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Philippe Cyrenne, Economics Professor, University of Winnipeg

On healthcare reform

In Brief:

A professor of economics at the University of Winnipeg, Philippe Cyrenne is the author of Private Health Care in the OECD: A Canadian Perspective *(with a section on Australia co-authored by Marian Shanahan.) Dr. Cyrenne holds a B.A.(Hons.) from the University of Winnipeg, an M.A. from Simon Fraser University and a Ph.D. from Carleton University. His areas of specialization are industrial organization, microeconomics and public economics. His most recent publications include articles on professional sports leagues in* Economic Inquiry, *on municipal tax credits in* Public Finance Review *(with R. Fenton) and on antitrust enforcement in* Review of Industrial Organization. *He presented a paper, "On the Coexistence of Public and Private Health Care Systems," to the Canadian Economics Association in 1998, and has engaged in research on the Canadian university system and on legalized gambling in Manitoba.*

Frontier Centre: Canada's Medicare system has been in place for almost 40 years. What has it accomplished?

Philippe Cyrenne: It has provided care to a lot of people, high quality care. I think, like any system, it will have some problems. It seems the main areas are waiting lists for elective surgery.

FC: That's the most important weakness, the waiting lists?

PC: The costs as well; people are concerned about the long-run sustainability of the system. I think those are the two things. Waiting lists and whether the system can be sustained in the future.

FC: Are there design flaws that could be easily addressed in the Medicare model?

PC: The one thing about it is that it is fairly rigid. As you know, the insurer and the provider are the same person. That is not necessarily a good thing, it can be problematic.

FC: When Medicare began, the most vocal objections came from the community of physicians. They were allowed to remain in private practice. In economic terms, based on your research in other countries, what would have happened if they had lost that argument and all become salaried?

PC: Well, salary and fee-for-service are two different incentive systems. Salaried physicians in other countries obviously don't have the same incentives that fee-for-service creates. In Sweden, for example, there is a feeling they should move more toward fee-for-service for incentive reasons.

FC: Have there been differences in provincial performance? Have those provinces that charge premiums, like

Ontario or Alberta, experienced fewer problems than those that don't?

PC: That is an empirical question and I'd have to look at the data to see whether that has been the case. But insurance premiums do provide another route for money into the system apart from explicit income taxes. So it's a bit more flexible, in terms of getting money into the system if required.

FC: All the OECD countries that you discussed in your book have some form of co-payment. Do you recommend that we charge user fees? Are they politically possible once they have been removed?

PC: There is a feeling that user fees can discourage demand. The extent to which it does depends on the level. But in the countries I looked at with user fees, there was provision for low-income individuals and yearly maximums that limit how much they pay in total for user fees. Usually the feeling was that user fees were there to direct resources to less costly forms of treatment, rather than to no treatment at all.

FC: Could you discuss the effects of zero price under Medicare? Is it the cause of our worst problems with the allocation of resources?

PC: If you charge zero price for something that has a positive marginal cost, then it is a subsidy. So what you're really asking is whether the subsidy is inappropriate. That depends. You could easily see a subsidy for people to take better care of themselves and that would subsequently place less demand on the system than you've got today. But if it is a subsidy for a medical procedure, that would be a welfare loss, unless you do it for equity reasons.

FC: Do you think we should rescind the provision in the Canada Health Act that mandates public ownership of hospitals?

PC: I think that the key issue is whether the patients get appropriate treatment. My own view is that it is the universality argument that is important to the Medicare system. I'm not certain whether people feel very strongly about whether they get treated in a private or a public hospital, but I could be mistaken.

FC: British Prime Minister Tony Blair recently said that his country's 15 percent limit on the private provision of health care was arbitrary and could rise. What is your impression of the National Health Service's latter-day commitment to contracted services?

PC: I think what they're trying to do is see whether they can get better care for their patients. There have been a series of experiments that have taken place in the UK, and I think they have been somewhat encouraged about introducing a more co-operative role with the private sector. With the officials of the NHS that I spoke to, there didn't seem to be any concerns about the inroads of the private sector.

FC: You distinguish between countries that offer national health programs as social welfare services and those that treat it as social insurance. What's the difference? Which is better?

PC: I think in the systems based on social insurance, health care is not seen as that much different from, say, dental insurance. It seems that in those countries you're able to have a much more flexible system in terms of provision and subsequently choice for consumers. The single-payer Canadian system is similar to Australia and the UK, and it tends to be less diversified in terms of provision.

FC: Those countries with social insurance systems, as you say, have no waiting lists. That's an important thing for us here.

PC: For elective surgery.

FC: In Singapore, which follows the social insurance model, pensions and health care are both financed by payroll taxes but in the form of privately held individual accounts. Does this model show promise for our universal system?

PC: If you're talking about medical saving accounts, there are mixed views. Some people think they lead to efficiency, because if you don't use the money then you can actually keep the amount you had put in for medical services.

FC: In Singapore they are using those accounts for mortgages and post-secondary education. There seems to be much more flexibility there that we don't have.

PC: One thing that I think is quite important, and what struck me when I looked at these different countries, is that each one had their own particular view of social policy, and that's important. The approach that you take in health care has to be grounded in your views of social policy. It's not clear that people would be familiar with medical savings accounts or receptive to them, even though they may have a potential to be useful. I'm not sure whether they would fit in the current system.

FC: In Canada, we've expanded inputs into public health care budgets much more than we've seen an expansion of patient services. Where does the difference go? Where does the money go when they put it in and it doesn't come out at the other end in more outputs?

PC: I'm not sure. Some people think that the size of the bureaucracy is bigger. But that's an empirical question; you'd have to see whether in fact that is taking place. Sometimes the cost could increase due to pure misallocation, in that the least costly form of care is not being provided.

FC: If you had absolute power for one day, how would you change Medicare?

PC: I don't think I'd feel comfortable with absolute power. I'm too much of a democrat. I would say that I'm quite flexible intellectually in terms of thinking about alternative approaches, but the key thing is that the universality requirement has to be maintained. I think the Canadian system and the systems I examined are really involved with redistribution to people who don't have the money for health care. I'm more flexible in terms of how the services are provided, whether public or private, as long as universality and redistribution exist.

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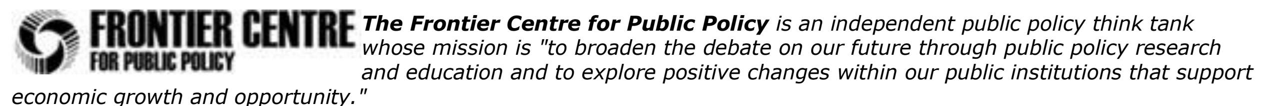

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