

CANADIAN HEALTH REFORM: A GENDER ANALYSIS

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ABSTRACT

We analyze the gender impact of the current Canadian system of first-dollar health insurance by examining the use of physicians' services and acute-care hospital services in the Canadian province of Manitoba from April 1, 1997, to March 31, 1999. First, we describe the use by age and sex of healthcare resources offered with universal access at no cost to individuals. Second, we argue that women have a particular interest in maintaining single-payer insurance, because women are moderately high users of healthcare resources, while men tend to be low or catastrophic users who would be shielded from the full force of market-oriented reforms. Third, we attempt to refocus the debate about the gender implications of market-oriented health reform by noting that medicare transfers resources to women of reproductive age from the rest of society, a form of social wage paid as in-kind compensation to women for nonpaid reproductive labor.

KEYWORDS

Health and administration data, women's health, healthcare costs, population health, single-payer, social wage, first-dollar coverage, Canada

JEL Codes: I18, H51, H42

INTRODUCTION

It has now been fifteen years since Uwe Reinhardt wondered whether health economists are saviors or "elephants in a porcelain shop" (Reinhardt 1989). Castigating us for "our profession's valiant attempt to force all of the healthcare process onto the Procrustean bed of that theory," he reminded us that health policy requires a defter hand than does economic theory. In particular, healthcare has traditionally been provided, even in the most market-driven societies, through a web of cross-subsidies that are "the hidden threads of a civilized social fabric" (Reinhardt 1989: 341). Canadian health insurance provides first-dollar coverage – a system with no user fees, co-payments, or deductibles – for physician and hospital care. Any Canadian citizen or legal permanent resident may receive care without any out-of-pocket expense. Recent challenges to this system illustrate Reinhardt's concerns.

This essay describes some of the cross-subsidies prevalent in Canadian healthcare under the current system of first-dollar coverage. Canadian medicare is the largest and most successful redistributive scheme in the country (Robert G. Evans and Noralou P. Roos 1999; Robert G. Evans 2002). Because health status is strongly correlated with socio-economic status, first-dollar coverage transfers resources from those with higher incomes to those with lower incomes. It also transfers resources from the young to the old and from the healthy to the sick. One of the most significant transfers is the transfer of resources to women of reproductive age from the rest of society. We argue that switching from the first-dollar coverage of the current system to a model of catastrophic coverage (coupled with individual responsibility for lower-cost, routine healthcare needs) would adversely affect women more than men, whose utilization patterns conform to the catastrophic model. Women, who have higher-median and lower-variance utilization during nonelderly adulthood, benefit from first-dollar coverage. If healthcare is valued as a social good to be equally accessible, we contend that a first-dollar system best addresses the risks women face in terms of higher lifetime care utilization. First-dollar coverage also serves as a social wage that offsets additional social costs women bear, namely unpaid social and reproductive labor, and lower earnings and income. Conversely, proposed reforms, designed to replace the current model with a combination of catastrophic insurance and programs designed to increase individual responsibility for routine care, can be seen as an attempt to undermine that social wage.

The case we make defies conventional economic theory, which argues that insurance is useful for low-probability, high-cost events and less useful for first-dollar coverage of routine, predictable, lower-cost healthcare. We recognize that the need for healthcare is a lifelong risk, whereas the conventional model of catastrophic insurance misses this characteristic of the demand. Our findings further suggest that if the same age-demand pattern holds in the United States, then the US Medicare system, which insures only those over age 65, is highly inequitable to women.

The paper is unique in two ways. First, it is "population based." The data we examine cover the entire population, including those people who make no claims on the healthcare system during our period of analysis. Cost estimates are provided for the entire population; our analysis does not rely upon an unrepresentative subset of the population, such as those who qualify for means-tested healthcare or those who belong to particular insurance or managed-health schemes. Second, because hospital care in Canada is nonprofit (block grants from various levels of government fund Canadian hospitals), the costs that we assign for hospital care are based on estimates of resource use, rather than on "charges" or "prices" that may not reflect actual use. That is, the costs in this paper are as close as we can get to opportunity costs. The results, however, may be generalized to other

jurisdictions to the extent that practice patterns and relative opportunity costs are similar.

THE CONTEXT OF THE POLICY DEBATE

Canadian medicare is premised on a widely shared, but not universally held, value judgment that healthcare is a social good that ought to be equally accessible to every Canadian regardless of ability to pay. It couples comprehensive, first-dollar health insurance for physician and hospital services with direct regulation of the healthcare sector. The provinces also make available, in whole or in part, a variety of other services, including long-term nursing home care, pharmaceuticals, and home care. Unlike physician and hospital care, however, many of these programs are means-tested, and they vary by province.

Accelerating healthcare costs in Canada, as in other jurisdictions, have created an environment that encourages the development of reform proposals designed to contain costs. A variety of proposals brought forward in recent years, particularly from market-oriented think tanks (such as the Fraser Institute) attempt to turn patients into cost-conscious consumers by forcing them to bear a greater proportion of the costs of their healthcare at the point of service. Proposals include incentives designed to encourage consumers to acknowledge the costs imposed by their health-seeking behavior. These incentives may take the form of user fees, as well as tax credits or tax deductions (for individuals who make little use of the healthcare system or who set aside their own money for private health insurance). They encompass “medical savings accounts” or “healthcare accounts” in which individual consumers control private or public money. Others have proposed surtaxes payable through the income tax system by individuals who consume healthcare (Jean-Luc Migué 2002).¹ Underlying all of these ideas is the notion that individuals overuse healthcare in Canada because they face no financial consequences for consuming physician or hospital services. A nonzero price, it is argued, can reduce consumption of medically unnecessary services without compromising health status; cost-conscious individuals will consider carefully their use of healthcare resources for which they must pay and use only the resources that are necessary.

Predictably, these proposals have attracted much criticism. Two major national task forces on the future of Canadian healthcare have reaffirmed the role of a national, publicly funded health insurance program of first-dollar coverage (Canada Senate 2002; Roy J. Romanow 2002). Indeed, both have called for an expansion of national coverage to include some kinds of home care and catastrophic pharmaceutical insurance.

Women have a particular interest in maintaining and expanding the current system of medicare and resisting market-oriented reforms. In many

jurisdictions, women's measured health status has declined when user fees are imposed (Priya Nanda 2002). In Canada, women's incomes continue to lag behind those of men. Because their labor-force participation rate is lower than that of men, and their jobs are more often temporary and insecure, women have less access to employer-provided health insurance and therefore fewer means to pay for user fees or co-payments. Moreover, in Canada, as elsewhere in the developed world, women continue to provide most of the caring labor in the household and therefore will bear the greatest burden of any reduction in hospital care or publicly provided home care that shifts the burden of care onto the household (Jan Blustein 2000).

Most significantly, however, women routinely use more healthcare, on average, than men, particularly during their childbearing years. Many studies in various health systems have found higher mean and median healthcare utilization by women of most adult age groups. By contrast, elderly men place greater demands on the system than their female counterparts (Lois M. Verbrugge 1986; Jean Randhawa and Rod Riley 1995; Lois M. Verbrugge and Donald L. Patrick 1995; Health Canada 2001). The reasons for this utilization pattern are not well understood. Some have argued that women seek care in gender-specific ways (Judith H. Hibbard and Clyde R. Pope 1983; J. David and Howard B. Kaplan 1995; Ruth Young 1999). In particular, their roles as mothers and caregivers to children bring them into greater contact with physicians, which encourages greater consumption of healthcare services. Others have noted that women tend to earn less than men and suffer greater rates of poverty and unemployment (Nancy Krieger 1991). The relationship between poor health status and lower socio-economic status is well documented (Ilmo Keskimaki, Marjo Salinto, and Seppo Aro 1995; Noralou P. Roos and Cameron A. Mustard 1997; Cameron A. Mustard, Marian Shanahan, Shelly Derksen, John Horne, and Robert G. Evans 1998; Elsie Pamuk, Diane Makuc, Katherine Heck, Cynthia Reuben, and Kimberly Lochner 1998; Evans and Roos 1999; Norman Frohlich, Randy Fransoo, and Noralou P. Roos 2002; David Mechanic 2002). Still others focus on the role that providers play in determining demand and argue that there has been an inappropriate (and expensive) medicalization of natural reproduction-related events, such as menses, pregnancy, and childbirth (Sally Macintyre, Kate Hunt, and Helen Sweeting 1996; John B. McKinlay 1996). And others claim that the health needs of women are naturally more complex than those of men, partly because of reproduction-related events and partly because of other sex-specific conditions (Susan B. Jaglal, Pamela M. Slaughter, Ronald S. Baigrie, Christopher D. Morgan, and C. David Naylor 1995).² Researchers using our database and adopting hospital-costing methods similar to those in this paper have discovered that age-adjusted annual costs for men and women are similar once they accounted for differences in reproductive biology and

the higher age-specific mortality rates among men (Cameron A. Mustard, Patricia Kaufert, Anita Kozyrskyj, and Teresa Mayer 1998).

HOW MUCH DO CANADIANS SPEND ON HEALTHCARE?

In this study, we examine the use of physicians' services and acute-care hospital services by all persons registered with the single-payer insurance agency in the Canadian province of Manitoba³ from April 1, 1997, to March 31, 1999. All permanent residents of Manitoba (that is, Canadians and landed immigrants) are fully insured for a range of healthcare services, particularly all physician services and hospital care ($n=1.1$ million). The plan provides a range of other services, in whole or in part, to Manitobans, including long-term nursing home care, public health services, prescription drugs, and home care. This study, however, is limited to physicians' services and acute-care hospital services fully funded by public insurance. Our data exclude nonresidents of Manitoba treated in Manitoba hospitals or by Manitoba physicians, but include the costs paid by the Manitoba Health Services Insurance Plan for Manitoba residents treated outside the province. The plan pays the Manitoba equivalent in costs for services incurred outside Manitoba, whatever the actual charges.

The province of Manitoba maintains electronic records of all physicians' services and all hospital admissions for each individual. The database includes both those who make claims and those who do not. The records contain patient identifiers that can be used to create individual histories of healthcare use while protecting individual privacy (Leslie L. Roos and J. Patrick Nicol 1983). Leslie L. Roos and Noralou P. Roos (2001) have provided a conceptual overview of the database and its validity, reliability, and usefulness. Previous studies have established the reliability and validity of these data (Leslie L. Roos, Sandra M. Sharp, and Andre Wajda 1989; Leslie L. Roos, Cameron A. Mustard, J. Patrick Nicol, Dale F. McLerran, David J. Malenka, T. K. Young, and Marsha M. Cohen 1993; Leslie L. Roos and J. Patrick Nicol 1999). Analyses based on the data have compared favorably with those using primary data collection (Leslie L. Roos, Noralou P. Roos, S. M. Cageorge, and J. Patrick Nicol 1982). Recognizing its strengths, weaknesses, limitations, and potential, researchers view the database as a unique resource for policy-makers (Noralou P. Roos *et al.* 1996). Research based on these data has been published in a wide variety of medical and health policy journals.⁴

The Physician-Claim File includes all physicians' billings for medical services provided under a fee-for-service arrangement. Some Manitoba physicians are salaried, but the practice in almost all cases is to submit "shadow billing" to Manitoba Health. All claims include diagnosis and fee. Services billed include ambulatory and hospital care, diagnostic imaging, and laboratory tests. The structure and organization of physicians' fee

schedules in Canada are similar to those in the US. The Hospital-Separation Abstract File contains details of each admission documented at discharge. Information includes diagnostic and procedure codes, admission and discharge dates, and patient demographics.

Provinces fund hospital care on a global facility basis rather than on a per case basis, so we used an established method to impute opportunity costs to hospital care; the costing method we used for hospital services in Manitoba is described by Greg Finlayson, Noralou P. Roos, Phil Jacobs, and Diane Watson (2001). We used resource intensity weights, provided by the Canadian Institute for Health Information, to impute appropriate per diem costs to different kinds of admissions and procedures (Phil Jacobs, Marian Shanahan, Noralou P. Roos and Michael Farnworth 1999). This method omits capital costs, the cost of blood and blood products, and salaries for residents and trainees.⁵ Costs associated with physician services in the hospital are recorded in the Physician-Claim File.

We divided the data into three fiscal years and examined each twelve-month period independently. In each year, we attributed costs to each individual, divided the population by sex and age, and ordered each age-sex group into deciles based on total cost incurred. Costs for individuals who died during the year were included until the date of death. Individuals who moved out of the province and left the plan before the end of the fiscal year were eliminated from the study. Because the results were similar for all three fiscal years, the results reported and discussed here are for fiscal 1999, the most recent data available to us.

Figure 1 shows mean per capita healthcare costs by age group for women and men, measured in Canadian dollars.⁶ Beyond infancy, mean expenditure increases with age for both men and women. Mean costs for men exceed those for women for people less than 15 or more than 64 years old. For people between the ages of 15 and 64, mean costs for women are greater than for men. The higher mean cost for elderly men is likely to be a statistical artifact. Our data suggest that costs are very high in the six months prior to death. Within any given twelve-month period, more men than women will be in the final six months of their lives for most ages above 65, and therefore will incur higher per capita costs. Only at advanced ages do the mortality rates for women, and therefore higher per capita costs, approach those of men. When adjusted for the higher age-related mortality for men, the discrepancy largely disappears (Mustard, Kaufert, Kozyrskyj, and Mayer 1998).

At every age for both men and women, expenditure is highly skewed. At least 80 percent of the people in each group spend less than the mean for their age and sex. For the population as a whole over three years, the healthiest 50 percent of the population uses 4 percent of the resources, while the sickest 1 percent accounts for 26 percent of the costs.

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Figure 2 shows mean per capita healthcare costs for the healthiest 70 percent of men and women in each age group. Expenditures by this healthy 70 percent of the population represent the kind of low-cost, routine medical

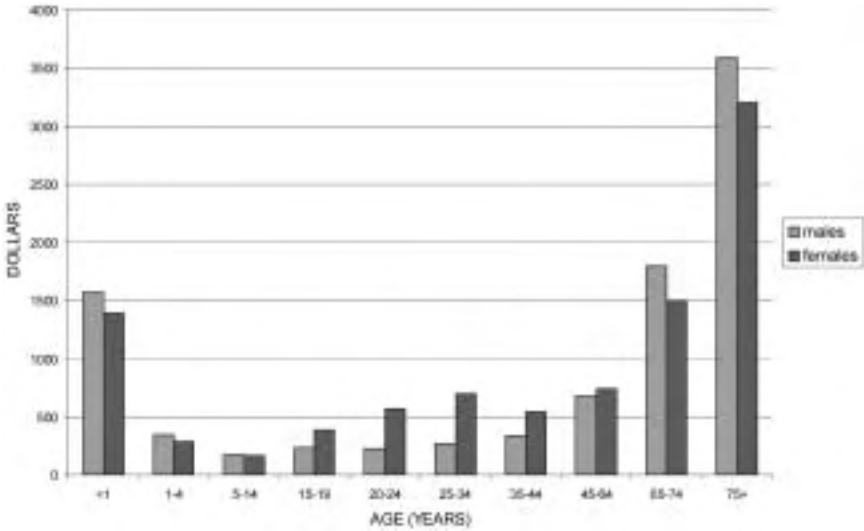


Figure 1 Mean per capita expenditures for men and women by age (Fiscal 1999)

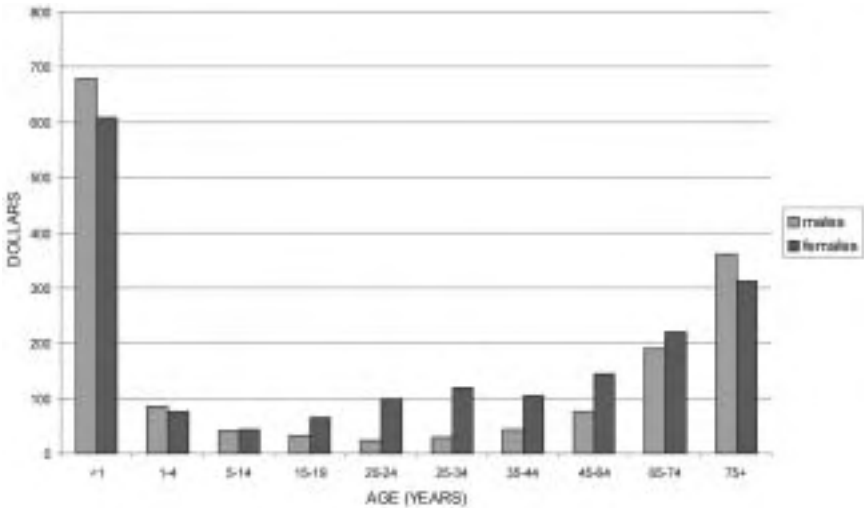


Figure 2 Mean per capita expenditure of the healthiest 70 per cent by age and gender (Fiscal 1999)

care that Canadian health insurance currently pays for in its entirety, but that proposed reforms would leave either entirely or partially to individuals.

Figures 3 and 4 show the expenditure patterns for men and women by cost decile in two different age groups. The dramatic rise in costs for the

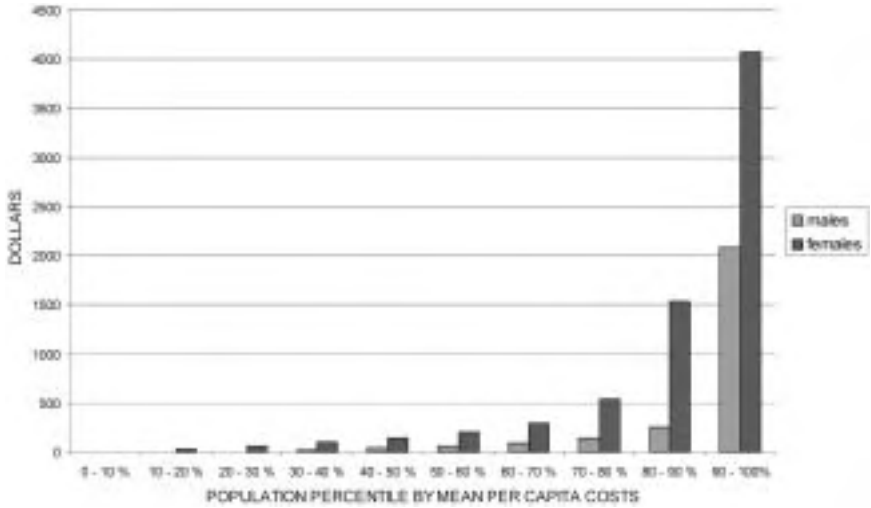


Figure 3 Distribution of costs incurred by women and men aged 25 to 34 (Fiscal 1999)

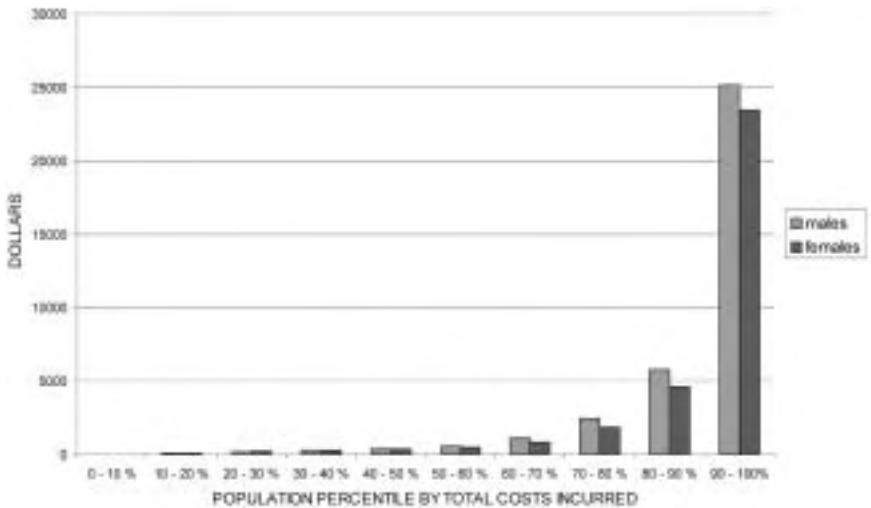


Figure 4 Distribution of costs incurred by women and men aged 75 or more (Fiscal 1999)

highest two cost deciles shows the degree to which health expenditures are skewed. For example, the mean cost for the healthiest 70 percent of 25–34-year-old males is under C\$100, while the mean cost for the sickest 10 percent is over C\$2,000.

That healthcare expenditure is skewed is not a new finding. In many different jurisdictions, a small percentage of the population accounts for a very large proportion of total costs. But the gender differences are less often noted. The costs for nonelderly men tend to be more skewed than costs for women of comparable ages. Figure 3 represents a relatively young and healthy age group: except for certain marginalized groups, chronic conditions have yet to make a significant impact on care patterns. Men in this age group tend to be either very low or catastrophic users. Most catastrophic costs for this age group are related to accidents. Women, as is typical, have a less skewed expenditure pattern. Most women in this age group visit a physician at least once a year, and many have expenditures related to childbirth. They thus face higher mean costs than do men.

Figure 4 represents healthcare costs by decile for men and women older than 75. Because of relatively small numbers, we chose not to subdivide this age group further. Above age 75, almost everyone has some healthcare expenditure. Catastrophic users may well be in the final months of their lives, where costs are concentrated. Because women are past their childbearing and child-rearing years, the differences in overall utilization patterns between men and women are minimal. Costs for men are marginally higher throughout the distribution, possibly because men suffer higher age-related mortality at many of the ages in this group and more men will consequently be in the final months of their lives (Cecile M. T. Gijbbers van Wijk, Annemarie M. Kolk, Wil J. H. M. van den Bosch, and Henk J. M. van den Hoogen 1992; Health Canada 2001). A number of studies have demonstrated that people incur a substantial portion of total healthcare costs during the final few months of life (Noralou P. Roos, P. Montgomery, and Leslie L. Roos 1987; James D. Lubitz and Gerald F. Riley 1993; Gwyn Bevan 1996).

The distributional implications of differential expenditure patterns for men and women under different kinds of health insurance schemes have not yet been addressed.

HOW WOULD PROPOSED HEALTHCARE REFORMS AFFECT MEN AND WOMEN?

Residents of Manitoba currently have access to physician and hospital care at no cost to the individual. Many critics argue that this is a very costly method of providing healthcare because individuals who face no financial incentive to constrain their use of healthcare resources will routinely place higher demands on the system than those who share the costs of their

health-seeking behavior. Our data cannot tell us whether resources are being appropriately allocated or whether certain individuals are imposing excessive costs on the system by demanding medically unnecessary care. But there is little evidence of widespread profligacy. Most people at every stage of life seem to use relatively little healthcare.

The proposals to subject Canadian healthcare to market forces by limiting demand include the introduction of user fees, caps on individual benefits, tax credits for nonusers, or specific taxes for heavy users, as well as the introduction of medical savings accounts. We focus on medical savings accounts because these were the focus of a recent and very vocal campaign by the Fraser Institute, the Atlantic Institute for Market Studies, and the Consumer Policy Institute, all policy advocates that favor market solutions to a wide variety of social issues. Healthcare in Canada is a provincial responsibility, and the province of Alberta accepted the idea of medical savings accounts, going so far as to set up a committee to facilitate their implementation. Two recent national reports on Canadian healthcare, however, ultimately rejected the concept after a loud and long debate between advocates and critics. Both reports cited two papers for their dismissal of the idea. In one paper, Samuel Shortt demonstrated that advocates of medical savings accounts tended to misstate the experience of other jurisdictions with medical savings accounts, and in the other, we showed that government healthcare expenditure would increase under any set of reasonable specifications (Evelyn L. Forget, Raisa B. Deber, and Leslie L. Roos 2002; Samuel E. D. Shortt 2002). No one has yet examined the differential implications for women and men of such a significant reform.

Medical savings accounts can take a variety of forms, but some essential features characterize all models. Individuals receive an allowance designed to pay for routine care, and at some level, which we term the catastrophic threshold, catastrophic medical insurance picks up any additional costs. Individuals pay the full costs of their care from their allowance. Between the allowance and the threshold is a corridor in which individuals are expected to pay the full costs of their care, either out-of-pocket or through private health insurance. Models differ on the levels established for the allowances and thresholds, and the principles used to adjust these levels. Some plans, particularly in a market-oriented system such as that of the US, create the allowance from individual contributions (often established at some portion of annual income), which may be tax-deductible. These plans often also include private catastrophic insurance, the premiums for which are payable from the allowance. In a public system such as Canada's, most advocates suggest that provincial governments pay the allowance from general tax revenues, using what they currently spend on physician services and block funding for hospitals. Most advocates, but not all, suggest that the government, instead of private insurers, similarly provide catastrophic

insurance. A final difference between plans is what would happen to any surplus in the individual accounts at the end of the fiscal year. Most plans would allow individuals to keep any surplus for use against future healthcare expenditure, but some would allow individuals to divert these savings to retirement plans or other expenditures. Other plans, particularly those contemplating government allowances, would claw back at least some portion of any surplus.

We have demonstrated elsewhere that medical savings accounts involve the transfer of resources to relatively healthy individuals and the imposition of additional out-of-pocket expenses on the sickest individuals in any cohort (Forget, Deber, and Roos 2002). When individuals may keep any surplus in their accounts and government-provided insurance picks up catastrophic healthcare costs for individuals, then costs to the province are necessarily greater than those imposed by the current system. Governments, then, would face the prospect of paying for the “incentives” offered to healthy individuals without being able to recover these costs from the sickest individuals. Figure 5 demonstrates the way such a system would work.

Healthy people who consume few healthcare resources would have a surplus in their accounts, represented by the difference between their use and the allowance. Everyone who consumes more than the allowance (including any money saved from previous years) would be responsible for costs falling in the corridor. Catastrophic costs, above the threshold, would be paid by government-provided insurance. Those whose allowance could cover additional costs might nevertheless choose to forgo care, advocates of

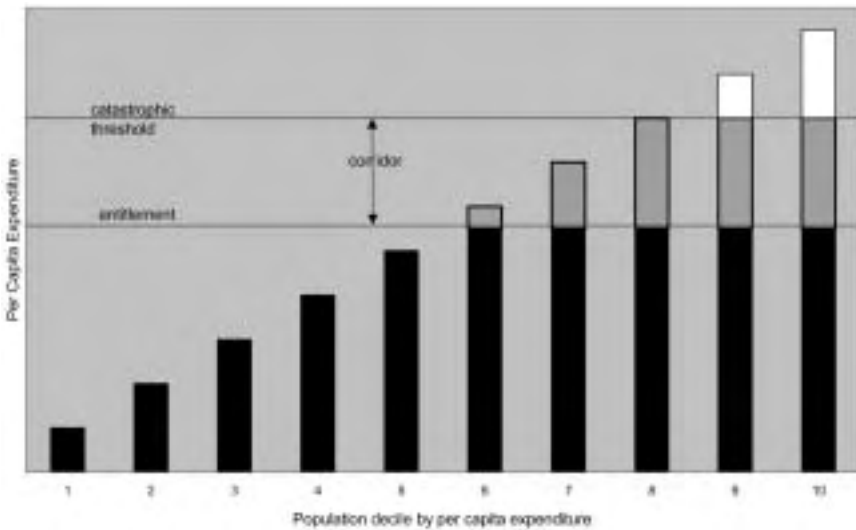


Figure 5 A hypothetical example of a medical savings account

financial incentives say, because they place greater value on saving part of the surplus for future healthcare needs. Those exhausting their allowances would face the immediate prospect of paying their healthcare costs and also may decide to forgo care. Clearly, those people who have catastrophic healthcare needs have no incentive to economize because at the margin the government pays all costs, while people whose costs fall into the corridor face an immediate incentive to forgo healthcare because they pay 100 percent of their costs at the margin. To the extent that low users retain any surplus in their accounts, they too have an incentive to use fewer resources. From the point of view of the government funder, however, reductions in use by low users are offset by the cost of the incentive transferred to these individuals to induce them to be frugal. If individuals are permitted to keep the entire surplus in their accounts, the government funder saves nothing – and indeed pays more – even if low users reduce their healthcare expenditure. Further, this system imposes significant costs on the sick: people whose costs exceed the allowance must either pay for their use of healthcare or use less.

We should perhaps note explicitly that most advocates of medical savings accounts argue that reductions in the use of healthcare induced by financial incentives are benign, in the sense that such reductions are likely to have few adverse health effects. There is, however, no reason to assume that individuals are more likely to forgo nonessential services. The best evidence that exists for how individuals react to financial incentives comes from the RAND health insurance experiment in the United States. The authors note that “cost sharing . . . reduces appropriate and inappropriate services – or highly efficacious and relatively inefficacious services – by the same proportions,” and they suggest that their findings did not support “the theory . . . that cost sharing reduces the least-valued services” (Joseph P. Newhouse and the Health Insurance Experiment Group 1993: 162).⁷ More to the point, if women forgo routine preventive care, including pap smears, mammography, prenatal care, and so on, it is likely that there will be health consequences.

To date, proposed reforms have not considered the differential impact of medical savings accounts by gender. Women have higher healthcare costs than men for many years of their lives. Although higher allowances for women than for men could cover these higher mean expenditures, one difference that a plan cannot adjust for is the fact that more women than men are moderately high spenders, especially during the childbearing years. That is, even with higher allowances, more women than men would have expenses falling into the corridor. Because the corridor represents a tax on relatively heavy healthcare users, the size of the burden imposed on women as opposed to men would depend on the precise formulations of the plan, including the levels set for allowances and the catastrophic threshold.

The analysis of expenditure patterns for men and women aged 25 to 34, as shown in Figure 3, has shown that women have less skewed expenditure and use healthcare more frequently, while men use healthcare for catastrophic costs. Women, because they are more likely to be moderate users, are more likely to fall into the corridor even if allowances are adjusted to reflect mean differences by gender.

As a second example, consider men and women aged 75 or above. Older women and men both have higher mean healthcare costs than do younger people, but the surprising outcome is that even for these elderly people, most consume relatively few physician or hospital resources. This evidence would seem to limit the scope for those who advocate user fees and medical savings accounts as a method to constrain undisciplined demand. There is little evidence that Manitoba residents, even older people who might be expected to require substantial medical care, consume resources with abandon.

The data very clearly show that women of childbearing age do tend to have higher mean and median per capita expenditure than men of comparable age. How much of this is due to simple biological need, how much is due to provider-induced demand, and how much is due to different health-seeking behavior on the part of those charged with the care of young children cannot be inferred from the data. Nor can we know whether different practice patterns, such as the substitution of midwives for obstetric care, might lead to lower costs or better outcomes. We do not know whether the care received by any population group, including women of childbearing age, is appropriate. Nor do we know, on the basis of this study, whether there are nonfinancial or extrasystemic barriers to care. We do know that women in Manitoba face no financial barrier related to user fees, co-payments, or deductibles when they seek physician services or are referred for hospital care. Higher costs associated with childbearing will also occur in other regimes, where private health insurance, out-of-pocket expenditure, and managed care might play a larger role. The difference is that in a single-payer insurance regime with first-dollar coverage – that is, in a system with no user fees, co-payments, or deductibles – the public purse will cover the full extent of these costs. Moreover, healthcare will not be rationed by price, as might occur when individuals pay some of their own costs; normally, we would expect this rationing to be greatest in people of lower socio-economic status who are making decisions about preventive or routine care. At least partly as a consequence of universal access, Canadian medicare represents a significant transfer of resources to women of childbearing age.

Ideally, we would have liked to calculate the transfer net of tax payments used to fund medicare. Unfortunately, this calculation was not possible for a number of reasons. Health services are primarily a provincial responsibility, and a complex cost- and tax-sharing arrangement between

each province and the federal government determines funding. The ways that each province uses taxes to support the scheme vary substantially. In Alberta, Ontario, and British Columbia, for example, each insured member pays a flat tax unrelated to age, income, sex, or actual or presumed use of the system. This tax pays for part of single-payer insurance, with the remainder coming from general tax revenue. In Manitoba, general provincial revenue funds medicare. Almost half of the provincial budget is, however, a transfer to the province from the federal government, either as a transfer for program funding or as equalization payments from the richer provinces.⁸ The calculation of tax incidence by demographic group, therefore, becomes quite complex and is well beyond the scope of this study. An initial attempt to calculate the net transfer (Cameron A. Mustard, Morris L. Barer, Robert G. Evans, John Horne, Teresa Mayer, and Shelley Derksen 1998) uses 1995 institutional assumptions, which have changed substantially. However, the direction of the bias is clear. As a group, women of childbearing age and those who care for small children still have lower incomes and fewer assets than do men of the same age. Consequently, these women as a group will pay less tax on their incomes and on consumption. Therefore, the transfer represented by payments made on behalf of women by the medicare system alone will understate the actual net transfer, which is reinforced by the (mild) progressivity of the overall tax system.

CONCLUSION

Any change in regime that imposes user fees, co-payments, or deductibles, or establishes medical savings accounts, attempts to constrain demand. Because they are disproportionate users of healthcare resources, women of childbearing age will feel the impact of these changes more heavily than men of the same age. That is, such changes will undermine the transfer of resources from men to women. Childbearing and childcare is unpaid social labor in which all members of society presumably have an interest. The existing medicare system in Canada represents a form of social wage paid as in-kind healthcare services to these women. While neither intended nor recognized by those who designed the medicare system, its consequence is nonetheless to address a remaining inequality of access to resources by gender and age. Any regime change that emphasizes market principles not only disadvantages this group of women, but also undermines a very significant form of social payment. If access to healthcare is considered a right, then the proposed reforms may even be seen as an additional tax on women.

The key message of this study is that no single social policy ought to be evaluated in isolation. All social programs represent attempts to balance issues of equity, access, and efficiency. Over time, these programs evolve

(with and without the express intentions of social policy designers) to create a web of entitlements and costs that impact different members of a society quite differently. As Reinhardt reminded American economists fifteen years ago, we must be ever mindful of “society’s concern over distributional equity, which does not set healthcare apart from most other commodities. ‘Greater efficiency’ in abstraction . . . is simply an oxymoron” (1989: 341). In the case of proposed health reform in Canada, attempts to make the system more efficient by imposing market discipline on consumers ignore the network of cross-subsidies that have grown up in the medicare system. These subsidies force us, often without our express recognition, to provide care for those whose needs are greater or whose resources are less than average. This resource transfer is, without doubt, not the most straightforwardly constructed form of taxation. Yet it is part of the implicit social contract upon which Canadian society is based. Social contracts can, and often do, develop without anyone recognizing all of their implications. It is incumbent, however, on those who would recommend large changes to understand all of the implications of what they propose.

This study has produced data that challenge attempts to reduce healthcare costs by imposing market discipline on healthcare consumers. Not only is there little evidence of widespread profligacy on the part of Manitoba healthcare users, but also the use patterns suggest that the current system of universal, single-payer coverage of all residents with no deductibles or co-payments leads to desirable distributional outcomes (Noralou P. Roos, Evelyn L. Forget, Randy Walld, and Leonard MacWilliam 2004). In particular, it represents a transfer of resources from the young to the old, from the rich to the poor, and especially from the rest of society to those women who still provide most of the unpaid social and reproductive labor that allows society to continue. Like any study, this one has limitations. We would very much like to extend the analysis to consider different types of households (childless single, single parent, childless couple, parent couple, and so on). We currently code our data by individual rather than by family. Subsequent analyses will build on family identifiers that will allow us to track expenditure by families as they evolve over time through marriage, common-law arrangements, divorce, birth, and death.

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ACKNOWLEDGMENTS

We are grateful to Nancy Folbre and two anonymous referees for their very helpful comments. Manitoba Health provided access to the administrative data used in this paper (Project No.: 2000/01-47). The study's endorsement by Manitoba Health is not intended, nor should it be inferred. We are pleased to acknowledge the financial support of the Canadian Institute for Health Research (Grant No.: CIHR MOP-68888 2002-4).

NOTES

- ¹ For links to many of these proposals and our responses, see our website: http://www.umanitoba.ca/centres/mchp/hot_topic/msa.html. The Fraser Institute submitted a discussion paper to the Romanow Commission (see Roy J. Romanow 2002) that encapsulates many of these themes (Migué 2002).
- ² Sex-specific conditions are those that impact differentially as a consequence of the biology of men and women, such as breast cancer, even if social aspects of gender influence these conditions and their treatment. Men do not have hysterectomies, and therefore these are sex-specific, even though many argue that practice patterns that result in a proliferation of hysterectomies are a consequence of a particular gendered society.
- ³ Manitoba typically ranks in the middle of the ten Canadian provinces with respect to major socio-economic and demographic variables. The population is slightly older and has a moderately higher proportion of aboriginal people than the Canadian average, both groups tending to have slightly poorer health status on average. But for the purposes of our study, the province is broadly representative of Canada.
- ⁴ A PubMed search using the keywords "Manitoba administrative" yielded seventy-four hits (thirty-two since 1999), ranging from the *New England Journal of Medicine*, *Social Science and Medicine*, the *Canadian Medical Association Journal*, the *Milbank Quarterly*, and *The American Journal of Public Health*, to such condition-specific journals as *Cancer* and the *American Journal of Urology*. Note that this search would not find articles that identify the same data using other words, such as "claims registry" or "physician-claims file," nor would it uncover research reports that use these data but are not indexed in PubMed. The linked database is widely used by clinician scientists, epidemiologists, and population health researchers in Canada.
- ⁵ We captured and allocated to individual patients approximately 58 percent of the total amount the province claims to spend on hospital funding. The remaining 42 percent of hospital expenditures fall in the following categories: services to nonresidents of Manitoba, outpatient services (including emergency department care but excluding

day surgery), physician remuneration (both physicians delivering direct services and those providing administrative services), building capital costs, and the “overhead” costs associated with each of these categories. The fees paid to physicians who provided services in hospitals were reported as part of the physician services costs. Our data do not capture salaries paid to trainees, such as house officers.

⁶ During the period 1997–99, when these data were generated, the Canadian dollar hovered about C\$1 = US\$0.64.

⁷ For further discussion of the relationship between our analysis and the RAND health insurance results, see “Medical Savings Accounts in a Universal System: Wishful Thinking Meets Evidence” (Raisa B. Deber, Evelyn L. Forget, and Leslie L. Roos 2004).

⁸ There have typically been three “have” provinces – Ontario, Alberta, and British Columbia – and Manitoba has always been a “have not.” The distinction is based upon gross domestic product per capita, with those generating less than the national average receiving equalization payments in order to provide residents of these poorer provinces with roughly comparable public services.

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