fees are a robust, ongoing field of research with dozens of papers and many review articles. Two studies stand out. The first is the RAND Corporation's landmark Health Insurance Experiment (HIE) (Brook, Ware, and Rogers 1984). Although dated, HIE followed gold standard research design. It marks a body of research in health insurance that most other studies struggle to match. The HIE sought to determine whether people change behaviour based on whether or not patients make a co-payment (see Laporte 2014 and others). If patients pay, will they forego needed care and will doctors provide more unnecessary care?

RAND randomized 5800 patients under the age of 62 to either a "free" Plan A (1294 adults, 599 children) or cost-sharing Plan B (2664 adults, 1245 children). Plan B was further divided into three groups based on 25, 50, or 95 percent cost-sharing of the service fee. Plan B showed a decrease in both necessary and unnecessary care, but virtually no change to health outcomes (even when pooling all levels of co-payment). The greatest change in use between Plan A (free) and Plan B (co-pay) showed up for the 25 percent cost-sharing group. In other words, higher fees did not translate into a greater change in behaviour.

The Medicaid Oregon experiment from 2008 offers more recent insight (Finkelstein et al. 2012). Oregon decided to expand Medicaid enrolment, but it could not enrol all applicants. So the state decided to host a lottery for all those who wanted one of the 6000 spots offered. It created a rare opportunity to compare 6000 patients, chosen by lottery, with age-matched controls who did not make it into the plan. As expected, financial hardship was reduced for the enrolled group compared with those who lacked insurance. Screening

rates and increased treatment for diabetes also increased for the enrolled group. However, researchers found no improvement in health in the enrolled group and no change in medication use (Powell 1966; Finkelstein et al. 2012; Baicker et al. 2013)

Arguments against user fees

The most frequent argument against user fees is that patients who cannot afford the fee will forego necessary care. Out-of-pocket costs can decrease compliance especially for those who are sensitive to even the smallest fee (Reynolds et al. 2020). For this reason, modern user-fee programs in Organisation for Economic Co-operation and Development (OECD) countries have robust exemptions for children, the elderly, the poor, and those with chronic illness.

As mentioned above, a poorly designed approach to user fees could punish those most in need of care and least able to pay (Johansson, Jakobsson, and Svensson 2019; Atchessi, Ridde, Zunzunegui 2016). Most countries seem aware of this and to prevent it have exemptions built around the needs and characteristics of a particular citizenry. A 2014 review looked at co-payments and the impact on demand, health, and distribution of care. The authors found no significant health effects. However, low income people and those who needed care tended to decrease their use of services the most (Kiil and Houlberg 2014).

Arguments in Canada seem rooted in a bias against any model of cost-sharing that (in any way) ties benefits to the amount of care an individual receives. For example, Michael Gordon, Jack Mintz, and Duanjie Chen (1998) proposed a tax-based alternative to privatization for Canadians. They described a health benefits tax based on the amount of health care people received. Exemptions would apply to the poor. The authors argued that patients would be more aware of costs, which would lead to greater patient participation and the ability of the health care system to offer a greater number of services overall such as drugs, homecare, dental services, and so on. Yet health consultant Stephen Lewis promptly attacked the proposal as a tax on the sick, full stop, and asserted that as such, we must never consider the tax (Lewis 1998). He argued that the cost of collecting the fees could cost more than the fees themselves. Although this is often stated as fact, most countries appear to have found ways to avoid this concern or have found the benefits of improved equity and allocative efficiency worth the management cost.

Others argue that the demand for care has nothing to do with costs. In this view, the demand curve is flat; the usual relationship between supply and

demand seems tenuous at best when the demand stems from an acute, life-threatening illness (acute care is price inelastic). Furthermore, patients have a knowledge deficit and operate at great disadvantage in any true medical marketplace. As such, advocates insist that any sort of market thinking must be categorically ruled out. However, leaving aside the argument about whether medical care can tolerate any element of market thinking, user fees are not market economics. Although user fees do inject an element of basic economic theory into health care, a small flat fee, designed with appropriate exemptions, does not look anything like a true marketplace with variable pricing, volatility, risk, opportunity, and so on (Crowley 2010).

Some suggest that, as a society, we need to provide more, better, and cheaper care because prevention reduces demand overall, which reduces total

“It seems hard to argue for timely care by supporting a first-dollar system that encourages overconsumption.”

spending. Opponents of user fees extrapolate from this position and try to paint all medical care as being more like a public health or preventative service. They argue that limiting any form of care risks greater costs later. Absent timely care, treatment ends up costing much more than had it been delivered promptly. This argument assumes that all patient services apply to conditions for which medical intervention can make a difference. Yet, as discussed above, we know that there are some conditions for which medical intervention is not necessary. Furthermore, this argument appears self-defeating: timely care demands first-dollar coverage, which creates overconsumption and leads to treatment delays that undermine timely care. It seems hard to argue for timely care by supporting a first-dollar system that encourages overconsumption and leads to long waits that block the very goal of timely care. Paradoxically, those who oppose fees in the name of prevention also tend to support central planning and rationing to limit overconsumption.

Others see fees as an additional (frustrating) roadblock to care in an already over-regulated system. This would be true if user fees were nothing but an added hurdle that offered no broader impact to the way the system functions. In many ways, Canada already has many deterrents for care – too many, in fact. Hospital parking fees function much like the hospital user fees that the CHA aimed to eliminate. Furthermore, why bother adding user fees to limit unnecessary use when we already ration care with wait lists, bureaucracy

(forms), restricting access to technology, imposing heavy regulations, and so on? Although this line of thinking has merit, it argues against one method that can improve efficiency – user fees – because we already have so many other methods that have failed to do so. The dozens of failed supply-side approaches, frustrating in themselves, are not a good enough reason to nix any demand-side safeguards that could limit overconsumption.

Finally, some argue that user fees are just another way to punish savers and cost-conscious citizens. Some patients will walk for blocks in the rain to avoid exorbitant hospital parking fees, even though they could easily afford them. Others pay the price at the hospital parking machine, even though they *cannot* afford it. Fees may do little to change the behaviour of spendthrifts. Fees need to be large enough to nudge the majority. Having said that, savers and spenders exist on a spectrum. Even the greatest possible fee (full payment for service) will not curb all spenders, just as the lowest possible fee (e.g., \$1) will give some savers reason to pause. This is an argument to get the fee right, not an argument to eliminate fees altogether.

For many, debate about user fees has moved beyond data – beyond real debate of any kind, in fact. Medicare has become part of our national identity (Crowley 2014; Martin and Meili 2015), and first-dollar coverage *is* medicare. User fees *at any level* eliminate first-dollar coverage, and as such user fees represent an existential threat to national identity (Norbery 2018). However, no one wins in an argument about identity and ideology. If we want to improve the system for all Canadians, we will have to be able to see that Canada, and being Canadian, is about much more than our peculiar (first-dollar coverage) approach to payment for health services.

Arguments in favour of cost-sharing

How can we decrease the consumption of health care, when it grows beyond providing a benefit to any particular person, so that we have more to provide for those who really need it? We used to rely on people being good citizens and behaving in such a way as to protect the “commons” and the shared public resource. That shared trust has gone. As Norberg said about 1970s Swedish citizens, they lost their sense of “You shouldn’t do that” (Norberg 2018).

Moral hazard

Health economist Kenneth J. Arrow listed moral hazard as the first of many “problems of insurance” in his seminal article, which launched the whole field of health economics (Arrow 1963). Arrow writes that “The welfare case for insurance policies of all sorts is overwhelming.” However, insurance against the cost of health care presents significant hurdles. Ideally, insurance applies to events over which individuals have no control; the cause of the event should be completely separate from the behaviour of the individual. Arrow goes on to make the following point:

Unfortunately, in real life this separation can never be made perfectly. The outbreak of fire in one’s house or business may be largely uncontrollable by the individual, but the probability of fire is somewhat influenced by carelessness, and of course arson is a possibility, if an extreme one. Similarly, in medical policies the cost of medical care is not completely determined by the illness suffered by the individual but depends on the choice of a doctor and his willingness to use medical services. It is frequently observed that widespread medical insurance increases the demand for medical care.

All forms of insurance face an unescapable problem. If people do not have to bear the cost of their decisions, they tend to make decisions without concern for cost. To be clear, such moral hazard is not a result of “moral perfidy but of rational economic behaviour” (Globerman 2016). First-dollar coverage for health care offers an extreme example. The insured service may have nothing to do with illness or health; the service might be as simple as settling a disputed bit of information found on the Internet. This approach tends to increase consumption beyond benefit (Evans et al. 2016). All-you-can-eat leads to over-eating. Pooled risk tends to increase the amount of risky behaviour overall, because individuals do not worry about bearing the full cost of their decisions. We consume to the margin.

Moral hazard is inescapable due to what Joseph E. Stiglitz, Nobel Prize winning economist, calls “multiple-information asymmetries.” These

asymmetries exist at multiple levels in health care and, so far, have been studied very little:

We do not know what the doctor is doing, what he should do, or what the consequences are of what he does (or does not do). Even if he did the right thing, the patient could have a disease that will have a bad outcome, so we can't judge whether the doctor has done the right thing by whether the patient survives... The doctor does not know the illnesses of the patient, the patient does not know whether the doctor is doing the right thing, and the insurance company does not know about either of those two. In the instance just described, there are three moral hazard problems. (Finkelstein 2014).

This leads economists to write about “supplier induced demand” (Barer, Stoddart, McGrail, and McLeod 2016, 273). To which we could add politician induced demand by agents keen to promote “free care” (Ferguson 2016). We need not expand “multiple-information asymmetries” beyond necessity to make our point. Given insurance against risk, demand expands in the absence of incentive for restraint.

Uncontrolled moral hazard creates inefficiency, which then causes a decrease in the social welfare. We end up paying more than we should and still many patients do not get what they need. Even when we think medicare has done a good job of not wasting money, moral hazard erodes the success. For example, we might spend the least amount of money to get the greatest number of CT scans. But no one knows whether we should have scanned in the first place. We try to determine need in *post hoc* analysis. But medical need almost always exists first in the mind of the patient and her physician. In the case of informational need, the need and its satisfaction remain in the mind; hidden and impossible to measure. Cancers and broken hips can be seen, tracked, and reported. Questions, counselling, or advice to delay treatment will frustrate the most determined accountant. This relates to medicine being a coping organization (Wilson 1991). Most of the time, we cannot see the work done or the results of the work. It becomes impossible to determine whether services and costs are legitimate.

Some deny that moral hazard exists for medicine. Most people avoid unpleasant tests and treatment if they can. Malcolm Gladwell defended this position in his *New Yorker* article “The Moral-Hazard Myth” (2005). In his view, people do not seek more liver transplants when they go on sale. The incentive to avoid care usually outweighs the incentive to consume even when it is free. This certainly applies for young to middle-aged males. Less so for others. Gladwell makes an evidential claim, which the evidence does not support. Moral hazard “irrefutably exists” (Einav and Finkelstein 2018). Einav and Finkelstein in their 2018 review state that, “The overwhelming, compelling evidence on this point – from several randomized evaluations as

well as countless, well-crafted quasi-experimental studies – should give any informed reader considerable pause when they hear claims to the contrary” (p. 978).

The most fascinating medical problems remain furiously hidden: “Disease never reveals all of itself” (Nuland 2008, xv). As Sir William Osler said, “Medicine is the science of uncertainty and an art of probability” (Bean 1954). No amount of evidence, guidelines, or artificial intelligence will remove the need for intelligent clinical judgment. On top of this, suffering is subjective. Treatment decisions rely on the uncertain, contingent nature of disease. One person with terrible osteoarthritis on their hip X-ray will have mild symptoms. Her best friend will have crippling pain with only minor changes showing on the X-ray. Given the uncertain and contingent nature of care, there is no way to identify and curb all unnecessary care. Necessity is insufferably subjective. Aside from things such as cancer and clogged arteries, most treatment decisions depend on a patient’s personal experience.

Genetics, physiology, and environment shape disease presentation. Pathology is contingent, not only in the sense that the future is never entirely certain, but in the philosophical sense. Propositions about particular diseases are neither always true nor always false for all cases at all times, which drives central planners to despair. The nature of medicine makes moral hazard inescapable with medical insurance.

How can we focus funding on what works and avoid low-value care?

We need to be clear about what kind of services user fees are designed to curb. Like any service industry, in health care each patient demands a different level of service. Some demand little and are easy to serve. Others demand far more – or require more – than any fixed pricing system can afford. When doctors and government sit down to negotiate, doctors point to the patients that require more care than current fees allow, and governments point to all the patients who present for care they could safely do without. Easy cases offer a greater financial return for effort expended, so naturally, doctors and hospitals are happy to see them. If patients have nowhere else to go, easy cases balance hard ones. But if patients have options, agents could (potentially) seek out easy cases and avoid hard ones, a behaviour known as cream-skimming.

Cream-skimming degrades clinical skills even more than it corrupts clinical culture; it fails as a business strategy in the long run. Cream-skimming is usually one of the first reasons people mention when they argue against private care. They take it to be self-evident that cream exists in medicare, and then they argue that greedy profiteers will seek to skim it, putting “unhealthy pressure” on the system. For our purposes, whether or not cream-skimming

plays any role in the public-private discussion is beside the point. The point here is that cream exists and medicare has no way to control it, other than water it down by making everyone stand in line to wait for care.

User fees work to eliminate cream before it forms. Removing people from the line who can safely go without care increases the amount of care (value) for those who truly need it. It decreases waste. Most people are anti-cream-skimming. User fees are anti-cream.

“ *The need to focus funding on high-value care has sparked a global value-based health care movement.* ”

The need to focus funding on high-value care has sparked a global value-based health care movement over the last 15 years – one that Canada watches from the bleachers. Value-based health care (VBHC) means lowering the price on services and treatments that work. Patients can still access services that have been shown to provide less value, but they will have to pay more for them. VBHC started out as “benefits-based cost sharing” (Fendrick, Smith, Chernew, and Shah 2001). It meets moral hazard head-on (Pauly and Blavin 2007). Experts have called for “value-based insurance design” for over 10 years (Chernew, Rosen, and Fendrick 2007). It seeks to “align the use of health care services with some notion of value” (Yeung 2019), with the focus on reducing costs for some kinds of treatment.

VBHC has a solid following in national pharmacare discussions. As raised in the introduction, Kai Yeung and Steven Morgan have suggested that a Canadian pharmacare plan would benefit from value-based insurance design (Yeung and Morgan 2019). However, it carries its own challenges: Joel Lexchin wrote a letter to the editor in response to Yeung and Morgan and asked, “Who assigns value in VBID [value-based insurance design]?” (Lexchin 2020). We should not use public funds for low value treatment, but who gets to decide?

But when it comes to clinical care, VBHC finds no purchase. Canadian authors do write about increasing value for patients, but at most, we mean doing things that work and stopping things that do not. However, Canada cannot, by definition, partake in the value-based movement. When the price of service is already zero, Canada has no way to participate without changing the whole definition of the value-based movement. We have made patient cost-sharing the topic-that-must-not-be-named.

A Conference Board of Canada webpage notes that VBHC is in its early stages globally, with little system-level progress. Fred Horne and Rachel Manion noted in 2019 that VBHC is a an “international healthcare transformation movement” and suggest that a made-in-Canada approach would focus on “delivering outcomes that matter to patients at the same or lower cost” (Horne and Manion 2019). It is unclear how this works in a zero-cost environment. The *Hill Times* published a piece that same year calling for a focus on outcomes that matter to patients, but the authors did not offer advice on how to make those decisions or who gets to decide (D’Angelo and MacLaine 2019).

The closest Canada comes to VBHC is with value-based procurement. Prada (2016) notes that VBID is popular world-wide; therefore, we should apply it to procurement. The more typical Canadian twist is to apply demand-side reforms to the supply side. Sanjay Cherian and Kelly Rakowski wrote about value-based payment models for physicians (Cherian and Rakowski 2012). Canadians are not getting their money’s worth, so we need to encourage value over quantity. But even if we did apply value-based insurance design to the demand-side of medicare, Canada might not achieve lower costs. Leaving patients on wait lists transfers costs to the waiting patients and saves the system money in the short-term. If user fees work to decrease the number of low-value services, we will have more capacity to help the high-cost care required by those currently on wait lists, which could cost more overall (as seen in Saskatchewan).

The same people who feel nervous about cost-sharing in medical care feel completely at ease with it for pharmaceuticals. When discussing a national pharmacare plan, most people assume that we will need some form of cost-sharing. At the very least, we will need strict limits on what we offer: completely free insulin but some fee for Viagra, if we even cover it at all. It seems normal and appropriate to discuss value-based insurance design when it comes to pharmacare – just not medicare.

Given consumers’ natural tendency to avoid costs, some countries employ user fees to inject a “steering effect.” For example, Johan Hjertqvist reviewed user fees in Sweden and Denmark and reported that Swedes pay around \$30 (the cost varies per county council) in order to decrease over-consumption, direct patients to appropriate places of treatment, and to inject an awareness of cost. A 10 percent increase in fees led to a 3 percent decrease in visits (Hjertqvist 2002). But fees are only one of many potential steering influences. Fees on emergency department care will have little effect if the wait to see primary care is two weeks. Patients will decide that paying the fee is still better than waiting too long to see their own family doctor. The “steering effect” of waiting will be greater than the fee.

Furthermore, complex fees create no change and are costlier to administer. In Denmark, “social steering” has played an even larger role than fees. Danish

patients tend to know their own physicians, prefer to see them first, and trust doctors to act on their behalf. Swedes not so much. Hjertqvist emphasized that fees are not a “silver bullet” and must be context specific. In support of this point, a review from 2017 looked at whether user fees encouraged use of primary care in a system without gatekeeping and found that differential fees caused an uncertain steering effect (Hone et al. 2017). Another study found that patients do not shop around when price transparency and cost-sharing is introduced (Benavidez and Frakt 2019).

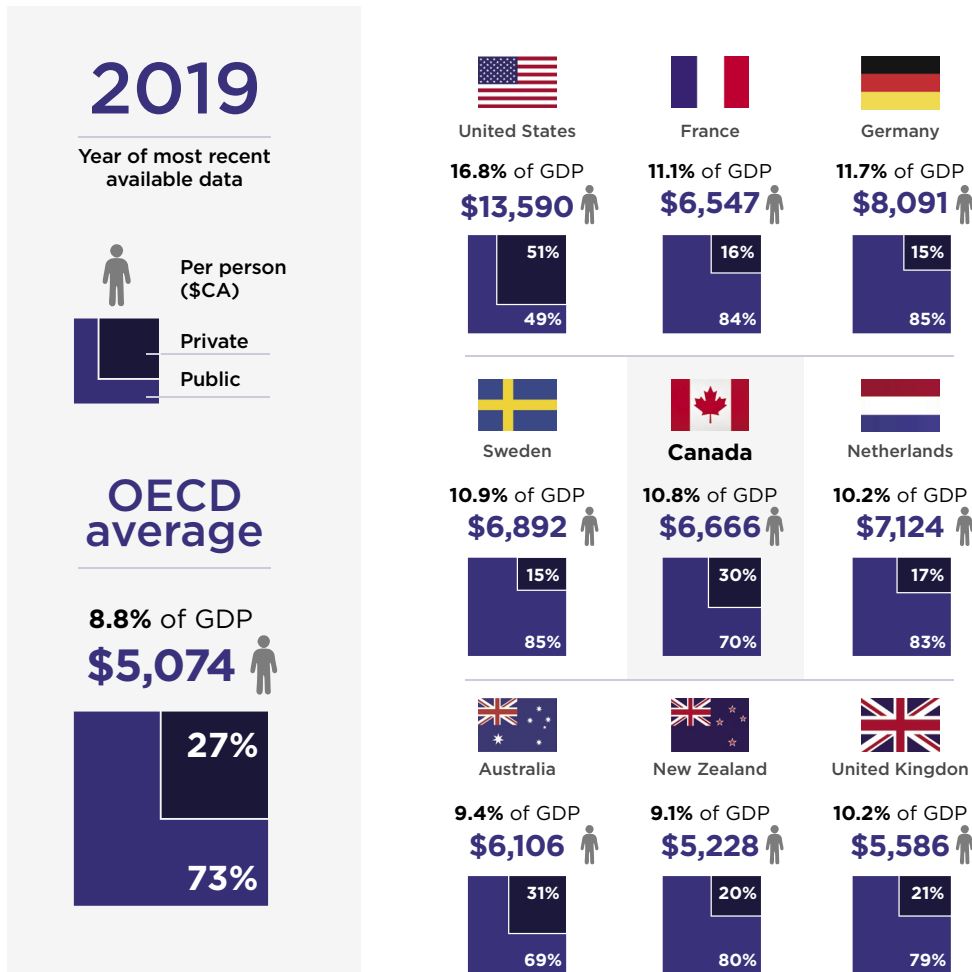
Increased equity

User fee exemptions for the sick, old, and poor solve concerns for vertical equity – the notion that people of higher means should pay more for public services. But how can we address horizontal equity – the idea that people of similar means should bear the same costs? Is it fair if one person earning \$100,000 chooses unwisely but her colleague who does not still pays the same taxes (premiums)? We expanded this in the introduction with our discussion about two sisters who each choose to use medicare at vastly different rates for similar disease. Is it fair that they both bear the same financial burden for the care they seek from the system?

In addition, first-dollar coverage ends up creating far more welfare inequity in the broader society than it eliminates. Medicare pays for all medically necessary care but very little pharmaceutical, dental, eye, or any other kind of care. Our approach to health insurance is a “mile deep and an inch wide” (Speer 2016). Cost-sharing might appear anti-egalitarian at a glance, but our current broader system is even more inequalitarian, with private insurance available only to a few. At first glance, user fees would increase the amount of “private” dollars in the system, which seems opposite to where we want to go, but they could open the door to fund more of the unfunded services that most citizens expect under other universal systems (Figure 1).

Finally, accessing care is not free, even though patients do not receive a bill for the care itself. Waiting for care carries a cost that patients must bear (Flood 2003, 49). There’s a reason people pay strangers to stand in line for them. Businesses such as InLine4You and LineAngel operate by hiring “spotters” to hold spots in line for people who cannot afford the time and expense of waiting. No such business exists for medicare. A system built on long wait times as a way to ration services unfairly benefits those who suffer little to no cost from waiting. A single parent who works two jobs suffers a much greater opportunity cost from waiting in a clinic than someone else who has “all the time in the world.” When it comes to accessing health care, one size does not fit all, especially for vulnerable patients. Properly structured fees could help address this horizontal inequity by decreasing waits overall.

FIGURE 1: HOW CANADA'S HEALTH SPENDING COMPARES



Notes:

For the United States, the public-sector share of social health spending includes compulsory private insurance expenditures. The public-sector share of total health spending is the sum of expenditures for government schemes and compulsory health insurance. Total current expenditure (capital excluded). Expenditure data is based on the OECD's *A System of Health Accounts 2011*.

Source: CIHI 2021

Economics, empowered patients, and Tommy Douglas's "good psychology"

Medicare is governed on the assumption that it is immune to market forces (Powell 1966). However, we ignore basic economic theory at our peril. In Canada "economics" means cost-accounting, not a true focus on economic theory per se. It rests on the old fallacy that good intentions must mean good methods; if the CHA has good intentions, its design must be good also. But economics is about incentives at least as much as it is about costs.

Laporte offers an in-depth review of the RAND and Oregon experiments. We need incentives on both the demand and supply side if we aim to take economics seriously. User fees address the lack of incentives on the demand side in Canada. Laporte notes that people will always abuse a system. Changing the system will simply change the type of abuse, but it will not eliminate abuse. We need to address the “incentive compatibility problem” – incentives need to result in what’s good for patients.

Furthermore, if the user fees go directly to those providing services, fees will inject an element of activity-based funding. This transfers some control to whomever pays for the activity. The extremes of control exist between state-run, first-dollar coverage at one end, and full patient payment at the other (either through self-pay, health savings accounts, vouchers, and so on). A user fee – that is, partial payment of a service – to the state or to the provider offer two intermediate positions along this spectrum. And of course, the user fee itself would inject an element of moral hazard if it gave institutions or providers the incentive to offer low-value services in pursuit of the fee.

For some services, patients want zero control: they just want someone to take care of them (e.g., trauma). But for most services, patients want to have some input. First-dollar coverage is paternalism in the extreme: patients have no meaningful input beyond expressing an opinion; they have no control; they are never sure if they are getting good or poor service; and their only option if they are not satisfied is to complain to the hospital or regulatory college. This does not improve services for the patient; in fact, it may do the opposite (analogous to the well-known risk of sending food back at a restaurant).

Properly structured, fees rebalance power between patients and a faceless bureaucracy. Having said that, user fees in the absence of any relationship with a particular clinician or clinical team are just a tax. The fee might curb patient behaviour, but it will do nothing to the providers. Without payment to a specific team, the patient pays into an abyss without evidence of impact on service. Fees only empower a patient if they encourage meaningful behavioural change in a specific clinician (or small group of clinicians) who works to earn the fee that a particular patient controls.

This brings us back to Tommy Douglas’ comment about “good psychology.” Many authors point to the inherent value of cost to reinforce public awareness that health care is most definitely not free (Hjertqvist 2002). Regardless of it being dismissed as playing any role in Canada, it would help establish and encourage the growth of a health partnership while curbing a sense of entitlement.

Conclusion

Canada abandoned user fees 36 years ago at the same time that the first solid evidence about the beneficial effects of fees came out. Since then, the body of evidence around health insurance has transformed what we thought we knew then. Other countries have addressed and solved all the arguments against fees. Around the world, most countries now use fees as a better approach to curbing overconsumption than rationing alone. We return to Victor Fuchs: “The public must pay for care under any system of finance” (1974). There is only one taxpayer, so there is no way to transfer the cost of care, for the average family, onto government, business, or the wealthy.

It is time for the federal government to explore how provinces could employ user fees within the broader environment of the *Canada Health Act*. User fees work to improve efficiency and equity. As such, allowing provinces to develop fee programs within clear boundaries would align with the spirit of the CHA. A 2010 review of empirical models of patient payment and demand noted a gap in research on the topic and could not offer any clear direction for policy-makers seeking to develop programs (Skriabikova, Pavlova, and Groot 2010). As such, coming up with appropriate fee programs will require exploration; provinces will need the room to try new ideas.

Provinces could build programs with exemptions and caps to protect the elderly and those with chronic disease. User fees would be borne by those who use the system *and can afford to pay the fee*. Fees could be designated as a tax credit to further achieve both horizontal and vertical equity. User fees enhance value from a limited public resource. They discourage low-value care (“cream”), thereby improving access for those who need care the most. Gordon, Mintz, and Chen already offered a method of means testing 20 years ago (1998). It could be done through the tax system without any issue of social stigma.

Of course, this proposal will attract debate for reasons beyond the pros and cons of user fees themselves. When governments change funding allocation within a fixed envelope, those affected always divide into winners and losers. Even an ideally structured user fee program would still invite attack from those who may stand to lose from such a program. For example, user fees should decrease the number of “easy” cases, leaving those who really need care as well as the anxious patients who will demand care no matter what fees exist (or other hurdles, such as waiting). Physicians will not like this. Anxious patients take more time and energy than “easy” ones. They are often inconsolable and prone to litigation. And sicker patients take greater effort.

Slightly anxious patients with almost nothing wrong with them are the easiest cases – offer something simple and they leave happy. A properly designed user fee program would eliminate these patients; therefore, all things being equal, doctors would probably oppose it. (Never mind that the whole fee structure system has been built up over 50 years on the assumption that since these “easy” patients exist they justify otherwise paltry fees for many office-based visits.) Unions will oppose them also: fewer patient visits means less union power. It also goes against the ideology of union leadership. And finally, many politicians will oppose user fees because user fees do not win votes. Voters show less enthusiasm for campaigns about efficiency and quality versus tax cuts and more free services.

Most other countries use some form of cost-sharing for health insurance because insurance does not work without it. Absent cost-sharing, rationing of care and vigilance about unnecessary use must become more comprehensive. An all-you-can-eat approach fails without strict limits on plate size and meal choice. Without any patient participation in payment for care, health care reform becomes a sophisticated effort to improve an economic model based on the soup kitchen. It interprets economics as cost control instead of a study in behaviour and incentives associated with the use of scarce resources that have multiple uses.

Most people would agree that free care is a luxury. Given pandemic debts, can we still afford to pursue it unchanged? Can we continue to ignore the randomized trials that have shown that cost-sharing decreases patient demand without harming patients? Or is it irrelevant given our current approach to rationing with wait lists and heavy regulation? User fees remain an active research focus around the world. It seems time for our federal and provincial leaders to strike a task force to examine how user fees might fit into the context of Canadian medicare. Patient co-payment should be explored as one way to protect and expand the services Canadians need and have come to expect.

About the author



Shawn Whatley is a practicing physician and a Munk Senior Fellow at the Macdonald-Laurier Institute. He is author of two books, *When Politics Comes Before Patients -- Why and How Canadian Medicare is Failing* (2020), and *No More Lethal Waits -- 10 Steps to Transform Canada's Emergency Departments* (2016). He is a frequent commenter on healthcare issues in traditional and independent media. Whatley served as Chief and Medical Director and then as Physician Leader (aka 'Medical Program Director') of Emergency Medicine at a large GTA hospital. He has served on a number of boards including the Ontario Medical Association and Canadian Medical Association. He is a Past President of the OMA.

References

Arrow, Kenneth J. 1963. "Uncertainty and the Welfare Economics of Medical Care." *American Economic Review* 53, 5 (December): 941-973. Available at <http://web.pdx.edu/~nwallace/EHP/ArrowUWE.pdf>.

Atchessi, Nicole, Valéry Ridde, Maria-Victoria Zunzunegui. 2016. "User Fees Exemptions Alone Are Not Enough to Increase Indigent Use of Healthcare Services." *Health Policy and Planning* 31, 5: 674-681. Available at <https://academic.oup.com/heapol/article/31/5/674/2355839>.

Baicker, Katherine, Sarah L. Taubman, Heidi L. Allen, et al. 2013. "The Oregon Experiment — Effects of Medicaid on Clinical Outcomes." *New England Journal of Medicine* 368, 18: 1713-1722. Available at <https://www.nejm.org/doi/full/10.1056/nejmsa1212321>.

Barer, Morris L., Greg L. Stoddart, Kimberlyn M. McGrail, and Chris B. McLeod (eds.). 2016. *An Undisciplined Economist: Robert G. Evans on Health Economics, Health Care Policy, and Population Health*. McGill-Queen's University Press.

Bean, William Bennett. 1954. "Sir William Osler: Aphorisms from His Bedside Teachings and Writings." *British Journal for the Philosophy of Science* 5, 18:172-173.

Beck, R.G., and J. M. Horne. 1980. "Utilization of Publicly Insured Health Services in Saskatchewan Before, During and After Copayment." *Medical Care* 18, 8:787-806. Available at <https://www.jstor.org/stable/3764080?refreqid=excelsior%3A64662c8d4be0a95c72148c347a26b4e4&seq=1> [paywall].

Benavidez, Gilbert, and Austin Frakt. 2019. "Price Transparency in Health Care Has Been Disappointing, But It Doesn't Have to Be." *Journal of the American Medical Association Health Forum* (August 22). Available at <https://jamanetwork.com/channels/health-forum/fullarticle/2759675>.

Brook, Robert H., John E. Ware, William H. Rogers, et al. 1984. *The Effect of Coinsurance on the Health of Adults: Results from the RAND Health Insurance Experiment*. Rand Corporation. Available at <https://www.rand.org/pubs/reports/R3055.html>.

Canadian Institute for Health Information [CIHI]. 2017. *Unnecessary Care in Canada*. Choosing Wisely Canada and Canadian Institute for Health Information (April). Available at <https://www.cihi.ca/sites/default/files/document/choosing-wisely-baseline-report-en-web.pdf>

Canadian Institute for Health Information [CIHI]. 2021. “How Does Canada’s Health Spending Compare?” Infographic. CIHI. Available at <https://www.cihi.ca/en/how-does-canadas-health-spending-compare#>.

Cherian, Sanjay, and Kelly Rakowski. 2012. “Moving toward Value-based Payment Models in Canadian Healthcare.” *Insights (Essays)* (October). Available at <https://www.longwoods.com/content/23068/moving-toward-value-based-payment-models-in-canadian-healthcare>.

Chernew, Michael E., Allison B. Rosen, and A. Mark Fendrick. 2007. “Value-Based Insurance Design.” *Health Affairs* 26 (Suppl2): w195-w203. Available at <https://www.healthaffairs.org/doi/10.1377/hlthaff.26.2.w195> [paywall].

Crowley, Brian Lee. 2010. *Fearful Symmetry: The Fall and Rise of Canada’s Founding Values*. Key Porter Books.

Crowley, Brian Lee. 2014. *Why Health Care’s Broken and How to Fix It: Three Drivers of System Reform*. Macdonald-Laurier Institute. Available at <https://www.macdonaldlaurier.ca/files/pdf/MLIKeyDriversofHealthCareReform-Final.pdf>.

D’Angelo, Monika Slovenic, and Cameron MacLaine. 2019. “Value-Based Health Care: Time to Focus on Outcomes, Not Outputs.” *Hill Times* (November 6). Available at <https://www.hilltimes.com/2019/11/06/value-based-health-care-now-is-the-time-focus-on-outcomes-not-outputs/223042>.

Douglas, Thomas C. 1984. *The Making of a Socialist: The Recollections of T.C. Douglas*. Lewis H. Thomas, ed. University of Alberta Press.

Dzakpasu, Susie, Timothy Powell-Jackson, and Oona M.R. Campbell. 2014. “Impact of User Fees on Maternal Health Service Utilization and Related Health Outcomes: A Systematic Review.” *Health Policy and Planning* 29, 2: 137-150. Available at <https://academic.oup.com/heapol/article/29/2/137/637405>.

Einav, Liran, and Amy Finkelstein. 2018. “Moral Hazard in Health Insurance: What We Know and How We Know It.” *Journal of the European Economic Association* 16, 4 (August): 957-982. Available at <https://academic.oup.com/jeea/article/16/4/957/4992078>.

Esmail, Nadeem, and Michael A. Walker. 2008. *How Good Is Canadian Health Care? 2008 Report: An International Comparison of Health Care Systems*. Studies in Health Care Policy. The Fraser Institute. Available at <https://www.fraserinstitute.org/sites/default/files/HowGoodisCanadianHealthCare2008.pdf>.

Feldstein, Martin S. 1973. "The Welfare Loss of Excess Health Insurance." *Journal of Political Economy* 81, 2 (Part 1):251-280. Available at <https://pdfs.semanticscholar.org/9707/071e1fbf3bce70af94d5a276a803ba3c079a.pdf> [paywall].

Fendrick, A. Mark, Dean G. Smith, Michael E. Chernew, Sonali N. Shah. 2001. "A Benefit-Based Copay for Prescription Drugs: Patient Contribution Based on Total Benefits, Not Drug Acquisition Cost." *American Journal of Managed Care* 7, 9 (September): 861-867. Available at <https://www.ajmc.com/view/sep01-301p861-867>.

Ferguson, Rob. 2016. "Ontarians Can Start Getting Free Flu Shots this Week." *Toronto Star* (October 24). Available at <https://www.thestar.com/news/queenspark/2016/10/24/ontarians-can-start-getting-free-flu-shots-this-week.html>.

Finkelstein, Amy, Sarah Taubman, and Bill Wright, et al. 2012. "The Oregon Health Insurance Experiment: Evidence from the First Year." *Quarterly Journal of Economics* 127, 3 (August): 1057-1106. Available at <https://academic.oup.com/qje/article-abstract/127/3/1057/1923446> [paywall].

Finkelstein, Amy, with Kenneth J. Arrow, Jonathan Gruber, Joseph P. Newhouse, and Joseph E. Stiglitz. 2015. *Moral Hazard in Health Insurance*. Columbia University Press.

Flood, Colleen. 2003. "Galvanizing Publicly Funded Health Care Systems Through Accountability." In Peggy Leatt and Joseph Mapa (eds). *Government Relations in the Health Care Industry*. Praeger.

Fuchs, Victor R. 1974. *Who Shall Live? Health, Economics, and Social Choice*. New York: Basic Books.

Gladwell, Malcolm. 2005. "The Moral-Hazard Myth: The Bad Idea Behind Our Failed Health-Care System." *New Yorker* (August). Available at <https://www.newyorker.com/magazine/2005/08/29/the-moral-hazard-myth>.

Globerman, Steven. 2016. *Select Cost Sharing in Universal Health Care Countries*. The Fraser Institute. Available at <https://www.fraserinstitute.org/sites/default/files/select-cost-sharing-in-universal-health-care-countries.pdf>.

Gordon, Michael, Jack Mintz, and Duanjie Chen. 1998. "Funding Canada's Health Care System: A Tax-Based Alternative to Privatization." *Canadian Medical Association Journal* 159, 5 (September): 493-496. Available at <https://www.cmaj.ca/content/cmaj/159/5/493.full.pdf>.

Grant, Hugh M., and Jeremiah Hurley. 2013. *Unhealthy Pressure: How Physician Pay Demands Put the Squeeze on Provincial Health-Care Budgets*. Research Paper 6, 22. School of Public Policy, University of Calgary. Available at <https://www.policyschool.ca/wp-content/uploads/2016/03/grant-physician-income.pdf>.

Hjertqvist, Johan. 2002. *User Fees for Health Care in Sweden: A Two-Tier Threat or Tool for Solidarity?* Health Care Commentary number 6 (May). Atlantic Institute for Market Studies. Available at <https://www.aims.ca/wp-content/uploads/2016/03/newsletter6.pdf>.

Hone, Thomas, John T. Lee, Azeem Majeed, Lesong Conteh, and Christopher Millett. 2017. "Does Charging Different User Fees for Primary and Secondary Care Affect First-Contacts with Primary Healthcare? A Systematic Review." *Health Policy and Planning* 32, 5 (June): 723-731. Available at <https://academic.oup.com/heapol/article/32/5/723/2930662>.

Horne, Fred, and Rachael Manion. 2019. "A Made-in-Canada Approach to Value-Based Healthcare." *Healthcare Papers* 18, 4: 10-19. Available at <https://pubmed.ncbi.nlm.nih.gov/31901064/> [paywall].

Irvine, Carl, and David Gratzner. 2002. *Medicare and User Fees: Unsafe at Any Price?* AIMS Health Care Reform Background Paper number 9. Atlantic Institute for Market Studies. Available at <https://www.aims.ca/wp-content/uploads/2016/03/fees2.pdf>.

Johansson, Naimi, Niklas Jakobsson, and Mikael Svensson. 2019. "Effects of Primary Care Cost-Sharing Among Young Adults: Varying Impact across Income Groups and Gender." *The European Journal of Health Economics* 20, 8 (August): 1271-1280. Available at <https://link.springer.com/content/pdf/10.1007/s10198-019-01095-6.pdf>.

Kiil, Astrid, and Kurt Houlberg. 2014. "How Does Copayment for Health Care Services Affect Demand, Health and Redistribution? A Systematic Review of the Empirical Evidence from 1990 to 2011." *European Journal of Health Economics* 15, 8: 813-828. Available at <https://pubmed.ncbi.nlm.nih.gov/23989938/> [paywall].

Lagarde, Mylene, and Natasha Palmer. 2011. The Impact of User Fees on Access to Health Services in Low- and Middle-Income Countries. *Cochrane Database of Systematic Reviews* (April 13). Available at doi:10.1002/14651858.cd009094 [paywall].

Laporte, Audrey. 2014. *How Markets Can Put Patients First: Economics Before Politics in Canadian Health Care Delivery*. Macdonald-Laurier Institute. Available at <https://www.macdonaldlaurier.ca/files/pdf/MLICanadasHealthcareCrisisSeries4-WebReady-01-13.pdf>.

Lewis, Stephen. 1998. "Still Here, Still Flawed, Still Wrong: The Case Against the Case for Taxing the Sick." *Canadian Medical Association Journal* 159, 5 (September): 497-9. Available at <https://www.cmaj.ca/content/cmaj/159/5/497.full.pdf>.

Lexchin, Joel. 2020. "Who Assigns Value in Value-Based Insurance Design?" *Canadian Medical Association Journal* 192, 1 (January 6): E15. Available at <https://www.cmaj.ca/content/cmaj/192/1/E15.full.pdf>.

Martin, Danielle, and Ryan Meili. 2015. "How Proposed User Fees for Health Services in Quebec Threaten the Canadian Health System." Evidence Network (October). Available at <http://evidencenetwork.ca/how-proposed-user-fees-for-health-services-in-quebec-threaten-the-canadian-health-system/>.

McKenna, Kate. 2017. "Quebec Health Minister Bans User Fees, Starting Jan. 26." *CBC News* (January 11). Available at <https://www.cbc.ca/news/canada/montreal/barrette-user-fees-abolition-1.3931504>.

Norberg, Johan. 2018. *Sweden: Lessons for America?* Video. Free to Choose Network. Available at <https://www.youtube.com/watch?v=jq3vVbdgMuQ>.

Nuland, Sherwin B. 2008. *The Uncertain Art: Thoughts on a Life in Medicine*. Random House.

Pauly, Mark V. 1968. "The Economics of Moral Hazard: Comment." *American Economic Review* 58, 3 (part 1 – June): 531-537. Available at <https://www.jstor.org/stable/1813785> [paywall].

Pauly, Mark V., and Fredric E. Blavin. 2007. *Value Based Cost Sharing Meets the Theory of Moral Hazard: Medical Effectiveness in Insurance Benefits Design*. Working Paper 13044. National Bureau of Economic Research. Available at <https://www.nber.org/papers/w13044.pdf>.

Peng, Ito, and James Tiessen. 2015. *An Asian Flavour for Medicare: Learning from Experiments in Japan, Korea, and Taiwan*. Macdonald-Laurier Institute. Available at https://www.macdonaldlaurier.ca/files/pdf/MLICanadasHealthcareCrisisSeries5_r4.pdf.

Picard, André. 2017. "Medical User Fees are Back – and It's Time for Honest Debate." *Globe and Mail* (January 31). Available at <https://www.theglobeandmail.com/opinion/medical-user-fees-are-back-and-its-time-for-honest-debate/article33828831/>.

Powell, J. Enoch. 1966. *A New Look at Medicine and Politics*. Pitman. Available at <https://www.sochealth.co.uk/national-health-service/healthcare-generally/history-of-healthcare/a-new-look-at-medicine-and-politics/>.

Prada, Gabriela. 2016. "Value-Based Procurement: Canada's Healthcare Imperative." *Healthcare Management Forum* 29, 4: 162-164. Available at <https://pubmed.ncbi.nlm.nih.gov/27278137/> [paywall].

Reynolds Evan L., James F. Burke, Mousumi Banerjee, et al. 2020. "Association of Out-of-Pocket Costs on Adherence to Common Neurologic Medications." *Neurology* 94, 13: E1415-E1426. Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7274913/pdf/NEUROLOGY2019000497.pdf>.

Salampessy, Benjamin H., Maaik M. Alblas, France R. M. Portrait, Xander Koolman, and Eric J. E. van der Hijden. 2018. "The Effect of Cost-Sharing Design Characteristics on Use of Health Care Recommended by the Treating Physician: A Discrete Choice Experiment." *BMC Health Services Research* 18, 1, Article 797. Available at <https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-018-3598-4>.

Skriabikova, Olga, Milena Pavlova, and Wim Groot. 2010. "Empirical Models of Demand for Out-Patient Physician Services and Their Relevance to the Assessment of Patient Payment Policies: A Critical Review of the Literature." *International Journal of Environmental Research and Public Health* 7, 6: 2708-2725. Available at <https://www.mdpi.com/1660-4601/7/6/2708/htm>.

Speer, Sean. 2016. "Less Funding, Fewer Strings Should Be Ottawa's Spur for the Provinces on Health Care Reform." *Inside Policy* (Oct 18). Macdonald-Laurier Institute. Available at <https://www.macdonaldlaurier.ca/less-funding-fewer-strings-should-be-ottawas-spur-for-provinces-on-health-care-reform-sean-speer-for-inside-policy/>.

Tamblyn, Robyn, Rejean Laprise, and James A. Hanley, 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. Available at <https://jamanetwork.com/journals/jama/fullarticle/1108322>.

Toronto Star. 2010. "Quebec Drops Plan for Medicare User Fees." *Toronto Star* (September 22). Available at https://www.thestar.com/life/health_wellness/news_research/2010/09/22/quebec_drops_plan_for_medicare_user_fees.html.

Vertesi, Les. 2003. *Broken Promises: Why Canadian Medicare Is in Trouble and What Can Be Done to Save It*. Epic Press.

Vogel, Lauren. 2011a. "Panel's Recommendations Could Open Privatization Floodgates, Delegates Warn." *Canadian Medical Association Journal* 183, 13: E991-2. Available at <https://www.cmaj.ca/content/cmaj/183/13/E991.full.pdf>.

Vogel, Lauren. 2011b. "No User Fees, but Perhaps User Fees." *Canadian Medical Association Journal* 183, 13: E970. Available at <https://www.cmaj.ca/content/cmaj/183/13/E970.full.pdf>.

Vogel, Lauren. 2011c. "Health Care Funding Model Flawed, Blue-Ribbon CMA Panel Argues." *Canadian Medical Association Journal* 183, 13: E987-8. Available at <https://www.cmaj.ca/content/cmaj/183/13/E987.full.pdf>.

Whatley, Shawn D. 2019. *The Most Responsible Politician: Who's the MRP for Health Care in Canada?* Macdonald-Laurier Institute. Available at https://macdonaldlaurier.ca/files/pdf/MLI_MostResponsible_Whatley_FWeb.pdf.

Whatley, Shawn D. 2020. *When Politics Comes Before Patients: Why and How Canadian Medicare Is Failing*. Optimum Publishing International.

Whatley, Shawn D. 2021. *COVID-19: Masking a Failed System?* Commentary (February). Macdonald-Laurier Institute. Available at https://macdonaldlaurier.ca/files/pdf/20210209_COVID19_Masking_a_failed_system_Whatley_COMMENTARY_FWeb.pdf.

Wilson, James Q. 1991. *Bureaucracy: What Government Agencies Do and Why They Do It*. 2nd ed. Basic Books.

Yeung, Kai. 2019. "Value-Based Insurance Design: Current Evidence and Future Directions." *Journal of Managed Care and Specialty Pharmacy* 25, 7 (July): 738-741. Available at <https://www.jmcp.org/doi/full/10.18553/jmcp.2019.25.7.738>.

Yeung, Kai, and Steven G. Morgan. 2019. "Should National Pharmacare Apply a Value-Based Insurance Design?" *Canadian Medical Association Journal* 191, 29 (July 22): E811-E815. Available at <https://www.cmaj.ca/content/cmaj/191/29/E811.full.pdf>.

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