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mythbusters

USING EVIDENCE TO DEBUNK COMMON MISCONCEPTIONS IN CANADIAN HEALTHCARE

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MYTH: USER FEES ENSURE BETTER USE OF HEALTH SERVICES

Tough economic times stir up anxiety over the affordability of public services—especially healthcare. As governments struggle to balance budgets, and healthcare spending continues to grow faster than the economy, conditions are ripe for old—and often discredited—policy ideas to make a comeback. User fees are no exception. At first blush, user fees appear to be an obvious solution. After all, any policy that promises to generate revenue[1] and reduce costs by deterring unnecessary use is hard to ignore.[1,2] But as research has shown over the years, the silver bullet of user fees really is the stuff of fantasy.[3]

The evidence indicates that implementing a medical toll booth to reduce healthcare traffic along a particular route can obstruct access to needed care, especially for those that are poor.[4] Viewing patients as responsible for the high costs of healthcare ignores the evidence against user fees and the opportunities for greater efficiency that can be found along the continuum of care.[5] A medical toll booth simply won't do the trick.

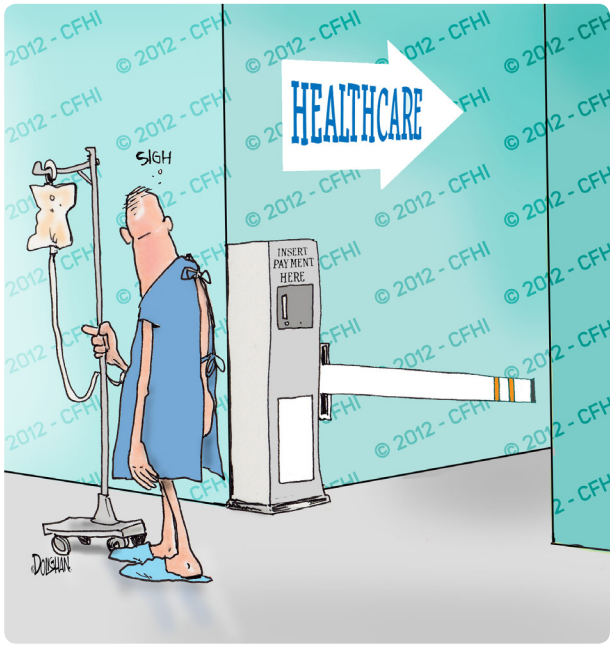
THE TANGLE OF NECESSARY AND UNNECESSARY CARE

The RAND Health Insurance Experiment, the largest and most rigorous study of user fees to date, found that the more patients had to pay for care, the less they used it.[6,7] Less care led to lower costs, but it didn't mean greater efficiency, because sometimes people received fewer services when they actually needed more. Patients did reduce their use of less-effective care, but there was a decrease in the use of effective care as well.[7] The RAND findings also showed that the proportion of inappropriate hospital stays and admissions was the same with or without user fees.[8]

The RAND findings have stood the test of time. In one study, user fees lowered the appropriate use of effective prevention services and medications to help manage chronic diseases.[4] User fees have also been shown to reduce inappropriate as well as appropriate antibiotic use to a similar extent.[9]

SAVINGS AT A COST

In Canada, user fees were introduced in Saskatchewan in the sixties and seventies. Subsequent research found that they



reduced the annual use of physician services by almost 6%. Notably, low-income families reduced their use of physician services by about 18%.[10] Saskatchewan's overall healthcare costs, however, did not go down. Indeed, over the period user fees were levied, physician fees increased and high income earners on average increased their use of physician services.[11]

User fees may also cause some people to forego necessary treatment. In Quebec, for instance, when the elderly and people on welfare had to pay user fees for prescription drugs, they took less medicine and their conditions worsened. As a result, they ended up with more visits to emergency departments and an increase in serious adverse events.[12]

A study of seniors insured through U.S. Medicare found that raising user fees for physician visits and prescriptions increased Medicare costs.[13] As in Quebec, many patients stopped taking their medications and ended up in the hospital. These findings are supported by a 2007 systematic review of prescription drug

cost-sharing.[14] Researchers found that although it is not certain that user fees lead to negative outcomes for all patients, their effect on the chronically ill was clear: increased emergency department use and hospitalizations.[14]

WHO PAYS THE PRICE?

The *Canada Health Act* effectively bans user fees for two main health services: hospitals and physicians.[15] There are good reasons for this. User fees shift costs to those that use the system the most: sick people. This amounts to a tax on poverty and age, since the poor and the elderly are less healthy than other groups.[15, 16, 17, 18]

The poor are especially sensitive to these fees, which have led to policies that exempt them from user charges. A 2010 report examining the possibility of a health deductible in Quebec suggested that such an exemption would thwart much of the revenue-generating potential of user fees.[19] Because healthcare utilization tends to be concentrated among low-income Canadians, low-income exemptions would significantly reduce the proportion of patients paying user fees.[19]

The poor are negatively affected by user fees in other ways, too. A study looking at the effects of prescription drug user fees found that low-income patients were more likely to stop taking medications to treat chronic disease.[20] These results are not surprising, as in the RAND study adverse health effects due to a decline in care were concentrated among low-income families.[21, 7]

User fees are a blunt instrument for targeting waste. They are aimed exclusively at patients, but patients have little control over which medical services they use.[11, 22] Patients choose whether or not to visit a doctor, but ongoing care and big-ticket items are ordered by physicians, the "gatekeepers" of the healthcare system.[23, 11, 22] What's more, physician fees account for only 14% of healthcare expenditures.[24] Patients are not solely responsible for the high costs of healthcare,[3] so it doesn't make sense to put cost containment on their shoulders.

CONCLUSION

While user fees are effectively banned for hospitals and physicians in Canada, we continue to have them for other health services.[25] If our goal is to ensure better use of health services, the evidence shows that user fees have not been capable of achieving it. Finding and eliminating inefficiencies across the continuum of care holds much more promise. The shift toward integrated and coordinated care delivery systems is encouraging, especially where they have been designed to meet the needs of specific populations.[26] That said, efforts to integrate healthcare services continue to be frustrated by user fees (routinely required for visits to physiotherapists, psychologists and for home care support, etc.) that can create access barriers to the most appropriate services.

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