FRASER FORUM

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On Balance

Canada's Health Care System: Ideas for Reform

Articles on:

- Don't Believe Everything the "Experts" Say About Health Care
- How to Ruin a Good Idea—Lessons from the British Columbia Ministry of Health
- Patient Empowerment in Europe
- Controlling Drug Costs

On Balance *Feature:*

- Private Health Care: The Editorial Opinion

February 1998

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Editor's Notes

The federal government is engaging in a lot of self-congratulatory back-patting these days, pleased with its projected budget surplus and ensuing "fiscal dividend." As a result of this potential surplus, for the past several months the government has been sounding out the public, in the form of musings in the media, about how to spend it. The middle-of-the-road solution it bandies about most often is that 50 percent should be spent on increased program spending, and 50 percent on a combination of tax cuts and debt repayment.

One beneficiary of the increase in program spending is sure to be health care, despite the fact that only the provinces are supposed to have decision-making power in this area. But is pouring taxpayer money, federal or provincial, into government-run health care the best use for the surplus? In this issue of *Forum*, several authors examine the Canadian health care system, and look at ways it can be made more cost-efficient and effective.

The solutions you will find on these pages are innovative; they include a lot more than simply extra government spending in the area.

—Kristin McCahon

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Cover Story

Don't Believe Everything the "Experts" Say About Health Care

David Gratzer

Recently, Toronto's Consumer Policy Institute entered the medicare debate by endorsing a plan to reform the financing of the health care system. Under its proposal, the government would directly give Canadians money in the form of "health allowances" to spend on their own health care needs.[1]

The proposal sparked sharp criticism from Deber Raiser, a professor in the department of health administration at the University of Toronto. Raiser argued that small problems would be neglected if people had a financial incentive not to see a doctor. "The whole idea behind health promotion—making people healthy instead of treating them when they're sick—is that you don't want people to come in until they have a heart attack or a diabetic coma."[2]

The criticism seems pretty effective. Creating a disincentive for health care abuse may sound like a good idea, but can it work? Does the average person really know the difference between a flu and meningitis, a mole and melanoma, heart burn and a heart attack? Encouraged not to use the system, could a patient not then *under use* health care, resulting in higher long term costs?

This argument is made by many other Canadian health care "experts." From University of British Columbia's health economist Bob Evans[3] to family physician and author Michael Rachlis,[4] most of the "experts" agree that health care ought to be free because ordinary citizens have no way of properly judging their own health care needs. The argument made by such "experts" is so effective that, of the major academic health policy centres in Canada, not a single one researches the concept of user fees or health allowances as a mechanism of reform.[5]

The argument is persuasive; its implications, profound. There's just one problem—it's wrong.

In the 1970s, the California-based RAND think tank set out to resolve this very issue. They tapped the expertise of some of the top scholars in the world to design an experiment that would measure the effects of

1 The CPI proposes that minor health care expenses—visits to the family physician, X-rays and other tests, and preventive medicine—would be paid from the government-funded health allowance while major health expenses—bouts with cancer, chronic illnesses, etc.—would be covered by government-funded mandatory catastrophic health insurance. The CPI's health allowance proposal is similar to the medical savings account system that has been advocated by The Fraser Institute for several years. The main difference between the two is that The Fraser Institute proposal allows for private spending on health care—a crucial element if the system is to work effectively.

2 Jane Coutts, "Group finds support in poll for health allowances idea," *The Globe and Mail*, November 13, 1997.

3 Robert G. Evans, *To Chelm and Back? Change & Resistance: Proceedings of the Sixth Canadian Conference on Health Economics*, pp. 6-31.

4 Michael Rachlis and Carol Kushner, *Strong Medicine: How to Save Canada's Health Care System*, Ontario: Harper Collins, 1994, pp. 154-160.

5 Based upon a conversation with Professor Ake Blomqvist, University of Western Ontario.

price on consumption and health outcomes. The RAND Health Insurance Experiment is one of the largest and longest running social science research projects ever completed. Headed by Harvard Professor Joseph P. Newhouse, it involved approximately 2,000 non-elderly families in the US, and ran from 1974 to 1982. The cost was a staggering $136 million (in 1984 US dollars).

The most interesting aspect of the RAND Health Insurance Experiment for the Canadian health care debate involves the use of medical services (additional work was done on dental and mental health services). Families were assigned two fundamentally different types of health insurance plans: a free care plan and a user-fee plan. Individuals with the free care plan paid no out-of-pocket expenses while the user fee group paid a certain percentage of their health costs up to a maximum of $1,000 (depending on their family income). In other words, individuals with the free care plan never paid a penny for any of their expenses: visits to the family physician were as free as a visit to the emergency room. The user-fee program was different in that individuals did pay part of their expenses out-of-pocket.

The RAND Health Insurance Experiment serves as an excellent test of the influence of price on health care demand. If health care is not influenced by price, there should be no difference in the expenditures of the free care group and the user-fee group. However, if price does influence demand, expenditures would be lower with the user-fee group, because these people had an incentive to spend less money.

So what did RAND find out? It found that the "use of medical services responds unequivocally to changes in the amount paid out of pocket."[1] Individual expenses in the free care plan were significantly higher than those in the user-fee group. Expenses were 45 percent higher for the free care individuals.

Comparing the free care group with the 95 percent user-fee group (up to $1000), it was found that in any given year, the free care people were more likely to:

- use medical services (28% higher probability),
- to see a physician more regularly (67% more visits), and
- to get admitted to the hospital (30% higher probability)

Even when people paid a rather small user fee (25% of total costs), there was a noticeable drop in health expenditures—10% less than the free plan.

The conclusion? Price influences demand.[2]

But what affect does having to pay for health care services have on individuals' health status? After all, it's all well and good that they consumed fewer medical services, but were they sicker as a result?

Again, the RAND Health Insurance Experiment is unequivocal: "Our results show that the . . . increase in services had little or no measurable effect on health status for the average adult."[3] People under the free care plan used more services, but it didn't matter. The RAND group noted that in only one specific instance did the free care plan have benefits over the user fee plan: for the poor with high blood pressure levels. The authors conclude, however, that a one-time screening examination accounted for most of the lower blood pressure levels seen in the free care plan.[4]

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1 Joseph P. Newhouse and The Insurance Experiment Group, *Free for All? Lessons from the RAND Health Insurance Experiment*, Cambridge, Massachusetts: Harvard University Press, 1993, p. 40.

2 The RAND study is not alone in its sweeping conclusions on the effects of user fees on patient use of health care services. See Martin Feldstein, "Econometric Studies in Health Economics," *Frontiers of Quantitative Economics*, North Holland Press: the Netherlands: 1974; and R.G. Beck, "The Effect of Co-Payment on the Poor," *The Journal of Human Resources*, vol. IX.

3 Joseph P. Newhouse et al., p. 243.

4 Joseph P. Newhouse et al., p. 243.

Health in Canada

How to Ruin a Good Idea—Lessons from the British Columbia Ministry of Health

Cynthia Ramsay

The bureaucrats at the British Columbia Ministry of Health has a lot of good ideas. They know that health promotion and population health programs can be cost efficient and effective. They recognize that health care consumers (patients) like to have some choice in the types of health care they receive. As well, they understand the importance of ensuring that every British Columbian, regardless of their income, has timely access to quality health care whenever they need it. However, when it comes to implementing these good ideas, the Ministry of Health is unwilling to give up any of its control over the system. Here are but a few recent examples of good ideas gone wrong, thanks to the BC Ministry of Health. In every instance, the Ministry took the opportunity to expand its realm of authority, and by doing so, ruined the good ideas.

Idea 1: Cancer screening is a good idea; releasing confidential records is not

Some health promotion and population health programs are cost efficient and effective (table 1). More than one study has concluded that, for women over 50 years of age, regular mammograms every couple of years helps in the early detection of cancerous lumps, thereby increasing the chances that treatment will be effective. This approach to health care can not only prolong many people's lives, but it can save the health system money. These "savings" then can be spent on other BC health concerns, such as improving ambulance services and access to diagnostic testing. These are reasons why the government's provincial cancer screening program is a good idea.

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Cost savings aside though, the main purpose of these programs is to educate people so that they can make wise health care decisions. The premise behind the programs is that if people understood that tobacco contributes to the development of lung cancer, they would *choose* to not smoke. If people knew that eating junk food is bad for their health, they would *choose* to eat more nutritious foods. If women knew what their risk of breast cancer was, and what the benefits of early detection were, they would *choose* to have a mammogram every couple of years once they reached age 50.

Do we really want to give up our freedom to make our own choices, good or bad?

The BC Ministry of Health forgot the most crucial point of these programs—to help people make intelligent *choices*. They decided to release confidential patient records—without patients' knowledge or consent—to the BC Cancer Agency so that the BCCA could direct mail the women between 50 to 74 years of age who are *choosing* not to have mammograms. Ministry officials no doubt believe that they are acting in the public good, but what's next? Do we really want to give up our freedom to make our own choices, good or bad?

Table 1: Some Life-Saving Interventions and Their Cost-Effectiveness

Life-Saving Intervention	Cost/Life-Year in $US*
Childhood immunization programs	≤ $0
Influenza vaccination for all citizens	$140
Influenza vaccination for high risk people	$570
Pneumonia vaccination for people aged 65+	$2,200
Pneumonia vaccination for people aged 45-64	$10,000
Pneumonia vaccination for high risk (low risk) people aged 25-44	$14,000 ($66,000)
Pneumonia vaccination for people aged 2-4	$170,000
Universal prenatal care for women	≤ $0
Smoking cessation advice for pregnant women who smoke	≤ $0
Smoking cessation advice for people who smoke more than one pack per day	$9,800
Cervical cancer screening every 3 years for women aged 65+	≤ $0
Annual (vs. every 3 years) cervical cancer screening for women aged 65+	$49,000
Mammography every 3 years for women aged 50-65	$2,700
Annual mammography for women aged 55-64	$108,400

*≤ $0 indicates an intervention that saves more resources than it costs.
Source: Tammy O. Tengs, et al. "Five-Hundred Life-Saving Interventions and Their Cost-Effectiveness," *Risk Analysis*, vol. 15, no. 3 (1995): pp. 369-390.

Idea 2: Increasing patient choice is a good idea; creating another legislated monopoly is not

In the nineteenth century, governments gave medical doctors the power to define what constituted medicine and who could practice it. By granting this professional monopoly, the government has contributed to our current reliance on the "medical model," treating illness rather than promoting health.

In recent years though, more Canadians have begun to opt for alternative health care such as chiropractic or acupuncture, and the monopoly power of medical doctors has eroded somewhat. However, as people increasingly have been demanding the services of non-physician practitioners, there have been increasing demands by these providers for "official" recognition by the government (and hence, government funding). They, like the medical doctors before them, use the argument that such regulation is necessary in order to protect the public from unfit providers.

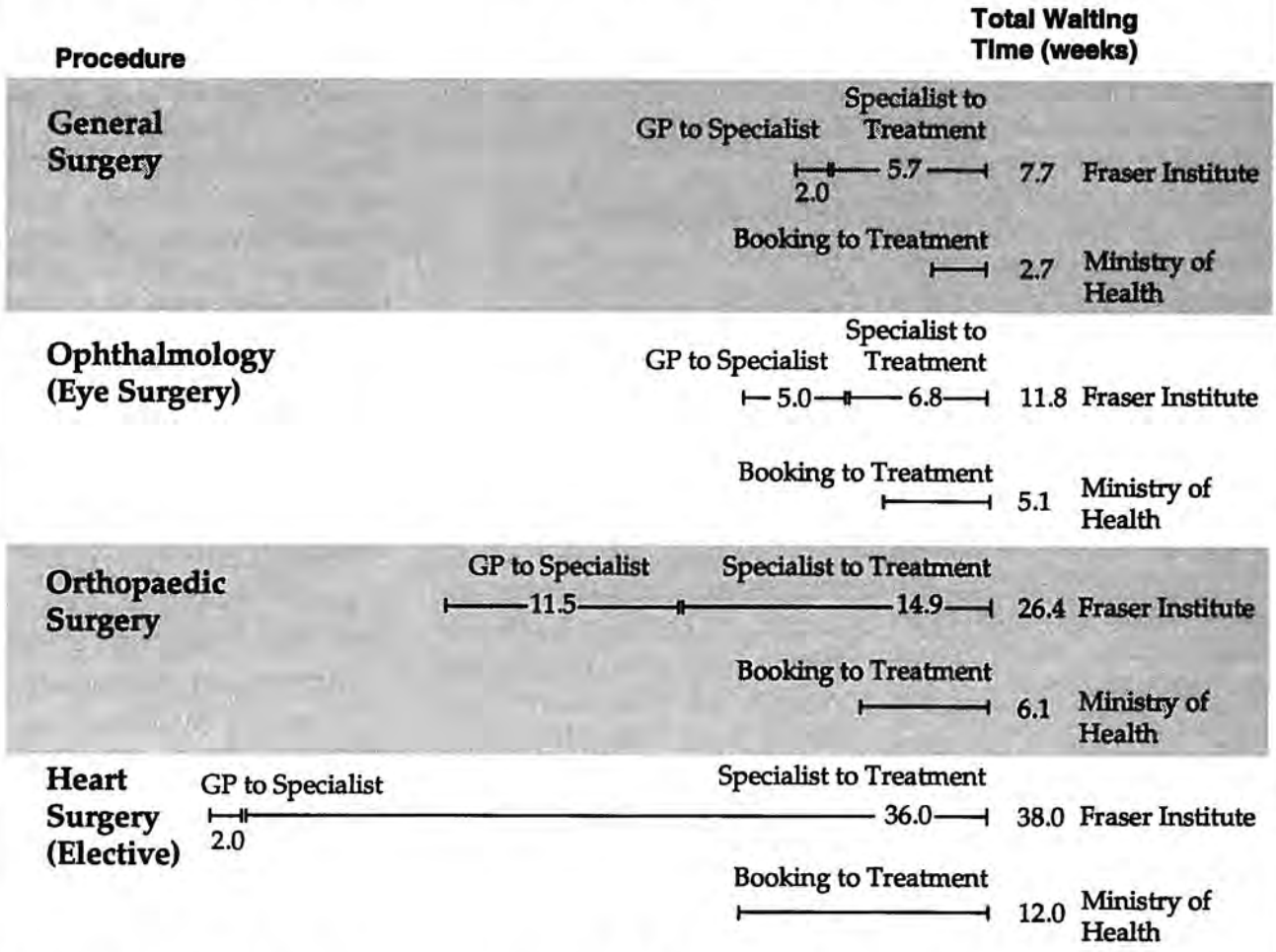
However, while "official" recognition is the preferred policy option for the group demanding it, it is not the best option for patients. It allows members of the "officially sanctioned" group to restrict entry into their occupation and, in effect, it gives each group a monopoly over a defined set of medical services, i.e., they do not have to compete with other groups to provide the designated services. As well, the members within the group no longer have to compete with each other in terms of price or the types of services they offer.

Recently the BC Ministry of Health established a College of Midwives. The newspaper headlines have read "Midwifery Gives Women a Choice" and "Demand for Midwives Rising."[1] However, while increasing patient choice is an excellent idea, creating another government legislated monopoly only prevents such freedom of choice in the end.

For example, before the government agreed to fund BC midwives, they charged between $1,500 and $3,000 for a course of care. By funding midwives' services at a flat rate of $2,250, patients have lost their ability to make quality comparisons between midwives on the basis of price. Obviously, a midwife who was offering a $3,000 course of treatment was offering

1 *The Vancouver Sun*, December 29, 1997, and January 7, 1998, respectively.

Figure 1: Wait Times for Elective Surgery in BC, 1996 (in Weeks)



Source: BC Ministry of Health and Ministry Responsible for Seniors, *Waiting List Report*, Fall 1997; Cynthia Ramsay and Michael Walker, "Hospital Waiting Lists in Canada," 7th edition, *Fraser Forum Critical Issues Bulletin*, Vancouver, The Fraser Institute, 1997.

different services than one charging only $1,500. With the new legislation, a midwife is a midwife—they are all members of the same professional organization, they will be paid a flat rate for a specified course of treatment. Midwives who are particularly good at their jobs will not get paid more. Midwives whose services are in great demand will not be able to offer more than 40 courses of care annually.

Since only people who register with the College of Midwives will be able to offer midwifery services, there is now a restricted supply of these services. This restricted supply will lead to rationing of care, since midwives are publicly funded; patients no longer have to worry about the costs, therefore, they won't. The demand for midwifery services has gone up since the legislation, not so much because they are now "official" members of the health care profession, but because their services are free to patients. It is only a matter of time before wait lists for midwives start forming. Indeed, there already are such lists for midwives in Ontario (the only province other than BC that has "officially" recognized them as a profession).

What should the BC Ministry of Health have done? How could it have truly increased *all* of the choices available to women, not just the number of government choices? It should have started to dismantle the system of legislated monopolies, replacing it with a system of certification. Certification provides an indication of the "attainment of certain

levels of proficiency" rather than specifying certain activities which only the certified group can perform. The market for services is more competitive than that with licensure or registration because health services can be purchased legally by consumers from either a certified or a non-certified provider. Certification allows for some overlap in the services which different providers can legally offer. It increases competition between the institutions certifying providers, and between the providers themselves. And competition is what drives innovation (research and development), creates efficiency, encourages quality of services, and increases the range of consumer choices.

Idea 3: Ensuring access to health care is a good idea; a government health care monopoly is not

Although BC spends more per capita on health care than any other province, there are real concerns about access to its health care system. British Columbia now has the longest waiting times for treatment after having seen a specialist than any other province.[1] Instead of reforming the health care system, the government seems intent on protecting the status quo and on minimizing the importance of waiting lists as a measure of the system's failure to meet the demands on it. There are 2 pieces of evidence to this effect: 1) the way in which the Ministry has chosen to measure wait lists, and 2) the strengthening of the Medicare Protection Act.

"Official" waiting lists

Last Fall, the BC Ministry of Health finally delivered on its promise to provide the public with regular updates on waiting times for surgery, treatment, and diagnostic services provided by BC's health care system. In *supposed* contrast to anecdotal evidence and to the results of The Fraser Institute's national hospital waiting list survey, which indicated that waiting lists were becoming longer in BC, the Ministry determined that waiting times for elective medical procedures have not changed significantly over the last few years.

. . . competition . . . drives innovation (research and development), creates efficiency, encourages quality of services, and increases the range of consumer choices.

However, the Ministry chose to define waiting as "the time the procedure is formally booked until it is actually carried out."[2] This means, for example, that you are not part of the Ministry's calculation if you have seen your specialist, found out that you need surgery but cannot be booked for surgery until the summer operating room (OR) schedule comes out. Since most hospitals only book OR times a few months out, this method of measuring waiting lists likely misses a large proportion of waiting patients.

Although BC spends more per capita on health care than any other province, there are real concerns about access to its health care system.

In contrast, The Fraser Institute defines waiting as the time you wait after finding out that there is something wrong with your health to the time you actually receive the treatment you need from the specialist. The Fraser Institute measures the entire waiting time: from your referral to a specialist by your general practitioner, to your appointment with a specialist, to the time you receive your treatment from the specialist.

Figure 1 gives a handful of examples, using BC Ministry of Health and Fraser Institute data for 1996, of the differences in

1 Cynthia Ramsay and Michael Walker, "Hospital Waiting Lists in Canada," 7th edition, *Fraser Forum Critical Issues Bulletin*, Vancouver, The Fraser Institute, 1997.

2 BC Ministry of Health and Ministry Responsible for Seniors, *Waiting List Report*, Fall 1997, p. 2.

waiting time measures, depending on how you define "waiting."

Enforcing the status quo

Using its waiting list numbers, the BC Ministry of Health has determined that the BC health care system is functioning well and thus needs to be protected. Its first news release of 1998 announces the enactment of the Medicare Protection Amendment Act. This Act further entrenches the government's monopoly over health services in the province. It strengthens "the provisions that prohibit extra billing and enhance[s] the [government's] ability to recover premium payments from people who are currently receiving health care benefits and consistently not paying premiums."[1]

If a British Columbian does not wish to partake in publicly provided health care benefits, he or she must sign a declaration to that effect. This would be a step towards increased patient choice if a person who chooses to opt out could then purchase private insurance. However, it is illegal for the private sector to provide any of the some 3,000 publicly funded services. Therefore, British Columbians who choose to opt out of the public health care system will not be insured. If they get sick, they are on their own—what kind of choice is this?

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BILL ROBSON, President, Ontario Parent Councils, "The Birth of School Councils in Ontario"
Reflective Closing Panel: Getting to Shared Decision-Making

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Conclusion

Having a good idea is not enough—a lot can go wrong from the time someone has the idea to the time that it is implemented. Efficient allocation and use of health care services will never happen if the Ministry continues to usurp the decision-making power of patients and providers. In order to effect health reforms that will truly increase patient choice and improve the overall quality and efficiency of the health care system, the Ministry is going to have to give a little. Until it does, it will be a shame watching all of its good ideas go to waste. ✉

"Experts"
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While a country's health care system must provide care for the less fortunate and the chronically ill, regardless of their income, the system as a whole must be designed on the basis of the majority of its users. Most Canadians can afford to contribute to their health care costs. Furthermore, it turns out that most people are pretty good judges of their own health care needs. It's a pity that Canada's health care "experts" don't know these things. Otherwise, they wouldn't be so adamant about the need for a publicly controlled health care system. ✉

1 BC Ministry of Health and Ministry Responsible for Seniors, "Medicare Protection Amendment Act Enacted," Press Release, January 5, 1998.

Lessons from the EU

Patient Empowerment in Europe

Paul Belien

For more than a decade, European nations have witnessed a continuous cycle of health care reform policies. Although each of these efforts to craft new public policy has been tailored to fit the specific political, social, and cultural circumstances of each country, there are many striking similarities among these attempts to reduce costs while preserving the quality and equity of medical care.

The market in health care

Everywhere in Europe, market-oriented health care proposals and policies have been introduced. But everywhere these have gone hand in hand with plainly anti-competitive mechanisms which have brought the command-and-control structure of Europe's health care systems under even greater government control. Market mechanisms were only introduced as a means to limit costs, not with the goal of empowering patients. The goal has been to limit the economic growth of the health care sector by restricting consumption.

In markets with an unrestricted supply of services and competition, prices decrease because of the natural expansion and differentiation of the services offered. Consumers have a real say. Since they demand, choose, and pay for a service, that service had better be good and reasonably priced. Consumers have rights—they can insist on quality—and they have obligations—to be cost-conscious and limit over-consumption (or pay the bill themselves).

In order to achieve patient empowerment, we need competition in health care services as well as an unrestricted supply of these services. The latter has been lacking from the so-called market reforms in Europe. These reforms were actually a form of managed competition or the creation of internal markets within a global budget in order to control costs. However, if one does not allow economic growth and expansion, the market becomes a perversity and consumers lose their options. In managed competition, consumers have no say. The competition we currently see in European health care systems is a competition to cut costs by lowering the quality that is provided, or to attract healthy patients and discourage the sick. This is a parody of health care and of markets.

Capitalization versus privatization

Markets and market mechanisms only make sense within a capitalist system—a system that is driven by capital. The problem with European health care systems is that capital is running dry. All of the European systems, even the present private ones, are financed on a pay-as-you-go basis whereby today's healthy and young foot the bill for today's sick and elderly. The costs of the present generation are shifted to the next generation, but this has become unsustainable given our present demographic evolution.

Today there are no adequate financial reserves available in the health care system. Without these reserves, economic growth is impossible. Therefore, we should transform our health care systems from pay-as-you-go systems into systems financed by means of capitalization. In a capitalization system, the money that is put into the system today is set aside for future needs. In the meantime, these savings are invested as capital and, as a consequence, they generate new capital. Only this "capitalist" approach will

allow the health care sector to expand.

Privatization of the health care sector can only be an answer to the current problems to the extent that it implies capitalization, hence an expansion of the health care economy. If, as is often the case today, privatized health care is also financed on a pay-as-you-go basis, private health insurers will also try to ration quality health care and restrict access to it. To replace the state with an insurance company is not an alternative to the current health care crisis, nor will it empower patients very much. If health care is rationed and patients' access to a treatment or a drug they need is blocked because of budget limits, it is hardly relevant to them whether the rationing authority is the government, a sickness fund, a health maintenance organization, or an insurance company.

A privatized health care system is preferable to a government-run system as it has one big advantage over a government-regulated system: it allows more room for experimentation. Privatized health care systems are better equipped for the future because they adapt more easily to challenges. They constitute interesting laboratories for health care reform. They toy with interesting ideas like medical savings accounts, health care vouchers, and bonuses.

However, the most crucial element in patient empowerment is capitalization rather than privatization, or the introduction of so-called market mechanisms. Capitalism is the medicine that we need.

Health care in Europe

As in Canada, most European governments think they know best what is good for patients. Regarding health care insurance, as a citizen—and hence a potential patient—one is trapped either within a government-run single-payer system, or within a government-regulated sickness fund system. If you prefer another kind of health insurance, one where as an individual you can choose your own options, you will have to purchase additional health insurance out of your own pocket. In this case you have to *pay twice* for health care, once through your taxes or your sickness fund contributions to the official government-run or government-regulated system, and once to your own private health insurer. Consequently, the option to buy health insurance on the market is only open to the rich, to those who can afford to pay twice.

In some European countries, citizens (or at least some of them) are allowed to leave the government-regulated system altogether. They can stop paying contributions and premiums to the official health insurance system and use the money they previously paid in taxes and premiums to buy their own private health insurance. In Germany, the Netherlands, and Switzerland, people do not have to pay twice in order to insure themselves according to their own wishes.

Germany

Germany is the prototype of the European social insurance-based health care system, or the so-called sickness fund system. Contrary to a single-payer system (like the one here in Canada) where health care is paid for and organized by the government either at a national or a regional level, a sickness fund system is, theoretically at least, an entirely private system. Health costs are not paid by the government with tax money, but by various sickness funds with money they derive from the contributions of their members. These sickness funds are private, independent organizations.

Though originally private organizations with members joining on a voluntary basis and providing health insurance according to market mechanisms, the sickness funds have become heavily government regulated over the last century. The sickness funds have almost become government institutions, where the government sets all the rules and decides everything. Hence, the difference between a government-run single-payer system and a social insurance-based sickness fund system has become merely theoretical: sickness fund systems provide universal coverage, membership in a fund is compulsory, and, in some countries, members are obliged to join the fund of their profession.

In a sickness fund system, fund members pay a premium which operates like a payroll tax. The government collects the money and distributes it among the funds according to the number of members. In Germany, in theory, 50 percent of the premiums to the sickness fund are paid by the employee and 50 percent by his employer. This is theoretical because the amount of the premium is set by the government as a percentage of the wages and is deducted from the wages before these are paid out—often the members do not know the amount of the premium, as they do not personally pay anything to the fund. The premiums constitute about 13 percent of the gross salaries of the working population.

Unlike other countries' sickness fund systems, people in Germany who earn over a certain income are free to opt out of the system. In this case they are no longer obliged to pay a percentage of their wages to the sickness fund; they can use this money to buy private health insurance. As with the sickness funds, where 50 percent of the premium is paid by the employee and the rest by the employer, the employer will also have to pay 50 percent of the premium if his or her employee opts out of the government system and joins a private insurer. German citizens who can leave the sickness fund tend to do so because people who are privately insured can choose doctors and hospitals who, when treating a privately insured patient, are not restricted by the many stringent government imposed budget limits that have been introduced in the past decades.

At present, over 10 percent of the German population has opted out of the public system. These people pay premiums which reflect the health risk of their age group in five-year cohorts. When you select private insurance in Germany, you pay the premium for the five-year cohort to which you belong. In the course of the insurance the premium is never increased as a function of the insured's age. Even as you grow older, you still pay the premium for the age group you were in when you joined the insurance plan. The premium can only be raised to reflect general increases in health care costs affecting all age groups. Because the premium you pay will always be the premium of the age group you were in when you bought your insurance, it is in your interest to insure yourself as young as possible. If you start to pay when you are young and your health risks are low, you pay less.

As insurers are not permitted to refuse clients, every citizen, whatever his personal risk, can acquire affordable health insurance in Germany. Contrary to the American system, individuals provide their own coverage, not the employer; thus, losing a job in Germany does not mean losing health coverage. In the American private health insurance system, the premium is calculated on individual risk. In the German private insurance, coverage provision is individual but the premium is calculated upon a group risk. German private insurance premiums will therefore never become exorbitant for people with a high individual health risk.

This all sounds very good, but there is a problem. Like the government sickness funds, Germany's private insurers are also predominantly financed on a pay-as-you-go basis. They, too, have hardly any capital reserves. The money which their clients of a certain age cohort pay today is not set aside for the future needs of this generation, but is almost entirely spent on the contemporary needs of the insurance company's elderly clients.

As insurers are not permitted to refuse clients, every citizen, whatever his personal risk, can acquire affordable health insurance in Germany.

The fact that the German private health insurance system is not financed on a capitalization basis and, as a consequence, lacks capital reserves, has two important consequences. First, the demographic evolution in society—which raises the average age of their members—forces private insurers in Germany either to increase premiums dramatically for their younger members, or to gradually ration health care because they spend more money than they receive. They, like the government, have begun rationing health care, deciding what care

their members can get and how much that care may cost.

Second, there is no portability of reserves. Once they have joined a private insurance company, clients cannot leave it without losing all of their rights. If you join your insurance company when you are 25, you will still be paying the premiums of a 25-year-old when you are 45. But if at 45 you decide to join another private insurance company because you have come to the conclusion that their service is better, the benefits of 20 year membership will be lost. You can only join the other company by starting all over again—you will be regarded as a new client and will have to pay the premium of a 45-year-old. If choosing another insurer implies that you lose everything you have paid for, the client is hardly left with a choice. If your private insurer starts to diminish the services provided, and you, as a client, do not agree, you cannot go somewhere else.

It is true that as a patient in a privatized health care system funded on a pay-as-you-go basis, you have more freedom than someone who is obliged to join a one-size-fits-all, government-run, sickness fund health care system. You can choose between different private insurers, each with different premiums according to the different service they provide. However, once you have made your choice, you can never really change your mind. You are as trapped within your private insurance company as others are trapped within their government-run National Health Service or their sickness fund.

The Netherlands

In The Netherlands, one third of the population is privately insured, and the number is rising. Like the Germans, the Dutch also leave the sickness fund system once they earn more than a certain amount of income, but in the Netherlands this financial threshold is lower than it is in Germany. The Dutch make private insurance affordable to everyone by covering the highest risks—the so-called catastrophic health care—under a different nation-wide scheme. They differentiate between catastrophic health care, which is very expensive, and common health care. There is a compulsory government-regulated single-payer system for the expensive health risks, and a sickness fund system for the other risks. Catastrophic health insurance is mandatory and paid for through income taxes. It covers very costly medical procedures and long-term care. For these costly risks, the citizen is pooled in the largest possible risk pool, namely, the whole nation.

Catastrophic care is financed by the Exceptional Medical Expenses Fund into which all citizens have to pay according to their income. In theory, this fund covers medical care which would be too expensive to insure against if one had to go to a private insurer, plus very long-term care. However, some "catastrophic" care is provided by the sickness funds, and some non-catastrophic care is provided by the Exceptional Medical Expenses fund. For example, the sickness funds cover hospitalization up to 365 days and the Exceptional Medical Expenses fund covers from the 366th day on, but a hospitalization of 100 days can certainly be considered a financial catastrophe.

The Exceptional Medical Expenses Fund also covers certain drugs, forms of medical equipment, day care, family care, etc. Though this fund has been used for other things, the concept seems sound. If some Canadians object to health care privatization on the grounds that certain health risks are too expensive to cover with premiums affordable to everyone, The Netherlands has something to teach them. Realizing that the costs of certain acute as well as chronic medical care are exorbitant, the Dutch have required all citizens to pay into a catastrophic pool.

The so-called non-catastrophic health risks are covered by the sickness funds. Sickness fund membership is compulsory. The premiums to the fund are paid partly by the employer, partly by the employee. They resemble a payroll tax amounting to 1 percent of the employee's wage for the employee, and 0.95 percent of the wage for the employer. Compared to the average premium of 13 percent in Germany and premiums of over 10 percent in other social insurance-based health care systems in Europe, the premiums in The Netherlands are low, but the Dutch sickness funds do not cover the forms of expensive catastrophic medical care,

which sickness funds in countries like Germany also have to cover.

What is specific to the Dutch sickness funds is that they expel their members as soon as they earn above a certain income. In Germany you are *free* to leave the sickness fund and purchase private insurance if you earn more than a certain amount. In the Netherlands you *have* to leave the public system. In this case, individuals can buy private insurance, if they want. Given that certain catastrophes are not covered if you do not take private health insurance, it would be very unwise not to insure yourself privately once the sickness fund has expelled you.

. . . like their German counterparts, the Dutch private insurance companies are undercapitalized. They, too, ration health.care.

Dutch private insurers tend to provide a slightly better service than the sickness funds. They purchase services for their members, provide patients with information about health care choices, and create contracts with a variety of providers offering different types of care. But, like their German counterparts, the Dutch private insurance companies are undercapitalized. They, too, ration health care. Certain treatments are limited by making them less available or totally unavailable. As is generally the case, most patients are often unaware of the costly cutting-edge medicines and technologies that are *not* being used in their care. This knowledge asymmetry creates a veil of ignorance that is very useful in limiting resource use in systems constrained by budgets.

Switzerland

Switzerland is the only country in Europe with a health care system that is totally based on private insurance. Health insurance is not compulsory in the Swiss Confederation. Nevertheless, 99 percent of the Swiss population is insured in a social insurance fund or a private insurance company.

Swiss insurance payments are more akin to private than social insurance in other European countries, as premiums are not linked to income, but are instead set on a per capita basis with weightings for age of entry into a fund, regional cost differences, and gender. The Health Insurance Law defines the catalogue of benefits to which all Swiss insurance members are entitled, but individual insurance funds can offer additional benefits over and above this basic package.

Private insurance-based health care systems are often criticized because premiums take into account the individual risk and, as a consequence, they can differ substantially. Germany, The Netherlands, and Switzerland have each reduced the inequities in their own way: Germany by pooling the risks and taking the average risk of a five year age cohort into account; the Netherlands by taking the very costly catastrophic chronic and acute medical risks out of the private system; and Switzerland by handing out government subsidies to groups with higher health risks, so that everyone, even a high risk individual, will be able to purchase health insurance. The government in Switzerland, by paying a percentage of the premiums of high risk individuals, contributes roughly one third of health care funding in the Swiss Confederation.

In order to prevent private insurers from skimming off the enrollee pool, Switzerland has introduced a risk-adjustment system. All insurers in the market have to pay a portion of the premiums or contributions they collect into a central fund. The relative financial risk of each insurer is then calculated, and insurers with a larger proportion of less healthy, high risk members receive from the fund an amount that compensates adequately for the higher financial risks involved in insuring their members. In effect, the insurers with healthier members subsidize those with less healthy members. This type of risk-adjustment prevents a situation in which all low risk people flock to insurance companies that can keep their premiums low because they hardly run any risks, while other insurers have to ask exorbitant premiums because they get all the high risks.

All of the health insurers operating within a single canton (the Swiss equivalent of a province) are subject to the risk-adjustment mechanism. Risk-adjust-

ment is based on age and gender only—income is not included as it is not a factor in determining premiums. Calculations are based on actual costs, but only for care that falls under the basic benefits package. The system reduces differences in premiums within cantons, but significant differences still exist across cantons since risk-adjustment is calculated only for care covered by the basic benefits package. Funds with members who require additional care—for instance, AIDS-patients—may be disadvantaged, or they may be charged an additional premium to cover care outside the basic benefits package.

The Swiss health care system is self-managing. The government supervises the system but does not interfere in its operation. All funds are open for membership to the whole population. The health insurers set their health premiums themselves, subject to the risk-adjustment system. Premiums differ from insurer to insurer, but so do the services to the patient. The Swiss insurance funds have considerable freedom over the benefits packages they offer, as long as they include a basic list of services as outlined in the Health Insurance Law. However, even this law specifies services in a relatively vague way. This has led to a considerable range of options for consumers. The insurers usually offer different benefit packages for their customers that can be supplemented with various programs specifically designed for children, housewives, professionals, farmers, and other such groups.

In Switzerland, it is the responsibility of the people themselves to purchase health insurance. This includes children, for whom parents are responsible. Every Swiss citizen has to pay a premium. Those on low incomes receive an income subsidy from the government, rather than a health care premium subsidy. Self-management tends to lead to novel and innovative contracts between health insurers and providers. Many Swiss insurance companies are experimenting with American style health maintenance organization (HMO) schemes. HMOs buy health services for their members and, by buying pharmaceuticals or medical services in large quantities, they can limit the price for each individual product. HMOs in Switzerland are group practices owned by groups of insurance funds which offer primary care and have informal arrangements with hospitals. Members who join HMOs are offered significantly lower premiums than people who do not join them.

Other insurers have been discussing the introduction of bonuses. If patients do not use any health services in a given period, or remain below a set expenditure amount, they are paid back part of the insurance premium as a bonus. This encourages patients to use the system in a more cost-conscious way. However, the need for such a bonus does not seem to be great in Switzerland because copayments are very high.

Copayments are an integral part of the Swiss system. They apply to primary as well as hospital care, and cover about one third of the annual health care expenses. Copayments have the intention of reducing over-consumption of health care services. Their levels are set by the government, and, in most cases, the government does not allow citizens to insure against copayments.

Patients currently pay all their costs of ambulatory care up to the level of a deductible which is currently around 150 Swiss francs per year (US$125), and 10 percent of costs above that level. Ambulatory care in this context comprises primary care with a physician or specialist, outpatient care in a hospital, and medicines. The 10 percent copayment, following the deductible, uses as the calculation basis the doctor's charge, the price of the medicine, or other appropriate fee schedules. There is also an annual maximum level of copayments. For adults this is set at 500 Swiss francs (US$417). Special regulations apply for children and families with several children. Insurance funds are free to offer their customers higher annual deductibles in return for lower premiums.

For hospital care, patients have to pay the hotel costs for the duration of their stay in a hospital. It is possible to insure against copayments for the hotel costs of hospital care (but never for primary care). There is also a copayment of 10 Swiss francs per day which patients owe for hospital treatment costs. Citizens are not allowed to insure

themselves against this type of hospital copayment.

Because one third of Swiss health care is financed through direct patient copayments and because it is illegal to insure oneself against most of these copayments, Swiss citizens have to rely on their private savings in order to prepare for future health risks to a large extent. As a result, the Swiss health care system relies a lot on capitalization. By forcing patients to pay a larger part of the health care costs themselves, patients are forced to start capitalizing by setting aside money for future needs and they are forced into patient empowerment—because they have to start making rational choices, which they cannot do without informing themselves.

Conclusion

It is a striking phenomenon that whatever country one goes to, and however bad a health care system it has, people will always tend to consider their own health care system "the best in the world." There is a certain laziness involved here. If it is the government's duty to pamper us and treat us when we fall ill, why should we worry? If one is forced to think about it, because the government is no longer capable of taking care of us, then we start to worry and look for examples of privatized and capitalized systems. Why? Because here we find that patients are empowered, and patients are put first. Why? Because the capital belongs to them. ✉

For Our Members

Institute News

Sherry Stein

The Government of Hong Kong recently hosted the Fraser Institute's director **Dr. Michael Walker**, showing him the developments in the country since the handover from Britain... **John Franklin**, a longtime supporter of **Calgary M.P. Rob Anders**, recently passed away, bequeathing a donation to a school of Anders' choice. Anders chose The Fraser Institute and, in particular, the Institute's student programs, directed by **Annabel Addington**...

The Fraser Institute was the credited source of information for the many media commentaries on the way to spend the fiscal dividend, all of which may have inadvertently been interpreted as an encouragement to spend the dividend. This is not so. In fact, says the Institute's **Michael Walker**, we are saying don't spend any surplus; we are advocating an optimal size of government of about 30 percent of GDP, a figure considerably less than the recent approximate 44 percent of GDP the government sector represented... An article in the December 1997 issue of *Reader's Digest*, **"The Extra Bite of Hidden Taxes,"** which stated that Canadian wage earners now lose, on average, 55 percent of their earnings to taxes, 10 percent more than the tax bite suffered by our US neighbours, credited The Fraser Institute with much of its information, including the Institute's **Tax Freedom Day**...

If you're on-line, why not check out the Institute's **Web site** at **http://www.fraserinstitute.ca** which features hundreds of megabytes of Institute publications since 1991, including Fraser Forums, Critical Issues Bulletins, books, Public Policy Sources, and Canadian Student Reviews, as well as news of upcoming seminars and student programs. Our site, which celebrated its 2nd birthday last month, has had 57,730 visitors; 1,127,366 pages of information have been downloaded since its birth...

Institute analysts have been busy on air and in print helping to position the Institute as the most effective organization of its kind in the country. In the past two years, the Institute received over **7,000 mentions** in Canadian media, an average of over 8 "hits" per day. Most recently **Owen Lippert** "faced off" on CBC on the topic "Welfare Reform and How It Affects Our Society from the Poor to

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Health Care

Controlling Drug Costs[1]

Bill McArthur, MD

In most technologically advanced countries, pharmaceutical costs have been escalating for the past 20 years. Since, in most countries, a large proportion of the expenditure on medication is funded through general tax revenues, these cost increases are viewed as a problem that must be solved. The Canadian experience parallels that in many other countries. While many nations have attempted to constrain their pharmaceutical costs, no solution has been universally effective, many initiatives have been implemented without evidence that they will work, and some have been introduced in spite of solid evidence that they result in increased illness and increased overall health costs.

Techniques for containing drug costs[2]

There are two fundamentally different approaches to pharmaceutical cost containment. The first involves attempting to influence the demand for expensive medications by introducing measures that have an impact on drug consumption and drug costs. These measures focus on encouraging prescribers to use the lowest cost drugs, and discouraging patients' demand for drugs. The second alternative involves "supply side" measures that tend to focus on the behaviour and performance of manufacturers, pharmacists, and prescribers. Ideally, the second alternative has no impact on the consumers who, in theory, still receive high quality products at the lowest cost.

Influencing the demand

Managed care

In the U.S. there is a growing trend toward "managed care," a concept that focuses on cost containment in all areas of a practice. Drugs are purchased in bulk at a competitive price, and efforts are made to ensure that prescribers use low cost but effective drugs. Competition between care providers rather than government regulation is the key factor in this system. However, complaints are emerging that physicians are being pressured by care managers to use the least expensive technology and therapeutics, and this is leading to a new political confrontation regarding patient care.[3] Any province looking into managed care as a solution to increasing health care costs should proceed cautiously, if at all.

Education

Programs designed to educate prescribers and patients are becoming popular. Some Canadian provinces, the UK, and the European Community (EC) have implemented programs of

1 This paper is a condensation of a much broader document on the same topic, entitled "Pharmaceutical Cost Containment: A Canadian Dilemma," which the author presented at The Fraser Institute conference "Putting Patients First," held in Vancouver and Toronto in November 1997. Copies of the full paper, including a bibliography of over 100 references on cost containment, are available from The Fraser Institute.

2 Pharmaceutical cost containment is addressed in considerable depth in L. Narine and M. Sen, "Pharmaceutical Cost Containment Policies: Intended and Unintended Impacts," University of Toronto: Department of Health Administration, forthcoming.

3 "Democrats Push for Patients' Rights," *Los Angeles Times*, Jan. 13, 1998, p. A10.

this type. The development of clinical practice guidelines in Canada is one example of this type of endeavour, but scientific evaluation of the outcomes is not yet available.

Cost sharing

A common way of reducing the taxpayer's contribution to the cost of pharmaceuticals is to shift part of the cost of drugs to patients, or their insurers. This technique has been applied in Canada, France, Germany, The Netherlands, New Zealand, Sweden, and the UK. Cost sharing may reduce costs because fewer drugs are purchased, but this has to be balanced with the possibility that it may cause undesired results, such as increased morbidity and higher health expenditures.

Mandatory budgets

France, Germany, New Zealand, and the UK have introduced various types of physician budget holding procedures. In all of these countries the budgets *include* drugs as well as other negotiated expenses. The budgets are the responsibility of individual physicians, or groups of physicians, and this makes individual practitioners accountable for pharmaceutical expenditures. Experience indicates that this produces a more cost conscious approach to prescribing.

Supply side measures

Reference based pricing

Reference based pricing (RBP) is a scheme that substitutes lower cost drugs for more expensive medications. The goal is to supply patients with the lowest cost drug available, but one which produces a therapeutically equivalent benefit. RBP can be divided into three phases.

Phase 1 RBP is a simple substitution of a generic (i.e. chemically equivalent) drug for a more expensive "brand name" agent. This confines an RBP program to those drugs where the patent has expired. Canada, like most other World Trade Organization (WTO) countries, recognizes 20-year patent rights. Typically in Canada, an innovative pharmaceutical company discovers a drug, spends 10 years developing it, and then has the right to market it at a price approved by the Patent Medicines Price Review Board (PMPRB) for about 10 years before the product is subject to competition from generic manufacturers.

Phase 2 RBP is the therapeutic substitution of drugs which are chemically related but not identical. A committee of experts recommends a list of less expensive drugs and the payer (the government) agrees to pay for only the least expensive drug.

Phase 3 RBP is the substitution of drugs with the same therapeutic goals but an unrelated chemical structure. As in Phase 2 RBP, a committee reviews the drugs and lists those with the same therapeutic goals. Again, the payer pays for only the cheapest.

In all phases, the more expensive non-reference drugs may be bought by the consumer with the purchaser paying the difference in price out of pocket.

In various forms, RBP has been tried in Denmark, Italy, Germany, The Netherlands, New Zealand, Canada, and was recently introduced in Australia. Over 20 studies of RBP programs in various countries reveal convincing evidence that the consistent outcome of Phase 2 and 3 RBP is increased sickness and increased overall health costs.

All Canadian provinces use Phase 1 RBP with their mandatory generic substitution programs, but the only province that has introduced the later phases is British Columbia. The BC program includes a "Special Authority" process which allows for the subsidization of the more expensive drug in certain cases. The BC government claims that this process overcomes the increased illness and increased cost problems seen in other RBP jurisdictions. However, this is no scientific evidence to support this claim, and most scientists in the field discount it as being highly unlikely.

Assessed value criteria

The "assessed value criteria" approach involves a complex anal-

ysis of the costs and benefits of a particular drug. Australia implemented such a program in 1993, and Ontario in 1994. In evaluating all new drugs, and changes to older ones, examining bodies usually consider factors such as value for money (cost effectiveness). Creating the complex economic models required to pursue these deliberations is expensive, and to date no scientific evidence has indicated that this method of cost containment is superior to any other. This approach needs further evaluation.

Legislated price controls

There are two main mechanisms in legislated price controls: price reductions and entry price control.

Price Reductions

Various jurisdictions have resorted to the blunt instrument of legislating obligatory drug price reductions. Since 1991, Italy, France, Germany, Spain, the UK, and the US have implemented legislated price reductions and/or price freezes of one type or another. These programs were implemented without any evidence of their potential benefit, or research, or pilot projects to identify and evaluate their merits.

Maximum Entry Price Control

Canada is one of the countries that has established a legislated method for controlling the price of new drugs coming into the market. This was done in 1987 when the Patent Medicines Price Review Board (PMPRB) was created as an economic "watchdog" over the "brand name" pharmaceutical industry. It is a quasi-judicial body with substantial authority, including the power to establish the price of new drugs coming onto the market (the final price for a drug is the result of negotiations between the PMPRB and the manufacturer). The producer no longer decides on the price to charge based on market factors such as anticipated demand, and anticipated sales volume (a prudent company will usually sacrifice a substantial portion of price in order to increase volume). Instead, the dynamic is one of convincing the PMPRB of the maximum price sustainable, remembering that there will be no subsequent opportunity to increase prices. Other countries that have employed a type of legislated pricing controls include France, Sweden, and Italy.

The evidence regarding the impact of regulation as opposed to free market competition on pharmaceutical costs does not support this type of mechanism. The PMPRB points to the fact that in Canada, drug price increases in recent years have been kept at or below the increase in the Consumer Price Index (CPI). However, other studies reveal that countries with legislated price constraints, while having lower prices over the first few years, actually have higher drug prices after 3 to 4 years.[1]

In the pharmaceutical industry a company forced to reduce the price on a subsidized drug will often compensate by increasing prices on another medication. This may be a drug requiring a prescription, or it may be an over-the-counter (OTC) medication, which is not subject to any form of price control. Another trend is for companies that are exposed to this restrictive legislation to gradually move their work into other areas. It is difficult to conceive how either of these outcomes benefits the public.

State formularies

Formularies are lists of drugs, published by the paying agency, which identify the drugs that will be subsidized by the payer. In Canada, every province has a formulary for subsidized medications, and hospital formularies are the norm across the country.

Miscellaneous measures

Several other supply side measures have been tried in various countries. These include profit limitations, prescription volume controls, professional fee controls, and import/export manoeuvring. All are described in more detail in "Pharmaceutical Cost Containment: A Cana-

1 J. Zammit-Lucia, R. Dasgupta, "Reference Pricing—The European Experience," *Health Policy Review*, Paper No. 10, University of London: Imperial College of Science, Technology and Medicine, 1995.

dian Dilemma." None have been shown to be effective.

Conclusion

Controlling drug costs is a complex matter which needs to be approached carefully. None of the measures described above is universally effective, many have been implemented without sufficient evidence of their effects, and some, such as Phase 2 and 3 reference based pricing, have been introduced in spite of evidence that they result in increased illness and increased overall health costs.

Using pharmaceutical policies for the purpose of pursuing political and ideological goals is not justifiable. The cost in terms of human illness and suffering, as well as the financial burden, is much too high. When a new program is conceived it must be evaluated by scientists competent in the field before the program is implemented. When there is no experience or research, the most that should be done is the development of small pilot projects in order to test, analyze, and refine the proposal. Failure to do this condemns good ideas to failure, while on the other hand, carefully planned trials will often allow a faulty proposal to be developed into a worthwhile program.

As citizens in a modern society, we deserve and we should demand access to the best modern pharmaceuticals that are available. There is evidence showing that using the drug therapy that is best suited for the individual patient, regardless of its cost, not only results in better health outcomes, but in health care savings as well[1]—good medicine and evidence-based public policy work. These, rather than simplistic cost cutting, should be the focus of our governments in their efforts to reform our health care systems. ✉

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Founded in 1997, the Canadian Property Rights Research Institute (CanPRRI) is a non-profit, non-partisan, public policy research and educational institute headquartered in Calgary, Alberta. Its mission is to research the role of the individual's right to own property in creating a free and prosperous society.

1 Susan Horn, P.D. Sharkey, D.M. Tracy, C.E. Horn, B. James and F. Goodwin, "Intended and Unintended Consequences of HMO Cost Containment Strategies: Results from the Managed Care Outcomes Project," *American Journal of Managed Care*, Vol. II, No. 3, March 1996, pp. 253-64.

Health Care in the Courts

Judging Health Care

Owen Lippert

Canada ought to have a Royal Commission on the legal system—headed up by doctors. Sound odd? Perhaps, but no odder than the current practice of federal and provincial governments appointing judges to make health care policy: Justice Emmett Hall headed the 1966 Royal Commission, Justice Seaton conducted the 1991 commission in British Columbia and, most recently, Justice Horace Krever delivered the report on the blood system. My theory is that governments know judges will deliver what they want—political control over doctors, patients, and hospitals. Judges will do so not because they're in cahoots with the politicians, but because they are conditioned to suspect market behaviour.

Let's take as an example Justice Krever. He insists that, as the first principle, blood be a "public resource." That is, the government, not you, owns your blood as soon as it's left your body. He does not even discuss alternatives to state control of the supply and use of blood products. To even further insulate the blood system from the discipline of the market and direct accountability to individuals, he suggests a limited-compensation no-fault insurance scheme that would protect negligent government officials.

Justice Krever reflects the orthodoxy launched by Justice Hall, consolidated in the 1984 Canada Health Act by lawyer Monique Begin, and now set to expand into drugs and home care by lawyer Allan Rock, Minister of Health. The mantra is simple. Health care is "too important" to be left to the market of doctors, patients, and hospital providers. Doctors will charge too much. Poor patients can't afford them. Public hospitals will be under-funded unless the government can deny the middle class access to private care, and force its citizens to pay the high taxes necessary to sustain a public system. In short, Canada's current health care system reflects a no-exceptions, no-compromise suspicion of market behaviour.

How do otherwise intelligent people develop such a pessimistic and narrow view of one of mankind's most basic activities, exchanging one good or service for another?

Attitudes towards the market are like attitudes towards anything—a learned response. What we think depends a lot more on what we experience than what we read. No surprise, then, that our judges seem obsessed with market failure. Judges spend year after year sorting out new disputes according to rules derived from old disputes. Tales of broken promises, theft, deception, fraud, abuse, and bankruptcy—that's the working day of an average judge. Small wonder they wear black robes. Now if all you do all day is see how two parties have failed to make the market work, you might be tempted to think it's not the individuals who are to blame, but rather the market itself.

What happens when you combine judges conditioned to see the market as a source of failure, and a political class anxious to prove they can provide goods and services better than the market? Public monopoly medicine delivered with all the gravitas of our judiciary.

Public monopoly health care, of course, has its defenders who thank the heavens for the medical moonlighting of Canada's judges. The public, faced with lengthening waiting lists, restricted access to new medical technology, and fearful of new taxes, is starting to have its

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Society's Welfare

Do the Poor Have More Children?

Chris Sarlo

How many times have you heard the ill-informed and insulting claim: "Poor women are baby factories?" If you have, it is based on anecdotal evidence or some preconception or prejudice about the poor. If it ever was true, it certainly is not so in recent years.

Overall, there is a positive relationship between family size and income. The higher the level of reported income, the more people in the family. However, there is no causal connection between income and family size. No one would suggest, for example, that you can increase your income by having more children or that higher incomes somehow promote fecundity. The fact is that age is the key 'third' variable that is strongly correlated to both income and family size, up to a point. Beginning in one's 20s, as we get older, our skills and labour market experience increases. This raises our value and hence, our income, which grows consistently, peaking, for most of us, in our late 40s. As well, people who have children typically have them in their 20s and 30s. Family size grows, on average, peaking in one's late 30s or early 40s. So the connection between family size and income is indirect, but another variable, age, plays an important role.

Table 1: Number of Children by Age of Head and Poverty Status (Families with Children Only)

Poor	Age of Head of Household			
Age of Children	20-24	25-29	30-34	35-39
Less than 7	1.20	1.12	0.85	0.55
7 to 11	0.02	0.35	0.59	0.57
12 to 15	0.00	0.03	0.28	0.40
16 to 17	0.03	0.01	0.02	0.19
Total	1.25	1.51	1.74	1.71
Non-Poor	**Age of Head of Household**			
Age of Children	20-24	25-29	30-34	35-39
Less than 7	1.06	1.30	1.24	0.74
7 to 11	0.05	0.21	0.50	0.73
12 to 15	0.00	0.03	0.14	0.43
16 to 17	0.04	0.01	0.02	0.11
Total	1.15	1.55	1.90	2.01

Source: Statistics Canada, Microdata File of Economic Families, 1995.

None of this tells us what to expect about the childbearing propensities of poor as against non-poor families. Because poor families with children tend to be younger families (both in the sense of having younger parents and having younger children), we might expect that the average poor family would have more children than the average non-poor family. And this is exactly what the evidence shows. Poor families have more children and have more young children in particular, than non-poor families. However, the average age of the head of a poor family is 7 to 8 years younger than heads of non-poor families, and is closer to the age at which family size peaks. So, to do a proper comparison, it is important to look at heads of poor and non-poor families that are at about the same age.

Table 1 displays the number of children by poverty status while

Table 2: Number of Children by Age of Head and Inequality Status (Families with Children Only)

Bottom 20%	Age of Head of Household			
Age of Children	**20-24**	**25-29**	**30-34**	**35-39**
Less than 7	1.27	1.25	1.00	0.58
7 to 11	0.03	0.33	0.64	0.63
12 to 15	0.00	0.03	0.24	0.50
16 to 17	0.03	0.01	0.02	0.16
Total	1.33	1.62	1.90	1.87
Top 80%	**Age of Head of Household**			
Age of Children	**20-24**	**25-29**	**30-34**	**35-39**
Less than 7	0.83	1.28	1.27	0.76
7 to 11	0.06	0.18	0.46	0.74
12 to 15	0.00	0.04	0.13	0.41
16 to 17	0.03	0.01	0.02	0.10
Total	0.92	1.51	1.88	2.01

Source: Statistics Canada, Microdata File of Economic Families, 1995.

using comparable age ranges for the heads of the families for 1995. My own "basic needs" approach is used in defining poverty, and a broad average income value for families with children—$16,000 (without regard to family size or region)—was employed for convenience, and to ensure reliable sample counts.

What the table shows is that poor families with only the very youngest heads have more children than their non-poor contemporaries, and even then, the margin is very small. Beyond this young group (age 20-24), non-poor families are the ones that tend to have more children. Clearly, there is no evidence here to suggest that, as a group, poor families have more children.

Is it possible that this result is peculiar to the poverty line chosen, and might not prevail with a different cut-off? To examine this issue, I used another cut-off which is commonly employed in the inequality literature, namely the income that separates the bottom 20 percent of families with children from the top 80 percent. In 1995, that income was $27,951. Table 2 displays the results of the comparison, again by the age of the head of the family.

While unequal families (in the sense here) have more children (and more younger children, especially) if the heads are under 30, they tend to have fewer children if the heads are over 30. This pattern is broadly consistent with that prevailing when a poverty line is used.

Finally, an examination of Statistics Canada income databases for the mid-1980s and the early 1970s confirms the hypothesis. There is simply no evidence in recent decades to support the view that poor families have more children, *on average*, than non-poor families. To the extent that there is a prejudicial stereotype regarding the childbearing propensities of the poor, that stereotype is incorrect. ✉

Judging Health Care continued from page 23

doubts. A recent COMPASS poll found that 67 percent of respondents agreed either a lot or somewhat that there "should be more medical services provided by private suppliers alongside the public health system."

Just as telling, Justice Hall's own son is a surgeon—in the United States. Perhaps he and the other Canadian doctors practising south of the border should come home to lead the next Royal Commission—if not on health care, then judicial reform. ✉

Asian Update

Calm in Hong Kong

Michael Walker

Joseph Yam, the Chief Executive of the Hong Kong Monetary Authority, is every inch a central banker. As I sat with him last week in his Hong Kong office he reminded me very much of the central bankers with whom I used to work at the Bank of Canada. Self-assured, cool, and remarkably calm in spite of the swirling chaos in financial markets surrounding Hong Kong, Joseph Yam pointed to the Certificate of Issuance hanging on his wall as being the key piece in the puzzle of why Hong Kong has not recently had the same symptoms of the Asian flu as its neighbours.

It's not as though Hong Kong has not had the same sorts of problems. Back in 1983 the first major strain of Asian financial flu sprang up in Hong Kong. Negotiations between the British and the Chinese governments about the future of Hong Kong had induced a state of high anxiety. The fear of hyperinflation and the associated worthlessness of currency caused Hong Kong residents to clean out the inventory of grocery stores in very much the same way that Indonesians and Malaysians are doing today.

Of course, this flight to commodities is a form of self-fulfilling prophecy since the flight itself produces a very rapid increase in what economists refer to as "the velocity of money." In more practical terms, people simply get rid of cash as quickly as they can when they receive it, and the corresponding pressure on the prices of what for the moment are a limited quantity of commodities, touches off the inflationary spiral that makes everybody's life more difficult. This spiral makes life difficult for governments who, in order to cover their expenditures, have to come up with more money. In 1983 the concern of Hong Kong residents, many of whom had lived through the Chinese hyper-inflation of the late 1940s, was that the government would resort to printing money, and hence create a complete financial collapse. The key element in this process is the lack of confidence that the government will be able to avoid such a chain of events.

In light of that history, is Joseph Yam's confident air anything more than an affectation? Yes! It is a result of the fact that there is something fundamentally different about Hong Kong's monetary system from those elsewhere in Asia. The 1983 process was stopped dead in its tracks by the adoption in Hong Kong of what is referred to as a currency board. The adoption of such a board was the suggestion of then Hong Kong economist John Greenwood, who will, incidentally, be in Vancouver on March 3rd at The Fraser Institute to give an assessment of the current situation in Asia. Greenwood suggested that the British government fix the value of the local currency to the US dollar using a currency board.

The central ideal behind the currency board and the reason why Joseph Yam was pointing out the Certificate of Issuance hanging on his wall, is that in order to issue more Hong Kong currency, the private banks which do so in Hong Kong must provide to the Monetary Authority an equivalent amount of US dollars. The exchange rate was set at 7.8 Hong Kong dollars to one US dollar, and the total Hong Kong money supply is therefore backed up by a reserve of equivalent value in US dollars.

So, when confidence falters and Hong Kong dollars are dumped, the immediate consequence is that interest rates in Hong Kong "spike," since the attempt to dump Hong Kong dollars for US dollars causes a contraction

continued on page 29

Study Release

Is There a Youth Unemployment Crisis in Canada?

Marc Law and Fazil Mihlar

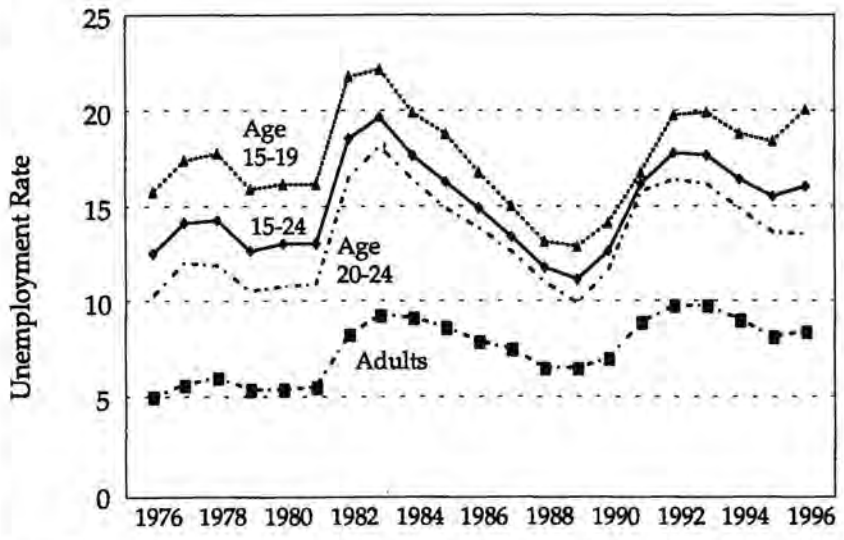
Recently the media have told us that there is a youth unemployment crisis. Consequently, there have been calls for politicians and policy makers to do something about it, so issues related to youth and the labour market have taken centre stage in discussions about public policy. Possible remedies for the alleged crisis figure prominently in current policy debates. Interestingly, however, very little analysis has been conducted to determine the magnitude of the problem. This means that the claim that there is a youth unemployment crisis in Canada has escaped careful scrutiny.

Evidence from labour market data

In our opinion, the youth unemployment crisis is more perception than fact. Youth unemployment rates are not high by historical standards: they were much higher during the recession of the early 1980s than they are at present. That youth unemployment rates have *always* been consistently higher and more variable than adult rates is not surprising; this reflects higher job turnover rates among youth, and the reality that young people, as newcomers to the labour force, are more likely to be in and out of employment than adults. Our analysis of national unemployment rate data suggests that youth unemployment is not a significantly larger problem today than it was in the past. There does not appear to be a general trend towards higher unemployment rates among Canadian youth.

It is noteworthy that both employment rates and labour force participation rates for youth have fallen considerably in recent years. In our view, the main reason for falling labour force participation and employment rates is a rising school enrolment rate for all youth. More and more young Canadians are staying in school for longer durations. To the extent that school enrolment reflects human capital formation, rising school enrolment is a positive development, since better educated individuals generally perform better in the labour market in the sense that they will be better paid, will be unemployed less, have more secure job tenure, and enjoy other labour market benefits.

Figure 1: Canadian Unemployment Rates by Age Group



Source: Marc Law and Fazil Mihlar, "Is there a Youth Unemployment Crisis?" *Public Policy Source* No. 8, The Fraser Institute, January 1998, p. 8.

Some commentators have attributed rising school enrolment to poor economic conditions. Empirical studies suggest otherwise; there is no tendency for school enrolment rates to vary with the business cycle. Rising school enrolment is simply a response by those wanting to work to a changing labour market. In our opinion, it reflects a growing realization that workplace success in the future will require workers with greater skill levels.

Regional aspects of youth unemployment

There is a very pronounced regional dimension to youth unemployment. Specifically, youth unemployment rates vary considerably among the regions. By and large, unemployment rates among youth are higher in provinces with higher adult unemployment rates. In general, young people are least likely to be unemployed in Alberta, and most likely to be unemployed in Newfoundland. This is not surprising, since the market for young people's labour is contingent on regional economic performance.

Similarly, employment rates and labour force participation rates for youth reflect provincial economic developments. Employment rates and labour force participation rates are higher in provinces with higher adult employment and labour force participation rates. Employment and participation rates are generally higher in Western and Central Canada than in the Maritime provinces. This, again, reflects the close relationship between the status of the youth labour force and provincial economic performance.

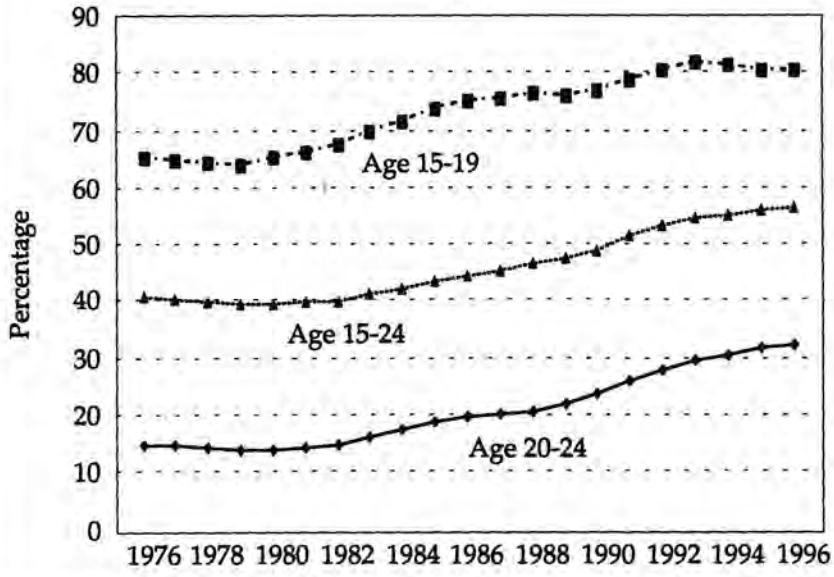
. . . youth unemployment rates vary considerably among the regions. By and large, unemployment rates among youth are higher in provinces with higher adult unemployment rates.

Statistical analysis of provincial-level data suggests a number of broad conclusions. Provincial youth unemployment rates rise or fall when provincial adult unemployment rates rise or fall. This is because macroeconomic performance is an important determinant of the labour market status of youth. Furthermore, as economic theory has long suggested is the case, increases in the real provincial minimum wage rates reduce youth employment rates, and vice verca. This is not surprising, since the young are likely to be those most affected by a high real minimum wage.

The evidence from micro-data

Studies of youth labour market micro-data suggest several generalizations. Specifically, higher unemployment rates tend to be concentrated among youth with the lowest levels of education. In general, young people with a high school education or less are more frequently unemployed than those with more education. This is not surprising since less educated workers are those with the fewest skills. In an environment where opportunities for unskilled labour are diminishing, the prospects for such

Figure 2: Proportion of Youth in School in Canada



Source: Marc Law and Fazil Mihlar, "Is there a Youth Unemployment Crisis?" *Public Policy Source* No. 8, The Fraser Institute, January 1998, p. 13.

workers are bleak. While more highly educated youth have recently experienced an increase in their unemployment levels, the real problem seems to lie with those who have the lowest levels of education. Hence, micro-level policies should target those with the lowest levels of education.

Modest policy measures

Policy action aimed at remedying the "youth unemployment crisis" should be modest at best. This is because (i) claims of a youth unemployment crisis are overstated; and (ii) the real youth unemployment problem is focused on those with the lowest levels of education.

At an aggregate level, the best solution to youth unemployment is a strong macroeconomic climate and a flexible labour market. A strong economy "lifts all boats;" the prospect of finding gainful employment improves for all individuals, including youth, when there is a strong and growing economy. A flexible labour market is also key, since labour costs are generally much higher in a rigid labour market than in a flexible one. Since young workers are newcomers to the labour market and have shorter job tenure than older workers, the adverse effects of an inflexible labour market are experienced disproportionately by young workers.

At a micro-level, the solution is to improve the educational system. As noted earlier, youth unemployment is highest among those with the lowest levels of education. Although school enrolment rates have been rising steadily for all Canadian youth, high school drop-out rates are apparently higher in Canada than in most other OECD countries. Hence, an important policy objective is to ensure that young people stay in school. Evidence from the United States suggests that government sponsored-training initiatives are unlikely to succeed in improving the employability and earnings of youth with low levels of education. This is because little can be done to compensate someone for neglecting the first 12 years of their schooling.

International test results suggest that Canadian students have quite poor numeracy and science skills. Since these skills are likely to be important in the future, it is essential that our education system redress this inadequacy. Market based educational reforms—for instance, school voucher or charter school initiatives—will likely result in a better match between educational supply and demand than is possible under the current system. This, in turn, should raise overall educational quality and reduce school drop-out rates.

[This article comes from a Fraser Institute ***Public Policy Sources*** *document entitled, "Is There a Youth Unemployment Crisis?" by Marc Law and Fazil Mihlar. It is available from The Fraser Institute for $4.95 plus shipping, handling, and GST. To order copies, call Cristina Roman at 1-800-665-3558, or, in Vancouver, at 688-0221, ext. 330.]* ✉

***Hong Kong** continued from page 26*

in the supply of money equal to the flight into US dollars. There can be no expansion of the money supply to make up for this flight since a corresponding supply of US dollars would have to be made available. The spiking of interest rates encourages more Hong Kong dollars to be held, and the downward spiral of confidence is halted in its tracks. The Hong Kong system works to automatically produce whatever interest rates are required to cause capital market participants to "shore up" the value of the Hong Kong dollar.

As for the rumour that Hong Kong will soon change the peg value of its currency, Joseph Yam will be quick to remind you that the central issue in Asian financial markets at this time is confidence. The central reason for the peg is confidence. It would be just plain dumb to adjust the peg at this time, so don't expect any adjustment. The time to adjust the peg, if that is desirable at all, will be during some future period of financial tranquillity and economic ebullience—a condition to which I am sure Asia will return in the not-too-distant future. ✉

Public Sector Employment

February Question and Answer

Joel Emes

Q: *How large is the public sector in Canada? How much is paid out to public sector employees in salaries?*

A: In 1996, the public sector employed 2.9 million people and paid out $103 billion in wages and salaries. Table 1 shows public sector employment and pay by province.

Public sector employment grew by 6.3 percent between 1981 and 1996; employment grew in every year from 1981 to 1992, but has been falling ever since. Only British Columbia and the territories employed more people in the public sector in 1996 than in 1991. The total bill for wages and salaries has fallen for almost every region since 1991; the only province with an increase was British Columbia.

Another way of measuring the size of government is to look at government spending as a share of Gross Domestic Product (GDP). If government spending as a share of GDP increases, the government makes more of the decisions, both important and routine, in the country. The private sector in the US, where government spending-to-GDP is only 33.5 percent, makes many more of the investment, location, and employment decisions than the private sector in Sweden, where the ratio is 68.8 percent.

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Table 2 shows the size of the government sector for fourteen countries from the late nineteenth century to recent times. This table is a partial reproduction from a recent International Monetary Fund study which looked at the growth of public spending and its effect on economic and social progress. One conclusion from the paper is that "most of the important social and economic gains can be achieved with a drastically lower level of public spending than what prevails today."

. . . countries with small governments have roughly equal or better real GDP growth and capital formation, lower unemployment rates, [and] smaller underground economies . . . than countries with medium or large governments.

The authors, Vito Tanzi and Ludger Schuknecht, observe that up until about 1960, increased public sector spending led to measurable improvements in social indicators (education and health). After 1960, however, big governments, whose spending increased to more than 50 percent of GDP, did not perform better in economic and social indicators than small governments, whose spending increased but stayed below 40 percent of GDP. In fact, countries with small governments

Table 1a: Public Sector Employment

	1981	1986	1991	1996	1981-1996 % change	1991-1996 % change
NF	55,076	59,088	61,301	56,403	2.4	-8.0
PE	12,237	13,542	15,256	14,824	21.1	-2.8
NS	117,805	114,503	120,723	108,059	-8.3	-10.5
NB	76,488	80,938	84,750	79,262	3.6	-6.5
QC	719,490	748,235	764,396	742,440	3.2	-2.9
ON	897,215	969,558	1,090,300	984,285	9.7	-9.7
MB	130,400	138,959	144,002	135,085	3.6	-6.2
SK	115,483	117,487	119,649	113,620	-1.6	-5.0
AB	260,564	285,731	297,291	261,852	0.5	-11.9
BC	283,131	289,143	326,997	350,550	23.8	7.2
YT	3,836	3,964	4,311	4,477	16.7	3.9
NT	8,119	9,622	10,949	11,103	36.8	1.4
Outside Canada	19,776	20,558	21,252	8,090	-59.1	-61.9
Total	2,699,868	2,851,600	3,061,781	2,870,527	6.3	-6.2

Table 1b: Public Sector Wages and Salaries, in Millions of 1996 Dollars

	1981	1986	1991	1996	1981-1996 % change	1991-1996 % change
NF	1,749	1,963	2,152	1,906	9.0	-11.4
PE	391	483	513	470	20.1	-8.4
NS	3,546	3,994	4,019	3,396	-4.2	-15.5
NB	2,372	2,699	2,762	2,617	10.3	-5.3
QC	25,592	25,261	26,380	25,390	-0.8	-3.8
ON	32,550	37,040	42,261	38,573	18.5	-8.7
MB	4,510	5,077	5,056	4,404	-2.4	-12.9
SK	3,772	4,179	3,866	3,409	-9.6	-11.8
AB	8,949	10,308	9,958	8,500	-5.0	-14.6
BC	10,511	10,565	12,061	13,024	23.9	8.0
YT	165	202	230	230	39.6	0.0
NT	366	457	591	592	61.9	0.1
Outside Canada	785	826	790	198	-74.8	-74.9
Total	95,558	103,154	110,612	102,739	7.5	-7.1

Source: Statistics Canada, special data request; and calculations by the author.
Note: Totals do not match the sum of the categories due to the suppression of confidential data by Statistics Canada.
Note: The definition of the public sector used in this table is based on Statistics Canada's Financial Management System and includes administration, government business enterprises, hospitals, school boards, the military, and universities.

have roughly equal or better real GDP growth and capital formation, lower unemployment rates, smaller underground economies, and more patents per 10,000 population than countries with medium or large governments.

Related research posits that there is an optimal size of government based on the simple idea that up to a certain level, government spending does more good than harm, but after the optimum level is reached, further increases in spending actually harm the countries' economy and people. An estimate for Canada using a model developed by Gerald Scully puts the optimal size of government spending at 29.8 percent of GDP. The last time total government spending was less than 29.8 percent of GDP was in 1966. If the spending-to-GDP ratio had stayed at 29.8 percent from 1966 to 1995, real GDP per person may have exceeded $32,000 instead of the $21,000 that we actually had.

This month's graph is further evidence that the government sector should not spend more than 30 percent of Canadian GDP. It shows a sharp drop in real GDP growth once the size of government exceeded 30 percent, and a reversal when the growth in government reversed. ✉

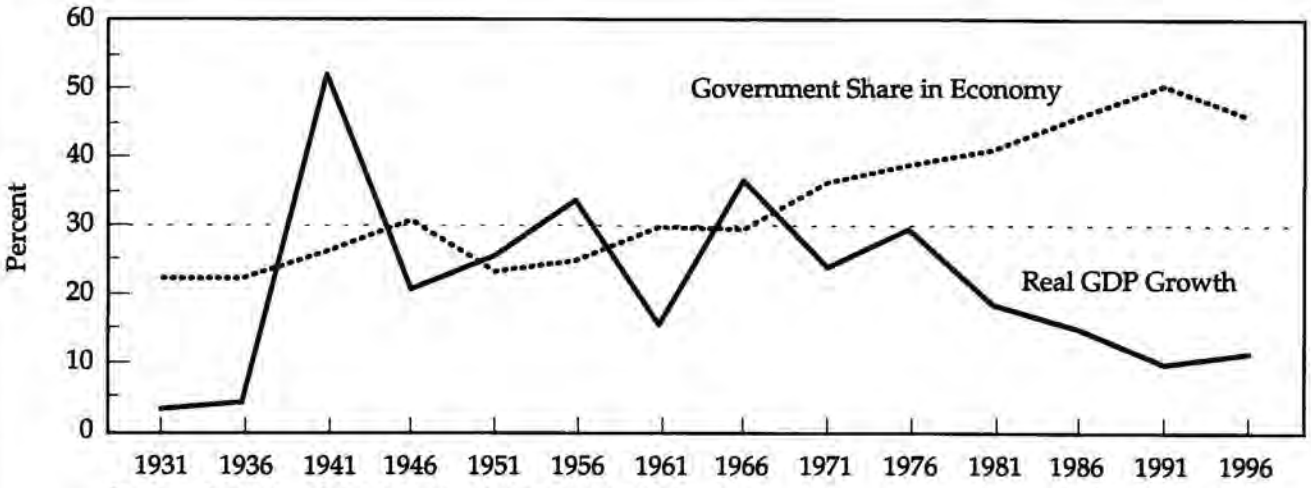
Table 2: The Growth of Government Expenditure as a Percent of GDP

	Later 19th century (about 1870)	Pre-World War I (about 1913)	Post World War I (about 1920)	Pre-World War II (about 1937)	Post World War II (1960)	1980	1990	1994
Austria	n/a	n/a	14.7	15.2	35.7	48.1	48.6	51.5
Belgium	n/a	n/a	n/a	21.8	30.3	58.6	54.8	54.8
Canada	n/a	n/a	13.3	18.6	28.6	38.8	46.0	47.4
France	12.6	17.0	27.6	29.0	34.6	46.1	49.8	54.9
Germany	10.0	14.8	25.0	42.4	32.4	47.9	45.1	49.0
Italy	11.9	11.1	22.5	24.5	30.1	41.9	53.2	53.9
Japan	8.8	8.3	14.8	25.4	17.5	32.0	31.7	35.8
Netherlands	9.1	9.0	13.5	19.0	33.7	55.2	54.0	54.4
Norway	3.7	8.3	13.7	n/a	29.9	37.5	53.8	55.6
Spain	n/a	8.3	9.3	18.4	18.8	32.2	42.0	45.6
Sweden	5.7	6.3	8.1	10.4	31.0	60.1	59.1	68.8
Switzerland	n/a	2.7	4.6	6.1	17.2	32.8	33.5	37.6[a]
United Kingdom	9.4	12.7	26.2	30.0	32.2	43.0	39.9	42.9
United States	3.9	1.8	7.0	8.6	27.0	31.8	33.3	33.5
Average	8.3	9.1	15.4	18.3[b]	28.5	43.3	46.1	49.0

Source: Vito Tanzi and Ludger Schuknecht, *The Growth of Government and the Reform of the State in Industrial Countries*, International Monetary Fund, 1995.
[a]1992
[b]Computed without Germany, Japan, and Spain.

February Graph

Joel Emes



Source: Statistics Canada and calculations by the author.
Note: 5 year real GDP growth rate.

Legal Viewpoint

Spousal Support—Heads She Wins, Tails He Loses

Karen Selick

The law of spousal support has become so repugnant to me lately that I often ponder giving up the practice of family law altogether. It's almost impossible to feel good about what you're doing. If you act for wives, you have to inform them about the kinds of claims they can make—including claims which I consider to be unjust or downright ridiculous. If you act for husbands, you have to be prepared to be on the losing side most of the time.

It seems that no matter what course a couple's married life took, the wife can always find some reason to claim spousal support. If she worked outside the home and supported her husband while he became a brain surgeon, her claim is for "compensatory support." If she did just the opposite, sitting around eating bonbons while the brain surgeon supported her, her claim is for "developing a pattern of economic dependency." I've even seen cases where the wife has claimed both grounds in the same action, oblivious to the possibility that the bonbon-eating lifestyle she enjoyed in the later years of marriage has already more than compensated her for whatever work she did in the early years, or to the idea that if she was such a great provider in the early years, there was nothing stopping her from maintaining her lucrative career throughout the marriage.

In fact, the only common thread running through most support orders is this: males pay.

I remember reading once about the peculiar notion held by some eastern philosophy that if you rescue a person from impending death, you become responsible for him for the rest of his life. Canadian courts seem to apply a similar prescript to support cases. Once a man has kindly provided a woman with a higher standard of living than she could reasonably have hoped to achieve on her own, he's stuck with providing it for years to come—maybe even the rest of her life—regardless of how she has behaved toward him or the reason they separated.

The Divorce Act enshrines this principle. It tells judges to alleviate any economic disadvantage arising from either "the marriage or its breakdown." That "or" is a powerful word. Suppose the marriage gave the wife an advantage rather than a disadvantage: a more affluent, leisured lifestyle than she would have earned on her own. Then, obviously, the termination of the marriage constitutes a disadvantage. So here's the upshot: if a man genuinely caused his wife some disadvantage during the marriage, he pays for that reason. But if instead he bestowed an advantage upon her, he pays for having stopped. Heads she wins, tails he loses.

Another objectionable thread woven through both the legislation and the case law is the notion that if a woman can't support herself after separation, the courts should make her ex-husband support her rather than see her go on welfare. Maybe the legislators and judges who came up with this idea thought it would placate opponents of welfare. If so, they've misunderstood the nature of the objection to welfare.

Welfare is objectionable because it is coercive and one-sided. It's not like charity, which is voluntary. It's not like a contract, from which both parties benefit. No, welfare simply forces some people to hand over money to oth-

ers whose predicament they didn't cause and who have provided no value in exchange.

The same could frequently be said about spousal support. Take, for instance, a recent Ontario case which I'll refer to as B. v. B, to save embarrassment to the people involved. The trial judge accepted the husband's evidence that this was a marriage "made in Hell." The wife, whose IQ was only 68, didn't work outside the home, but also didn't do housework. She watched a lot of television, while the husband assumed responsibility for cooking and cleaning, in addition to being the sole breadwinner. They argued a lot, and she was occasionally violent towards him. The trial judge awarded her only time-limited support, saying, "this husband started to pay for this marriage about three months after it occurred, and then he paid for the next 15 years, and I am not prepared to make him pay for the rest of his life."

On appeal, the Divisional Court removed the time limit on the wife's support, stating explicitly that the burden of the wife's support should fall on family members, not on taxpayers. Why? What principle of justice or morality warrants making Mr. B. pay, as opposed to some unrelated taxpayer? Neither of them caused the wife's need for support. Neither of them will ever receive any significant benefit from her existence.

In fact, we've thrown out just about every principle there ever was—from the notion of contract to the notion of fault—that made matrimonial law rational, comprehensible, predictable, controllable, or just. While some people may feel that no-fault support has been a liberating event, it's clear that for others, it has meant nothing but grief and involuntary servitude. It's about time we re-examined the unfashionable idea of marital conduct to see whether justice can ever again form part of matrimonial law. More on this next month. ✉

Fraser Institute Calendar of Events

Tuesday, March 3, 1998
Hyatt Regency Hotel, Vancouver
Round Table Luncheon with speaker John G. Greenwood, Chief International Economist, Chancellor LGT Asset Management, San Francisco, on "Asia's Financial Crisis—Causes, Cure and Outlook."

Friday, March 20, 1998
Sutton Place Hotel, Toronto
HALF-DAY CONFERENCE: "Liquor Retailing: Options for Ontario"

Monday, March 30, 1998
Renaissance Hotel, Vancouver
Economic Advisory Luncheon
and
Thursday, April 2, 1998
TBA, Toronto
Evening Lecture
with Nils Lundgren, Stockholm, Sweden on "The Dramatic Success of School Vouchers in Sweden."

***Wednesday, April 15, 1998**
TBA, Vancouver,
HALF-DAY CONFERENCE: "Endangered Species: The Case for Private Protection."

Friday, April 17, 1998
Hyatt Regency Hotel, Vancouver
Roundtable Luncheon with speaker Carol Crawford, Commissioner, US Trade Commission, Washington on "NAFTA Dispute Resolution: Expectations and Experience."

***Tuesday, April 21, 1998**
Sheraton Wall Centre, Vancouver
CONFERENCE: "Sensible Solutions to the Urban Drug Problem."

***Friday, June 26, 1998**
TBA ,Vancouver
CONFERENCE on "Electronic Commerce: Free Markets in Cyperspace."

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**Date may change.*

Economic Terminology Explained

The Ricardian Equivalence Theorem: Back to the Future?

Marc Law and Jason Clemens

David Ricardo, the great 19th century classical economist, first postulated the theory that bears his name in a seminal work entitled *The Principles of Political Economy and Taxation*, in 1817. In this work, Ricardo advanced a hypothesis which is known today as the Ricardian Equivalence Theorem (RET). Its central insight is that how a government chooses to finance its expenditures is irrelevant for real economic activity. According to the RET, consumption and capital investment choices are not influenced by the timing of government taxes and deficits. While the amount government spends does influence real economic activity, the particular way in which government finances its spending does not. Hence, according to the RET, economic activity is neutral with respect to the mix of debt and taxes that the government uses to finance its expenditures.[1]

The main hypothesis of the RET can best be illustrated through an example using the Breland family. Suppose the world consists of two periods—today and tomorrow—and assume that the government spends a fixed amount each period. The government has many ways it can finance its expenditures. It can a) balance its budget each period by levying taxes both today and tomorrow which generate revenue equal to its spending each period. Or it can b) run a deficit today by issuing bonds, and raise taxes tomorrow. Or it can c) run a surplus today and then cut taxes tomorrow. Notice that regardless of whether the government uses method a), b), or c) to finance its expenditures, the total lifetime tax liability of the Breland family is the same. While the timing of that tax liability is different in each case, the total value of the Breland's tax liability is fixed. If the Brelands seek to smooth their consumption over time, as discussed in last month's article, then what is relevant to them is the total value of their tax liability, not its timing. Hence, the timing of taxes and deficits used by the government to finance its spending is irrelevant to the Breland family's consumption choices.[2]

Let us make this example more concrete. Assume that the government decides to cut taxes in the present period with no change in expenditures (operate in deficit today) and that this tax cut generates $500 in extra disposable income for the Breland family in the current period. Assume also that the lifetime tax liability of the Brelands is $100,000, based on the level of government spending during their lifetime. If the Brelands are forward-looking, they will realize that lower taxes today imply higher taxes sometime in the future. In order to smooth their consumption over time, the Brelands will save the extra $500 generated by the tax cut and use these savings to purchase $500 in government bonds. When the bonds mature, the Brelands will

1 For a comprehensive review of the literature on Ricardian Equivalence see John J. Seater (1993), "Ricardian Equivalence," *Journal of Economic Literature*, 31: 142-190. See also Robert J. Barro (1989), "The Ricardian Approach to Budget Deficits," *Journal of Economic Perspectives*, 3: 37-54.

2 Seater, p. 143, asserts that the Ricardian Equivalence Theorem is simply "a generalization of the Life Cycle-Permanent Income hypothesis (LCPIH)" in which the consumption-based LCPIH is extended to include government purchases, taxation, and debt. See the January 1998 edition of *Fraser Forum* for a simple discussion of the LCPIH.

use the proceeds from the bonds (principle and interest) to compensate for the higher taxes they will have to pay in the future. The Brelands choose to do this because they realize that with no compensatory decrease in spending, the government has simply shifted their tax liability to the future. The RET, therefore, predicts that a tax cut, with government spending held constant, will have no effect on consumption or capital accumulation.

if individuals only care about their own consumption . . . it is possible for individuals to make themselves better off following a tax cut by forcing future generations to bear the burden of the future tax increase.

The RET is often discounted in public policy discussions regarding the government budget. This is because many scholars believe that the assumptions built into the RET are not generally applicable in the "real world." One major criticism of the RET is that, applied in a dynamic setting, it requires individuals to have an infinite planning horizon. This is obviously implausible given that nobody lives forever! Indeed, Paul Samuelson and Peter Diamond, two prominent Keynesian economists, have formalized this criticism and shown that, if individuals only care about their own consumption, then the RET is invalid.[1] In such a world, it is possible for individuals to make themselves better off following a tax cut by forcing future generations to bear the burden of the future tax increase.

In a famous 1974 paper published in the *Journal of Political Economy*, Robert J. Barro re-asserted the applicability of the RET.[2] According to Barro, individuals with finite lives will behave *as if* they have an infinite planning horizon if they care about the welfare of their children. In other words, if parents are "inter-generationally altruistic," children (and future generations) are incorporated into the planning decisions of parents. Altruism of this sort allows the "treatment of another's utility as an extension of one's own."[3] In such a world, the RET holds, since the parents behave as if they expect to live forever!

Both the Samuelson-Diamond critique and Barro's re-assertion of the RET are again illustrated using the Breland family. Suppose the government implements a 10 percent tax cut which is financed by government bonds. Assume also that the Breland parents will not live to see their taxes increase. If the Brelands behave according to the Samuelson and Diamond model (i.e. they only care about their own welfare), then they will use the proceeds from the tax cut to increase their consumption and thereby force their children, John and Mary, to bear the burden of a future tax increase. The RET obviously fails to hold in this scenario since the tax cut induced the Breland parents to increase their current consumption. However, if the Brelands behave as Barro posits (i.e. they care about their welfare *and* their children's welfare), then the fact that Bob and Jillian may not live to see their taxes rise is irrelevant. If Bob and Jillian are inter-generationally altruistic, they will save the tax cut and pass on their saving to their children as a bequest in order to offset their children's higher future tax liability. In this scenario, RET holds.

Many critics of deficit financing often decry the fact that higher deficits today will leave future generations worse off. Steven Landsburg, an economics professor at the University of Rochester, makes an interesting counter-argument. In his new book entitled *Fair Play*, Landsburg argues that current deficits will only leave your children

1 See Peter A. Diamond (1965), "National Debt in a Neoclassical Growth Model," *American Economic Review*, 55: 1126-1150; Paul A. Samuelson (1958), "An Exact Consumption-Loan Model of Interest With or Without the Social Contrivance of Money," *Journal of Political Economy*, 66: 467-82.

2 Robert J. Barro (1974), "Are Government Bonds Net Wealth?" *Journal of Political Economy*, 82: 1095-1117.

3 Seater, p. 147.

worse off if you want them to.[1] As we noted above, RET fails to hold if parents do not care about the welfare of their children. Since there is nothing stopping parents from leaving altruistic bequests to future generations, children are only worse off if their parents want them to be.

. . . the central policy issue is how much government should spend, and not how it finances that spending.

In spite of the simple and powerful intuition of the RET, many economists remain sceptical about its real world applicability.[2] Challenges to the RET have been made on a number of grounds, including non-altruistic bequest motives, childless families, liquidity constraints, uncertainty, differential borrowing costs, distortionary taxes, and interest rate and growth rate differentials. Obviously some challenges to the RET are more serious than others. For instance, the criticism based on the possibility that certain individuals face liquidity constraints and would therefore prefer debt to current taxes is a valid criticism of the framework underlying the RET.

Given the restrictive assumptions which must hold in order for the RET to be true, it is difficult to accept that the RET is strictly applicable to the real world. Nonetheless, there is common agreement among macroeconomists about the approximate applicability of the RET.[3] Indeed, it is interesting to note that statistical tests of the RET have, in general, been inconclusive. In a recent paper by Emmanuela Cardia, it was shown that most of the statistical tests used to determine whether or not the RET holds are invalid.[4] In this paper, Cardia constructed two artificial economies—one in which the RET holds and one in which it does not—and then used these artificial economies to generate simulated data. Cardia then applied a number of standard statistical tests to the simulated data and found that the tests were unable to distinguish the Ricardian economy from the non-Ricardian one. Clearly the jury is still out on the Ricardian Equivalence Theorem.

There is a very important public policy implication that can be derived from the RET which substantially alters the terms of the current debate in Canada about "how to spend the fiscal dividend." If one believes that the RET is a reasonable approximation of reality, then the debate on how to spend the fiscal dividend is really a red herring. The fundamental insight of the RET is that while the timing of taxes and deficits has no impact on real economic activity, the amount the government spends does. This is because greater levels of government spending raise an individual's total tax liability, but changes in the timing of deficits and taxes (holding government spending constant) do not. Viewed from this perspective, the central policy issue is how much government should spend, and not how it finances that spending. Policy discussion should therefore focus on the optimal size of government (i.e., how much should government spend?) rather than on the mix of debt and taxes used to finance those expenditures.[5] ✉

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1 Steven Landsburg (1997), *Fair Play: What Your Child Can Teach You About Economics, Values, and the Meaning of Life*, New York: The Free Press.

2 Seater provides an excellent overview of these criticisms. See also B. Douglas Bernheim (1987), "Ricardian Equivalence: An Evaluation of Theory and Evidence," in S. Fischer, ed., *Macroeconomics Annual*, Cambridge: MIT Press.

3 In particular, Seater concludes that the RET is a "close approximation of reality."

4 Emmanuela Cardia (1997), "Replicating Ricardian Equivalence Tests with Simulated Series," *American Economic Review*, 87: 65-79.

5 For further information see the forthcoming Fraser Institute publication on the optimal size of government in Canada.

Institute News continued from page 18

Big Business"... Environmental Economist **Laura Jones** discussed global warming on Montreal's top English language call-in show, **CJAD's Tommy Schnurmacher Show**, on Vancouver's **CBU-AM Rick Cliff Show** and in widely published editorials... **Fazil Mihlar**, Senior Policy Analyst, was quoted in the *Toronto Star* on the current unrest of unions. Fazil also reported widely that the Canada-US Free Trade Agreement signed 10 years ago is, from a trade perspective, a resounding success... And the French language *Journal de Montréal* reported on the Insitute's health care studies, in particular, on waiting times for surgery...

The Fraser Institute expresses its condolences to the family of **Bruce Howe**, who passed away recently following a valiant fight with cancer. Among the numerous positions Bruce held during his illustrious career, which spanned both the public and private sectors, was his appointment as **Fellow of The Fraser Institute**. Bruce's most recent work for the Institute focused on the privatization of Crown Corporations, and culminated in the publication of a *Critical Issues Bulletin* which he co-authored with Frank Klassen, "The Case of BC Hydro: A Blueprint for Privatization."

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Response to Readers

A number of readers have responded to the article entitled "The Doomsday Bug?" from last month's edition of *Fraser Forum*, which dealt with the year 2000 computer problem. As a result, here are a few notes of clarification.

First, some technical issues. Although I wrote about mainframes, it is true that there are many examples of non-compliant systems in decentralized or stand-alone environments. I used this focus to simplify the text. Along the same lines, the metaphor I used to explain the problems other than calendar changes in non-compliant systems was not the strongest. I suggested that math errors could cause a computer system to crash when it would have been clearer if I had described difficulties with data transfer packages. These difficulties can occur when references are made to values that are no longer valid. I also agree that there are wider issues than those I tackled in my article, such as non-valid references, bugs, and loops, which will inevitably be exposed by tampering with source code. It is, after all, a problem that was built into the systems from the start. Finally, as some readers pointe out, a full chronological year is not necessary for compliance testing, which can be conducted in a partition or in a stand-alone PC. However, it is the general consensus of bug consultants that it is prudent to have a Y2000 system running live for one year prior to January 1, 2000.

On the broad issue of who will ultimately suffer the greatest loss due to the bug, however, I continue to feel that government—particularly large government—will have the greatest difficulties. In my discussion with numerous technicians working in small business, big business, non-profit organizations, and government, the clear indication is that government has made the least progress towards compliance. Apparently this is also the view of Canada's Auditor General, Denis Desautels, whose October 1997 report *Information Technology, Preparedness for the Year 2000* strongly suggests that the federal government needs to dramatically step up its preparations for the year 2000.

—Mark Weller

Environment

Let's Talk about the Weather

Laura Jones

We could have guessed that it wouldn't be long before the latest weather events would be blamed on increases in greenhouse gases from industrial activity. In what seems erratic logic, any unusual weather event from a record high temperature to a blizzard is now blamed on global warming. Understandably, the apocalyptic vision of warming leads us to expect droughts and floods—but more ice storms? Much to the disappointment of those who live in Winnipeg, the purveyors of doom claim it is not just more "hot, hot, hot" that we should expect, but more temperature *extremes*. This, of course, is quite convenient because it means that any unusual weather event (and there is nothing all that extraordinary about unusual weather events) is touted as irrefutable evidence that 1) we are indeed experiencing global warming, 2) it is our fault, and 3) we can expect worse events to follow unless we take action.

But how reasonable are these arguments? Do extreme weather conditions such as snow storms provide any evidence that we are cooking the planet? The media seem to think so. In response to a stormy winter two years ago, *Newsweek* ran a cover story "Blizzards, floods and hurricanes: blame global warming." The Red River flood last year was blamed on warming and, more recently, the CBC ran a story on "The National" about whether the ice storm in Montreal could be blamed on warming.

But those most familiar with the science of climate change are dismissive of the media hype surrounding individual weather events. According to a recent poll of officially designated professional state and regional climatologists in the United States, 72 percent said that weather events in the past 25 years have not been more severe or frequent in their states. Of the 19 percent who said that they were, less that a third attributed the changed weather patterns to global warming.[1] What is mainstream media, then, is hardly mainstream science. John Christy, an atmospheric scientist at the University of Alabama and contributor to the Intergovernmental Panel on Climate Change (IPCC) reports, explains: "It is extremely frustrating as a scientist to see in the media that every weather woe is now being blamed on 'climate' change when in fact these events are part of the natural variability of the climate system."[2]

So what of drought and record temperatures—other apparent symptoms of warming? The recent statement by the National Oceanic and Atmospheric Administration (NOAA) that 1997 was the warmest year on record may seem more like reasonable proof of the apocalypse, but don't jump on the bandwagon just yet. The average temperature in 1997 was only three-quarters of a degree above the average for the past 30 years. In addition, the warming only appears in the ground-based measurements. The satellite data show a slight global cooling over the past 19 years (including 1997). Finally, the one thing we

1 *Survey of State and Regional Climatologists*, Citizens for a Sound Economy Foundation, September-October 1997, Washington, DC. Complete results of the CSE survey available online at: http://www.cse.org/surveyenviroreg100897.htm.

2 John Christy, "Evidence from the Satellite Record" in Laura Jones, ed., *Global Warming: The Science and the Politics*, Vancouver: Fraser Institute, 1997, p. 73.

know for sure about the weather and climate is that they change naturally. As a result, it would be ludicrous to point to one warm year and claim that it represents a trend in climate for which man is responsible.

Even if global warming were happening, it may surprise you to hear that scientists predict *fewer* extreme weather events in a warmer world. According to Robert Davis, a professor of Climatology at the University of Virginia, global warming should create warmer polar air masses, a condition that would lead to less snow in North America, not more.[1] Davis explains: "The theory behind heavier snowstorms is that a moister atmosphere will precipitate more. Yet this logic lacks a circulation-based understanding of snowstorms on the American east coast. In addition to sufficient moisture, eastern blizzards require a deep layer of below-freezing air over the region—there is no logical reason to expect these polar air masses to become colder from global warming."[2]

Increased flooding caused by global warming is another theory that doesn't make sense, because it snows less when it is warm and many floods are the result of melting snow. Finally, there is no evidence to support claims that warming will increase hurricane activity. In fact, according to Robert Balling, director of the Office of Climatology at Arizona State University, "there is plenty of evidence from which to argue that the greenhouse effect will suppress hurricane activity."[3]

Attributing individual weather events to a larger trend in climate is media reporting at its worst. It is alarmist, sensational and misleading. Given the importance of the debate about global warming both in the science and policy communities, it is time to return to our senses. As Robert Davis puts it: "the impulse of the non-scientific person is to blame just about any anomalous weather event on mankind's industrial productivity. Yet, most of these projections fail under the scrutiny of scientific evidence. And, if sound science is not the fundamental basis for policy decisions on global-climate change, then these decisions have no sound basis."[4] ✉

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1 Patrick Michaels and Robert Davis, "Why So Cold and Stormy This Past Winter?" *Consumers' Research*, April 1996, pp. 15-17.

2 See Robert Davis, "Extreme Weather, Atmospheric Circulation, and Global Warming," in Laura Jones, ed., *Global Warming: The Science and the Politics*, Vancouver: Fraser Institute, 1997, pp. 118-119.

3 See Robert Balling, "The Spin on Greenhouse Hurricanes," in Laura Jones, ed., *Global Warming: The Science and the Politics*, Vancouver: Fraser Institute, 1997, p. 136.

4 Robert Davis "Extreme Weather and Atmospheric Circulation" in Laura Jones, ed., *Global Warming: The Science and the Politics*, Vancouver: Fraser Institute, 1997, p. 122.

Measuring Wealth

National Income and the Ice Storm

Filip Palda

Journalists out east have editorialized at length about what the ice storm has taught us. My nugget of wisdom came to me while squirming under the cold shower: the ice storm proves that Statistics Canada's measures of national income need to be revised. Why is that?

For me, income is something that points directly to good feelings. National income statistics often fail to make this connection. The wood, kerosene, batteries, and candles that allowed me to bumble about in the shadows of my house and make the fires over which I scorched hotdogs to husks cost me more than the electricity that in normal times I would have used to effortlessly cook, light, and heat. The difference in costs will show up as a rise in national income. There will be no government record of my burnt meals and shivering nights.

British economist Maynard Keynes explained the problem this way: according to national income statistics, if you marry your maid, national income goes down. The salary you no longer pay her is deemed to be a fall in the country's wealth, even though the two of you may be happier than before the marriage. In telecommunications, the national income stats measure output by the number of minutes the phone lines are used. This ignores the improvements to the quality of our lives that come from faxes and email. These novelties allow us to pack more information into a 30 second fax or email than into a 30 minute phone conversation. The fewer minutes you spend on the phone are now available for you to spend with your family. That counts as a fall in national income.

Improvements to the qualities of our lives are a challenge to measure. How do you account for the convenience of doing your banking with an automated teller when your night shift ends at 4:00 a.m.? Yale economist William Nordhaus used sophisticated technical and historical insights to isolate and measure the benefits from improvements in lighting technology. He calculated that in 1970 a dollar spent on lighting bought only about a tenth of the amount of brightness (as measured in kilolumen hours) that it buys today. At the turn of the century, that dollar bought you 4 percent of what it gets you today, and in 1800, a dollar got you one quarter of one percent of the brightness of today's dollar. But in terms of national income, that dollar gets counted the same way. The better safety of cars today, and improvements in medical care, and a long list of improvements to the quality of life are absent from statistics on gross domestic product. Don't look to these statistics to capture much of the suffering from the ice-storm.

As the power starts to come back on, people are getting a sense of how much better off they are now than in "the old days." I now understand why people wore housecoats and house hats, and that patrons crowded pubs not so much for the alcohol, as for the heat. These insights could give us some perspective on the talking heads who announce on television that gross domestic product per capita has hardly budged in 20 years, that life is rougher than it was back then, and that no progress has been made in bettering the lives of the poor. National income numbers, as they are calculated, are not up to the task of telling us about such improvements. US economist Leonard Nakamura estimates that if we took these improvements to quality into account, we would see the late 20th century as a time of growing prosperity. People who have recently travelled back in time courtesy of the ice storm, will have the raw information needed to weigh this statement. ✉

Spending and Taxation

Dividing Up the Dividend

Gordon Gibson

In an article in the November *Fraser Forum* on the proper way to use the "fiscal dividend" arising from the very high tax rates of the federal government, I suggested that one way it *not* be used was to increase CHST (Canada Health and Social Transfer) payments to the provinces—even if that is exactly what the provinces are demanding. Rather, I suggested that in this area Ottawa should phase out the CHST (which stands at about $12 billion, a very significant budget item), and lower federal taxes by the same amount.

The logic, of course, is that social programs are the constitutional responsibility of the provinces, and proper accountability in a democracy requires that the spending government also do the taxing. Provinces would thus assume the CHST tax room vacated by the federal government. (The differing financial resources of the provinces are compensated for by the federal expenditures on equalization, now standing at about $8 billion, and capable of a modest increase, if required, as part of ending the CHST.)

In addition to accountability, considerations of efficiency also point to provincial administration of social programs. The provinces (or in the larger provinces, sub-regions) are demonstrably better equipped than the enormous and remote federal government to carry out programs that actually require management, and for one reason or another are not to be done by the private sector.

But if local management is the right place to end up, getting there poses some large practical problems. The greatest of these is political—i.e., the federal government is very concerned about losing direct contact with voters, lest it becoming increasingly irrelevant in a world that is both globalizing and decentralizing. That is why the federal government has always tried to paint itself as the defender of medicare, even though about 90 percent of the dollars that fund medicare come from the provinces, and the real foundation of medicare is public demand, not government at all.

Thus, there is currently a huge debate under way in the federal government in the wake of the First Ministers' Conference, which agreed to try to negotiate a "framework" between the two levels of government with respect to setting social policy. The Ontario caucus (almost two-thirds of the government support), takes the traditional Liberal approach of centralized, big spending, in the belief that this wins votes. Other caucus elements outside of Ontario, and particularly some Quebec ministers with a keen eye on national unity, are far more for decentralization.

We want governments to spend less, and provide better service.

This is all a part of the political marketplace, and like any market, it works better with information. Since Ottawa has the power of the taxation hammer (i.e., the ability to tax all across the country and concentrate spending where it wishes), only better information and arguments will persuade the federal government to reform in this area. Fortunately, the arguments that matter to politicians—namely, political arguments—exist, and are persuasive.

Of course, one hopes that a political argument can also be good public policy, and that is possible here. To lay the foundation for that, note the doctrine of comparative advantage. Local units (private or public) are de-

monstrably better in administration. However, the federal government has a large comparative advantage in efficiently raising money and writing cheques according to simple rules that do not require much judgement or knowledge of local circumstances or cases.

In other words, the federal government is very good at income redistribution. Now, it is up to the voters how much income redistribution they think is ideal in any given society, but clearly Canadian voters have quite an appetite for this. This points to the appropriate way for the federal government to maintain and enhance its political profile, and yet withdraw from trying to fine-tune the delivery of services—a job it does very badly.

The seniors' benefit and child tax credits are examples. These large-scale, income redistribution programs (one a cash payment; the other a tax credit), help provide an income base related to need. (The old-style, universal Old Age Pension is gone for everyone under 60.) The political advantage for the federal government of such programs is that the citizen receives a cheque (or credit) explicitly identified with Ottawa. Indeed, this is a great advantage over the current CHST, for which the federal government receives little or no credit on the expenditure side, yet suffers the opprobrium from collecting the tax.

So, which new direct-to-citizen programs (if any) should the federal government consider? These should be developed in cooperation with the provinces, to achieve two ends. One would be, as with the revamped child tax credit, to provide a common trans-Canada base on which the varied and case-specific social programs of the provinces can be built. The second end is to make sure that all of this is done by way of trade-off, to try to shrink the total role of government in the economy, while improving services.

Three new areas show particular promise for the federal government. The first is very low cost, and very controversial, with the likely objections coming from the provinces. We all know that the first key to improving the efficiency of government programs comes from measurement. How effective are program outputs compared to goals? The federal government should be given a performance auditing role in the social policy area. Once it is out of the field, it will have the necessary objectivity to do this job. Citizens would find a rigorous interprovincial comparison of social program costs and effects very beneficial in calling their own government to account.

The second area is also low cost, and imaginative. Pilot projects are useful in improving government programs, but they often involve extra costs, and are onerous for any one jurisdiction. Federal support can assist such projects without offending proper accountability.

The third area will take much more exploration, and will be the subject for a future article. That area is the quest for equality of opportunity for Canadian children, wherever they may be born. The federal government is particularly well positioned to bring this elusive concept closer to reality.

We want governments to spend less, and provide better service. Exploitation of comparative advantage is the key to this. But political realities must be accommodated along the way. The next and final instalment of this series will discuss how improvements in Canadian federalism can bring these threads together, with particular emphasis on children. ✉

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Social Policy

Solving the Urban Drug Problem: An Agenda for a Rational Debate

Patrick Basham

In my neighbourhood on the edge of Vancouver's Downtown Eastside, a corner-store clerk refers to most residents as "extras from *The Night of The Living Dead.*" Welcome to the city's so-called "Killing Fields," where local health authorities declared a state of emergency after needle sharing among 6,000 injection heroin and cocaine users produced the highest rate of HIV infection in the Western world. The annual cost of HIV/AIDS treatment for this area is a staggering $45 million.

In many North American cities substance abuse is public health enemy number one. But can the myriad social problems that feed off the illicit drug trade be tolerated *ad infinitum* without a franker public debate over the nature of drug policy?

The evidence suggests prohibition campaigns have met with mixed results, at best. Approximately 2.8 million Canadians have a family member with a drug problem; British Columbia police estimate that 60 percent of all non-drug crime is motivated by drug use. The preference for crack cocaine in Toronto, for example, is the result of prohibition, a reflection of the economics of a war on powdered cocaine. In 1995, $57.3 *billion* was spent in the US on illegal drugs. Such an unregulated, untaxed industry is, unsurprisingly, a very profitable one that continues to attract entrepreneurial entrants.

Since the early 1980s drug use has declined among casual middle-class drug users. But among hard-core users, drug use has remained constant. This suggests our "one size fits all" approach to drug policy is inefficient; instead, a variety of approaches may be necessary. Current laws, however, prevent us from drawing the necessary distinctions between types of drug users; revealingly, most North American police officers do make this distinction.

The criminal justice system has been unable to significantly reduce illegal drug use. For prohibition to succeed, is the only option an unprecedented infusion of public money into law enforcement? This is the so-called "Singapore" model, and one with little appeal to those concerned about civil liberty.

But there's a wide policy spectrum within which to place any new drug policy, ranging from authoritarian Singapore at one end, all the way to full-scale, free market legalization at the other end. What's critical is that such a debate be placed firmly upon the political agenda, and that we begin to engage in a discussion about whether, and how, to implement reasonable alternatives to the status quo.

If it proves possible to legitimize the discussion of drug policy without condoning drug abuse, to determine where the pragmatic options lie, we must answer the following questions:

If some drugs are illegal because they're dangerous, addictive, and produce unacceptable social consequences, do scientific appraisals of drug-related risks prove that so-called "soft" drugs (e.g., cannabis, ecstasy) more closely mirror alcohol, tobacco, and nicotine than so-called "hard" drugs (e.g., heroin and cocaine)?

Can we, and if so, how do we make prohibition work better? The "harm reduction" approach seeks to reduce the harmful effects of both drug use and pro-

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Internet Technology

Monopoly and Telephony

Mark Weller

During Expo '67 in Montreal, many new technologies were displayed, technologies that embodied the hopes of the future, technologies that were to be available to the consumer very soon. My particular favourite was the video-phone, which allowed one party to see the other when the two were connected during a call. One commentator's remark in particular stands out: "better make sure you comb your hair before you use one of these!"

Unfortunately, the implementation of technology rarely goes as planned. The videophones have been just one casualty. Not only are there the inevitable technical glitches, but, even more worrisome, are the government-erected barriers, regulations, and taxes that prevent the new technologies from fully developing. The telecommunications industry has been particularly hard hit by regulation, which often has a perverse way of preserving old technologies.

One current example of this is internet telephone technology. A few weeks ago, Bell Canada and the Stentor Group asked the Canadian Radio and Telecommunications Commission (CRTC) to limit the ability of internet service providers (ISPs) to offer telephone services. The companies view this as unfair competition, and want the CRTC to stop it by treating ISPs like phone services.

The technology in question is one you may have seen on television, or perhaps in reality. Internet phone initially involves the use of computers with microphones on them to sample and transmit voice messages. However, with the development of newer compression technologies, companies like iPhone have come up with a way to provide real time audio communication between computers over the internet. So, if you and your friend both have microphones and speakers on your PCs, and you have internet access that allows for this service, and you are both running the software, you can talk across the net.

Now, at first blush, this modest technology would not seem much of a threat to the regional phone utilities. When I first looked at this technology about two years ago, I have to admit I thought it was a flash in the pan. After all, as long as you had access to a telephone, why would you go through this process to make a call, other than for the novelty of it? However, since then, these technologies have become easier and easier to use. As well, you can interact with the regular phone system much more easily, send faxes, and take advantage of new phone sets that are designed to plug directly into your computer.

The real advantage, though, is economic. When it comes to long distance communication, the internet phone services cost no more than your existing internet service fees. So if you are on a flat rate per hour of $2, then your charge per minute is just over 3 cents. That is a 50 percent saving over even the cheapest long distance plan, and most users actually pay less than 3 cents a minute for net access.

Long distance telephone providers have been concerned about this for a while. However, since they have largely benefited from de-regulation, they have been slow to approach the CRTC for intervention. Not so the local phone monopolies which have, of course, suffered due to competition which has forced them to offer broader service at cheaper prices. The Stentor/Bell consortium has asked the CRTC to force internet service providers to comply with regulations and pay additional charges because they are con-

cerned that consumers might use the net to reduce their phone costs. Specifically, the group wants all ISPs to register with their local phone company and pay fees that would subsidize local phone service—a sort of tax on ISPs for providing a service that consumers want.

The one hope for consumers may lie in the fact that it is difficult to distinguish between different types of data traffic being sent across the net. Regardless of its technical feasibility, however, it is clear that the CRTC should not implement these policies. Charging ISPs would simply create a disincentive for the development of iPhone and other technologies and is completely inconsistent with the CRTC's broader initiatives to allow for greater competition and less regulation.

Once again, here is an example of how regulation can cause even the beneficiaries of a new technology to act irrationally. In a monopoly, the enemy is competition. If Bell had to compete with ISPs for customers, I have no doubt it would soon become a key player in the market for internet telephony. However, instead, it is pursuing a wrong-headed policy of requiring ISPs to be treated like phone providers.

All this leads us to understand why there are still no videophones. It is easy to imagine that if the net ever got to the point where live television signals could be sent over the web, another consortium would soon appear. Just as the regional Bells are arguing to the CRTC that they should receive an internet fee, so too, one can envision the cable companies asking that ISPs be charged if they provide television services across the net.

Once again, the CRTC is positioned to make a decision that could foster greater connectivity, and prepare Canada for the twenty-first century, or to defend a vested interest, and in so doing postpone the future. One hopes that the government will resist siding with one stakeholder over another, and instead let the market determine which technology serves consumers best. ✉

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hibition by marrying drug enforcement with treatment and education. Advocates suggest, for example, that the public health benefits of free needle exchange programs exceed the moral costs of condoning drug use.

Should our objective be learning to live with drugs so they cause the least possible social harm? Since 1994, the Swiss have experimented with supervised injections for 1,000 addicts at heroin maintenance clinics. The results suggest a drop in both illegal heroin and cocaine use and falling crime figures.

Should any legalization proceed gradually, beginning with soft drugs? What would be the affect on children? Would legalization lead to more drug use, and thus to even higher health costs? Could it lead to even more crime by lowering inhibitions? Or would legalization result in a safer, cheaper product, and fewer resources spent on law enforcement?

Public opinion isn't ready for legalization, although reform is growing more acceptable. According to an *Angus Reid* poll, 51 percent of Canadians support the decriminalization of marijuana (up from 39 percent a decade ago). But public opinion *is* ready for a rational investigation of what has, and hasn't worked, domestically and internationally, and whether or not it is time to use persuasion and education, rather than force, to shape people's attitudes and actions.

Since British Prime Minister Tony Blair appointed his first "drug czar," his country has begun a belated debate on the issue of illicit drugs. In Canada, the need for such a public airing of respectable, if differing opinions on this highly emotive subject is no less overdue.

[Note: The Fraser Institute is planning a one-day conference on drug policy, entitled ***Sensible Solutions To The Urban Drug Problem****, to be held in Vancouver on April 21, 1998. For further information about the conference, please call (604) 688-0221, ext. 310 or (416) 363-6575, ext. 310.]* ✉