Health care as a commodity

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One of the arguments that is often advanced in defence of the public health care system in Canada appeals to the idea that medical care should not be treated as a "commodity." The recent Romanow *Report on the Future of Health Care in Canada*, for instance, says that, "Canadians view medicare as a moral enterprise, not a business venture."[1] Public provision is then urged on the grounds that this is the only mode of delivery compatible with this constraint. This argument has received surprisingly little scrutiny, despite the important role that it plays in structuring the recommendations of the report, not to mention the broader public debate. This is unfortunate, since not only is it, in my view, a bad argument, but it is one that actually obscures the rationale for the current public system. It encourages the widely shared misperception that health care is a pure public good in our society (financed through taxation, then provided "for free" to all citizens). Provincial governments in Canada do not, for the most part, deliver health care services directly to the population. What they provide instead is health insurance. They rely primarily upon the private sector to deliver care. Thus the Canadian health care system more closely resembles what is often described as a quasi-market, or a "public market." The justification for the role of the public sector in health care can be traced back to market failure in the insurance sector, and not in the market for health care services.

This quasi-market structure is one of the primary sources of efficiency gains in the Canadian health care system. For example, while the failure of the National Health Service in Britain to adopt new information technology eventually generated a major institutional crisis, the Canadian system shows no sign of such difficulties. Part of the explanation undoubtedly stems from the fact that doctors in Canada have every incentive to adopt new information technology as it is developed, simply because administrative expenses come directly out of their pockets. A doctor's office in Canada is essentially a small business venture – with everything from the rent

[1] Commission on the Future of Heath Care in Canada, *Building on Values: The Future of Health Care in Canada*, (Ottawa: Government of Canada: 2002). CP32-85/2002E-IN, p. xx. The implications of this phrase were made clear in Romanow's speech at Yale University, just prior to the release of the report, when he claimed that health care was a moral venture, and "not a commodity." See "In Canada, publicly-funded health care is 'moral enterprise', says official," *Yale Bulletin & Calendar*, 31:8 (Oct. 25, 2002).

and the secretary's salary to the tongue depressors and bandages paid for out of the doctor's billings. There is no question that doctors are doing cost-benefit calculations – one of the hallmarks of "commodification" – when they decide what services to offer. But that is part of what makes the system work so well. Failure to recognize this imposes an unnecessary rigidity upon the system, and leads defenders of the public sector to reject (as objectionable forms of "privatization") various private-public delivery structures that in fact pose no threat to the integrity of the public system.

Commodification

In principle, there is nothing wrong with the claim that some particular good or service should not be treated as a commodity. There are two central cases in which such claims are widely regarded as justifiable.[2] The first argument against commodification involves the observation that certain types of goods are so closely connected to the integrity of persons that the buying and selling of them is inconsistent with human dignity. Goods of this sort are by their very nature unsuited for purchase and sale. Furthermore, the creation of markets for them generates perverse incentives to violate the integrity of persons. This is why we do not buy and sell transplant organs, why many believe that surrogate motherhood contracts should be void, and so forth. However, this argument seems clearly inapplicable to the case of health care. I have never heard anyone suggest that there is something intrinsically wrong with buying and selling of health care services, or that it is inconsistent with human dignity to do so. It is generally the *refusal* to provide such services that provokes outrage.

Thus the second argument against commodification is much more important. It has been observed that in some cases, moral incentives are able to secure a superior level of provision of a particular good than pecuniary ones. Since the creation of a market tends to encourage self-interested behaviour, commodification can have the perverse effect of provoking collective action problems, and thus reducing the efficiency of a particular sector. This dynamic is best-known from Richard Titmuss's study of blood supply, and his argument that a system of

[2] For an overview of the issues, see Michael J. Trebilcock, *The Limits of Freedom of Contract* (Cambridge, MA: Harvard University Press, 1993), chap. 2.

voluntary donation will secure higher quality donors than one in which people are paid for their blood.[3]

Subsequent studies have confirmed that pecuniary incentives can have the effect of "crowding out" moral incentives, and can thus create collective action problems where previously none existed. Bruno Frey and Felix Oberholzer-Gee, for example, have established such a result in his study of the willingness of citizens to accept NIMBY ("Not In My Backyard") projects, such as nuclear waste disposal sites.[4] Nuclear power plants produce benefits that are enjoyed quite widely, but impose highly localized costs (such as the dangers associated with waste storage and disposal). This gives local communities an incentive to "free ride" – to use the power, but then refuse to accept either generation or disposal facilities in their region. Frey found that in one Swiss village that had been identified as the best disposal site, only a slender majority of citizens (50.8%) were willing to accept the creation of such a facility in their community. However, when offered quite large sums of money as compensation (US$2,175-$6,525), support for the project plummeted to 24.6%.

It is not difficult to see what is going on here. If one does a simple cost-benefit calculation, it is very unlikely that any community would find it to be in their interest to accept a nuclear waste disposal facility. The value of the power that they (along with everyone else) receive is simply not worth it, especially when there is some chance that concerted resistance to the project will result in its being located in some other community (i.e. that free-riding is a feasible strategy). Thus monetary compensation is not likely to tip the balance for many people. The only way to get citizens to accept such a facility is through a moral appeal, which might lead them to overlook their self-interest in favour of the "greater good." The fact that the initial consent was underwritten by reasoning of this type is confirmed by the fact that willingness to accept the project was highly correlated with support for nuclear power generation. (Absent this assumption, this correlation is difficult to explain, since proponents of nuclear power have the same free-rider incentive as opponents. Furthermore, the impact that the offer had upon citizens' perceptions of the risk associated with the project was negligible.)

One can imagine a similar set of motives structuring the delivery of health care. Doctors, for example, generally feel bound by a duty of rescue, which leads them to provide medical

[3] Richard M. Titmuss, *The Gift Relationship* (London: Allen & Unwin, 1970).
[4] Bruno S. Frey and Felix Oberholzer-Gee, "The Cost of Price Incentives: An Empirical Analysis of Motivation Crowding-Out," *American Economic Review*, 87 (1997): 746-755.

services without compensation when they come upon the scene of an accident, or when there is an emergency on an airplane. Airlines often provide some consideration for doctors who have had to attend to in-flight emergencies, but this is widely understood to be a gift, not a payment. If instead airlines developed a formal compensation arrangement, so that doctors signaled their availability when embarking upon the craft (becoming, in effect, "on call" to the flight crew), in return for a flat payment, one could predict an overall decline in the health and safety of passengers. If regarded as a voluntary transaction, rather than a moral obligation, many doctors would decline to participate in such an arrangement (e.g. preferring to start their vacations the moment they get on the airplane, rather than the moment they get off).

It seems clear to me, however, that this argument cannot be extended to cover the health care system in general. One might imagine a system in which all doctors were salaried employees of the state, and dispensed care out of a sense of moral obligation. Under such a system, health care would not be a commodity, in the sense that doctors would not receive pecuniary compensation for the particular services delivered, and choice of treatment options would not be affected by such considerations. One might draw an analogy between the role of doctors under such a system and the way that the police force currently operates in our society. Personal security is a basic right, not a commodity. When someone feels threatened, they call the police, who then intervene in order to restore that person's security (or initiate criminal charges in the event that they are too late, etc.). The police do not charge per house call, nor do they receive pecuniary compensation for the number of interventions that they make. They act out of an obligation "to serve and to protect."

Certain advocates would like to see health care as a basic right, along the lines of personal security. When they are sick, citizens would have the right to pick up the phone and call a doctor, in much the same way that they currently are entitled to pick up a phone and call the police in the event that they attacked. However, there are three things worth noting about this proposal. First, this is clearly not how our health care system currently works. Although our system does generate a universal entitlement (so that every citizen has guaranteed access to medical care regardless of ability to pay), it does not rely upon moral incentives to motivate physicians. It is almost entirely run on a fee-for-service basis. Even doctors who are paid through capitation arrangements are still being paid for the quantity of services that they provide (it is just that the primary unit used to calculate compensation is the number of patients, rather than the

number of procedures). So if there is something wrong with treating health care as a commodity, then there is something gravely wrong with the organization of our present health care system.

Second, it is highly doubtful that a system based purely on moral incentives would be more effective at delivering health care to the population than the current one. Above all, there is no evidence that the current system is crowding out moral incentives. The conduct of doctors is still governed by a very strong sense of professional obligation. A doctor who dropped everything at 5 pm and went home would find it very difficult to find a job at any hospital in Canada. The fact that doctors are paid per procedure would appear to be encouraging them to do more work, not less. A system in which all doctors were salaried might therefore be less efficient, and would be unlikely to generate improvements in patient care.

Finally, turning back momentarily to the analogy with the police force, while no one doubts that personal security is a basic human right in our society, not a commodity, no one has ever suggested that this should prevent people from purchasing more of it, above and beyond the baseline established by the state. There is in fact a thriving market for private security services, alongside the public. Thus the mere fact that something is a right does not mean that it cannot *also* be a commodity, especially when some people have a strong desire to consume more of it than the community at large is willing to provide through the public sector. Thus the commodification argument does nothing to justify a state monopoly of the health sector, nor does it show that there is anything wrong with a two-tiered health care system.

Distribution according to need

When taken literally, the claim that health care should not be a commodity is extremely weak. This suggests that people who use this argument understand it in a slightly different fashion. In fact, one often finds the claim about commodification made as a somewhat oblique way of introducing a concern over distributive justice. Consider, for example, recent statements by British Chancellor Gordon Brown, concerning the original mission statement of the NHS: "The NHS was built around the cornerstone of universal access to health services, regardless of ability to pay. And at its core is the recognition of health care as a fundamental human right, not a consumer commodity."

These two phrases often occur together. People identify the idea that health care should not be a commodity with the suggestion that it should be distributed in accordance with need,

and not ability to pay.[5] Thus the claim is not that there is something intrinsic to health care that means it unsuitable for purchase and sale. What underlies the argument instead is a set of fundamentally distributive concerns.

Yet if distributive justice is the concern, then there is something vaguely demagogic about the commodification argument. There is no reason why the to-each-according-to-need principle has to be in tension with the use of a market to provide the goods. After all, people tend to spend their money on things that they *need*. Food, clothing and shelter should also be distributed in accordance with need – but this is precisely why we have a *market* for these goods. "But what about the needs of people with no money?" comes the natural reply. Here we must tread carefully. The mere existence of poverty is not an argument for socialized medicine, any more than it is an argument for socialized food. It is an argument for income supports and poverty relief. It's why Americans have food stamps. Thus the argument from poverty clearly fails to capture what is distinctive about health care, what justifies public provision.

It is at this point that we can start to see how the anti-commodification argument obscures the genuine rationale for the public health care system. The important difference between food and clothing, on the one hand, and medical care, on the other, is not that the latter is a "human right" and the former are not. The difference is that it is extremely easy for individuals to predict their need for food and clothing, and to budget accordingly. Medical expenses, on the other hand, are extremely unpredictable. Disaster can strike at any time, and even the most prudent individual may not be able to set aside an appropriate amount to pay for care. As a result, a simple market for health care would be extremely inefficient. This is why health care, unlike food and clothing, is paid for almost exclusively through insurance systems (or, as is increasing the case in the United States, through large, highly diversified health management organizations). It is the uncertainty that attaches to the consumption of medical care that constitutes the dominant characteristic of these markets. It is also what provides the primary rationale for public provision.

Markets for private health insurance are subject to extremely severe information asymmetries. This leads to serious adverse selection problems (insurers attract bad risks, forcing firms to refuse insurance to certain groups, and institute costly underwriting practices for others), and moral hazard (cost control is difficult, because it is very expensive for insurers to determine

[5] Similar arguments can be found in the Romanow report, *Building on Values*, p. xx.

whether claims that they receive are justified). Both of these problems generate enormous transaction costs at best, complete market failure at worst. The Canadian "single-payer" system eliminates the adverse selection problem in one fell swoop, by creating a single mandatory universal plan. It also minimizes moral hazard, by centralizing negotiations over fee structures, and eliminating the collective action problem in enforcement. However, it is extremely important to the structure of the Canadian system that the government delivers health *insurance* as a public good, not health *care*. And the reason that government provides insurance of this type is not that there is something intrinsically wrong with buying and selling heath insurance, it is that markets fail to do so efficiently.

It is also worth noting that unless one is clear about the fact that government in Canada provides health insurance, not health care, it is impossible to justify the monopoly that it exercises in this sector. Government provides roads, but there is no reason why people should not be able to build their own roads as well. But in the case of health care, it is important to recognize that the efficiency gains that justify the public-sector role arise primarily through the elimination of an adverse selection problem. In other words, it is the mandatory pooling of the entire population into one insurance scheme that generates the efficiency gain. Thus the rationale for government monopoly is precisely that it prevents "cream skimming" among private insurers – which is to say, it prevents the state from becoming itself the victim of an adverse selection problem.

Finally, focusing on the role of insurance shows how misleading it is to put emphasis on the principle of distribution according to "need" rather than "ability to pay." All insurance systems, whether public or private, distribute resources according to need. Car insurance provides new cars to people who "need" them, i.e. those who just crashed their old ones. Fire insurance provides new houses to people whose old ones burned down. But in neither case is state intervention necessary. Thus it does not help the case for *public* provision of health care to appeal to the principle of distribution according to need. It merely distracts from the more powerful arguments that are available.

Two-tiered medicine

The suggestion that health care should be distributed in accordance with need, not ability to pay, is also sometimes accompanied by the suggestion that there is something wrong with the

thought that the rich might be able to purchase a superior level of care. Many people object to private clinics on the grounds that they would permit "queue-jumping." Because there are some waiting lists, the concern is that people who are willing to pay out of their own pocket will be able to buy their way to the front of the line, and will therefore receive better quality care.

This is an argument that needs to be formulated extremely carefully, in order to avoid the charge of "leveling down." One way of achieving greater equality is to improve the condition of those who are at the bottom. But it is just as easy – and in many cases easier – to achieve equality by worsening the condition of those who are at the top. When this is done without improving anyone else's condition, it is referred to as leveling down. It amounts to cutting down all the tall poppies, while leaving the rest of the field intact.

Most people agree that leveling down is unattractive. If we are going to tax the rich, for example, we should be able to show that doing so generates some benefit for the poor. Otherwise it's just punitive. Unfortunately, people who care about equality are not always as careful as they should be to avoid the charge of leveling down. Recent debates over two-tier medicine provide some uncomfortable examples of this.

Part of the problem stems from an ambiguity in the term "queue-jumping." There is no question that, if there is a line-up, and some people are allowed to buy their way to the front of the line, then that worsens the condition of everyone else in the line, because it bumps them all back. That is genuinely objectionable. The case is quite different when people are able to jump the queue by leaving it entirely. Suppose someone who is on the waiting list for an MRI gets impatient and goes to the United States to have the test done. This person has "jumped the queue," and so will probably wind up with better health care. But this sort of queue-jumping in itself does not harm anyone. In fact, all of the people on the waiting list behind that person are better off, since they all get bumped forward.

There is no question that when people jump the queue in this way it exacerbates inequality. However, if we look carefully, we can see that prohibiting this sort of queue-jumping is leveling down. We are promoting equality, not by improving the quality of anyone's health care, but simply by preventing the rich person from acquiring higher quality care.

The Romanow report is actually quite careful on this subject, stating that the problem with private MRI clinics is not that they "permit people to buy faster service," but rather that

when they do so, people are able to jump the queue "back into the public system for treatment."[6] In other words, the problem is not that the rich are able to purchase better care – that in itself does not harm anyone else. The argument is that, because they are purchasing a diagnostic procedure, they bump others back when they show up for treatment. This is what generates the harm.

But consider a less controversial case. The concept of medical "need" is always structured by budgetary considerations. The government could choose to vaccinate the entire population against hepatitis B. It chooses not to do so, simply because hepatitis B is not very common in Canada, and the vaccine is expensive (about $100 retail). Thus the ratio of expense to medical benefit does not support universal inoculation. Nevertheless, any citizen who, for one reason or another, is at high risk of contracting hepatitis B, is perfectly free to go to the doctor and request it. But they must purchase the vaccine, or else charge it to a private prescription-drug plan.

This is the current situation in Canada, and there is no question that it is a form of two-tiered medicine. People who are willing and able to spend $100 for this vaccine will enjoy superior health (i.e. at very least in the form of reduced risk of illness). But is this an objectionable form of two-tiered medicine? People have different levels of tolerance for risk, and have different attitudes towards health. Some people are willing to pay an enormous amount to protect themselves from disability and disease, whereas others have a positively cavalier attitude (smoking, driving motorcycles, etc.) A universal insurance system, while attractive from an efficiency perspective, does have the disadvantage of imposing a "one-size fits all" package upon citizens. When individuals are prohibited from purchasing supplementary private insurance, or additional health care, outside the system, it imposes a tangible loss of welfare upon those who have an above-average level of risk-aversion or health-consciousness. In order to justify the imposition of such losses, very substantive moral considerations must be brought to bear upon the issue. One must demonstrate that such choices would generate significant harm to others – merely appealing to the principle of equality will not suffice.

Thus it seems to me that, unless one is willing to subscribe to "leveling down" egalitarianism, there is nothing wrong with the two-tier vaccine program. Two-tier systems are objectionable, in my view, only insofar as they undermine the integrity of the public *insurance*

[6] Commission on the Future of Heath Care in Canada, *Building on Values*, p. xxi.

mechanism. For example, the problem with proposals that recommend individual "medical savings accounts" is not that they would permit the rich to purchase a superior quality of care; the problem is that they eliminate or scale back the insurance mechanism that is at the core of the present system.[7] A number of other proposals would allow objectionable forms of cross-subsidization to emerge between the public system and the private sector. (For example, equipment and facilities paid for with public funds might be used to provide services to paying customers on the side. The latter would then receive a superior standard of care, but without paying the true cost.) Unfortunately, the habit that many people have of talking as though health care were a pure public good in our society makes it all but impossible to state clearly what is wrong with these proposals.

Conclusion

The claim that health care should not be treated as a commodity is a misleading and inadequate way of defending the public health care system in Canada. Interpreted literally, there is almost nothing to be said for the claim. Interpreted as an indirect way of making a claim about distributive justice, it is highly misleading, and encourages widespread confusion about the difference between a state-run insurance plan and state provision of insured goods. While distributive justice concerns no doubt justify some government role in the health sector, they do not justify anything nearly as extensive as the current health care system in Canada. Furthermore, such arguments cannot explain why the state should exercise a monopoly, by prohibiting the development of a parallel private system. The only good arguments for such practices stem from the recognition that the current system provides insurance, with a provider-purchaser split at the level of health care delivery. In other words, the only way to defend the structure of the current system is to start with the recognition that health care is, and should be, a commodity.

[7] For a proposal of this type, see David Gratzer, *Code Blue* (Toronto: ECW Press, 1999).