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Universal care

Noralou Roos and associates[1] report mean per capita physician and hospital expenditures for Winnipeg residents for 1999–2000. Although they do not supply overall mean expenditures, the means for the middle socio-economic quintile ($286/person for physician costs and $333/person for hospital costs) are probably close to the overall means.

Data from the Canadian Institute for Health Information (CIHI)[2] suggest that Roos and associates omitted a significant proportion of physician and hospital expenditures from their calculations. According to CIHI data for Manitoba,[2] public expenditures for physicians were $382/person in 1999 and $420/person in 2000; for hospitals these figures were $895/person in 1999 and $944/person in 2000.[2] Total public health expenditures for the province were $2380/person in 1999 and $2621/person in 2000. Overall, it appears from this comparison that Roos and associates[1] included only about a quarter of all public health expenditures in their analysis.

Given evidence from other comparisons of funding and patterns of health care use among regional health authorities,[3,4] it is unlikely that the costs for Winnipeg reported by Roos and associates[1] were that much lower than those for the rest of Manitoba (as in the CIHI data); hence, other reasons for the higher values reported by CIHI are more likely. For example, the analysis by Roos and associates might not have captured salary costs for physicians on salary, and it appears that the majority of hospital costs were not included.[1]

The fact that Roos and associates incorporated only a minority of public health care costs in their calculations does not necessarily reduce the validity of their conclusions, which were based on comparisons among socioeconomic groups and among groups of individuals with different levels of use of health care services. Nevertheless, some caution is needed in the interpretation of their results.

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Noralou P. Roos and associates[1] document the role of poverty as a justifiable factor for increased utilization of health care services, because those of low socioeconomic status have poorer health status. However, the authors do not appear to prove that universal comprehensive insurance does not increase utilization.

For years, during informal discussions at work, continuing medical education courses and social events, I have been hearing family physicians readily acknowledge that their rate of referral to specialists is probably excessive and that they have ordered questionable investigations under perceived pressure from patients and fear of legal action. In these situations, universal health insurance has undoubtedly freed both physician and patient from financial accountability.

To reduce the present financially unsustainable rate of annual growth in health care, Canadian politicians should follow the suggestions of Roos and associates[1] by focusing on evidence-based medicine, physician practice patterns and hospital management, but not user fees and medical savings accounts. Fortunately, recent proposals that might moderately reduce utilization[2] inspire optimism that sufficient funds will be generated justly and fairly. Such funds are urgently required for the financial sustainability of Canada's health care system. Modest annual premiums could be introduced, calculated as a fair percentage of income above the poverty line. In addition, health care services could be treated as a taxable benefit on income above the poverty line, with a maximum calculated as a fair percentage of income.

Canadians accept average annual expenses of more than $1000 for car insurance,[3] $700 for gambling[4,5] and (for anyone who indulges in a large coffee and a doughnut each weekday) $500 at Tim Hortons, but, remarkably, they appear reluctant to preserve health care by paying for a modest portion of their physician and hospital services!

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Noralou Roos and associates[1] cite several reports as saying that a zero price for health care services leads to unnecessary use of the system.[2,3] However, this belief does not take into account the time and effort involved in accessing health care services, particularly for people of low socioeconomic status. People in this situation may be less likely to own a car or to be able to afford public transport, which limits their transportation options and makes it difficult for them to visit a medical clinic. Walking to a clinic may be an option, but clinic location, a patient's disability (especially for elderly patients) and harsh winters often make walking impractical. Furthermore, it may be difficult for a single mother to bring her children along when she needs medical care for herself, but because single mothers are more likely to live in poverty,[4] inability to pay for child care may be an issue.

Because of these barriers to accessing health services, people of low socioeconomic status may be less likely to visit a physician in the early stages of a health problem. Such a delay could result in a worsening of the condition, leading to a need for more expensive treatment or even admission to hospital. This might help explain the higher costs of treating patients of low socioeconomic status, as reported by Roos and associates,[1] and suggests that we should focus on accessibility rather than on implementing user fees as a way to reduce health care costs.

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[Two of the authors respond:]

Jon Gerrard observes that the expenditures we report[1] are lower than those reported by CIHI.[2] Our analysis is based on contacts that patients have with the health care system and includes only those costs that can be attributed to patients. When we discuss the appropriateness or potential impact of user fees or medical savings accounts, only these costs are relevant. CIHI[2] develops its "estimates" of public sector health expenditures on physicians and hospitals from diverse sources that were not relevant to our analysis. CIHI data on total public health expenditures include not just hospital and physician spending but also expenditures on drugs, other professionals (such as chiropractors and optometrists), public health, home care, health research and other aspects of health care.