Controversy

Rebuttals

Dr. Gordon and colleagues respond:

Steven Lewis (page 497), by dismissing our commitment to Canadian medicare,[1] misses the main point of our article. Our view is that recent health care cutbacks have resulted from governments relying on "distortionary" income taxes, at high rates, to fund health care expenditures. If one were to shift to a more efficient and still equitable source of revenue, the cost of raising revenue to fund public expenditures would decline, thereby allowing governments to spend more on socially valuable programs.[2]

Our proposed tax-based benefit system would improve efficiency by making service providers more accountable and recipients more conscious of the costs and treatment options of health care delivery. Lewis views the lack of accountability as a good thing because it saves costs. We believe that the current funding system promotes inefficiency and thereby imposes significant societal costs. Concerns about the costs of tracking utilization are exaggerated, especially since Ontario is already implementing a system to inform patients of their care costs.[3]

An alternative funding scheme based on user fees, which is gradually creeping into the system, encourages efficiency but sacrifices equity. Our proposal is more equitable than a user-fee system, in which poor people suffer disproportionately compared with rich people, a point not apparently understood by Lewis. The funding mechanism we propose would be progressive because the amount paid would increase as a proportion of income (low-income people would be exempt). In addition, it could allow for an expansion of health care services covered by medicare (e.g., dentistry, universal drug coverage, home care), a move contrary to the recent step-wise increase in services falling into the private sector.[4]

The issue of equity can only be considered over the lifetime of the individual. The discussion by Lewis of our revenue estimates is way off the mark. One cannot look at a single year and suggest that the tax is unfair to elderly people and those who are sick in that year. Everyone uses the health care system at some time. On a lifetime basis, our proposal would not discriminate against the sick.

We support a publicly funded universal health care system. It is a matter of how to fund the system in an efficient and equitable manner that may determine its long-term viability.

Michael Gordon, MD
Jack Mintz, PhD
Duanjie Chen, PhD
University of Toronto
Toronto, Ont.

References

1. Gordon M. A system worth saving. *CMAJ* 1996;154:1395-6.
2. Dahlby B. The distortionary effect of rising taxes. In Robson WR, Scarth W, editors. *Deficit reduction: What pain, what gain?* Toronto: C.D. Howe Institute; 1994. p. 44-72.
3. Patients to get peek at what doctors bill OHIP. *Toronto Star* 1998 July 10;Sect A9.
4. The health report. *Macleans* 1998;June 15:14-44.

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Mr. Lewis responds:

Repeating unsubstantiated assertions and faulty logic does not make them valid. None of the points raised in the rebuttal by Gordon and colleagues rescues their case.

Their principal claim is that taxing the sick to raise some revenue, rather than taxing everybody to raise all the (public system's) revenue, promotes efficiency and improves fairness. These are important and entirely unsubstantiated claims. To claim that the implicit transfer of income from the sick to the healthy serves to save medicare may get high marks for its bizarre creativity, but it fails on all other counts.

The choice is not between a user-fee system and a taxing-the-sick regime proposed by Gordon and colleagues, as they would have us believe. It is between their scheme and the progressive, universal, tax-based system we have now. They are fixing a problem we don't have by destroying principles most of us cherish.

Saskatchewan Health used to send people annual statements of the costs of the services they had used. It quit doing that. People didn't know whether they should feel guilty or virtuous, and the government couldn't explain what the point was. Nor was there any attempt to calculate costs (particularly hospital costs) accurately on an individual basis.

The proposed system *must* discriminate against the old

and the sick to raise revenues, and *must* hit individuals hardest when they are sick and old. Only if all of us were precisely identical in health status and service use over a lifetime would the proposal be non-discriminatory. Fantasy cannot eliminate discriminatory taxation; sound policy can.

Gordon and colleagues assert, but do not document, that my estimates of how much revenue their scheme would gross (not net) is "way off the mark." My analysis points out the fundamental flaws in their assumptions and transparently recalculates revenue potential, erring if anything on the high side. Let careful readers decide who's on and off the mark.

Steven Lewis, MA
Health Services Utilization
and Research Commission
Saskatoon, Sask.

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