/products/standard/prprofile/prprofile.cfm?G=35 (accessed 2004 Mar 2).
5. Annual report 2001–2002. Toronto: Ontario Lottery and Gaming Corporation; 2002. Available: corporate.olgc.ca/pdf/ann_rep_eng.pdf (accessed 2004 Feb 27).

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Noralou Roos and associates[1] cite several reports as saying that a zero price for health care services leads to unnecessary use of the system.[2,3] However, this belief does not take into account the time and effort involved in accessing health care services, particularly for people of low socioeconomic status. People in this situation may be less likely to own a car or to be able to afford public transport, which limits their transportation options and makes it difficult for them to visit a medical clinic. Walking to a clinic may be an option, but clinic location, a patient's disability (especially for elderly patients) and harsh winters often make walking impractical. Furthermore, it may be difficult for a single mother to bring her children along when she needs medical care for herself, but because single mothers are more likely to live in poverty,[4] inability to pay for child care may be an issue.

Because of these barriers to accessing health services, people of low socioeconomic status may be less likely to visit a physician in the early stages of a health problem. Such a delay could result in a worsening of the condition, leading to a need for more expensive treatment or even admission to hospital. This might help explain the higher costs of treating patients of low socioeconomic status, as reported by Roos and associates,[1] and suggests that we should focus on accessibility rather than on implementing user fees as a way to reduce health care costs.

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References

1. Roos NP, Forget E, Walld R, MacWilliam L. Does universal comprehensive insurance encourage unnecessary use? Evidence from Manitoba says "no." *CMAJ* 2004;170(2):209-14.
2. Ramsay C. Medical savings accounts: universal, accessible, portable, comprehensive health care for Canadians. *Crit Issues Bull* Vancouver: The Fraser Institute; 1998.
3. Holle P, Owens D. Universal medical savings accounts: consumerizing medicare to end waiting lists and improve service. Policy series, no 5. Winnipeg: Frontier Centre for Public Policy; 2000.
4. McIntyre L, Connor SK, Warren J. Child hunger in Canada: results of the 1994 National Longitudinal Survey of Children and Youth. *CMAJ* 2000;163(8):961-5.

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[Two of the authors respond:]

Jon Gerrard observes that the expenditures we report[1] are lower than those reported by CIHI.[2] Our analysis is based on contacts that patients have with the health care system and includes only those costs that can be attributed to patients. When we discuss the appropriateness or potential impact of user fees or medical savings accounts, only these costs are relevant. CIHI[2] develops its "estimates" of public sector health expenditures on physicians and hospitals from diverse sources that were not relevant to our analysis. CIHI data on total public health expenditures include not just hospital and physician spending but also expenditures on drugs, other professionals (such as chiropractors and optometrists), public health, home care, health research and other aspects of health care.

Although most physician costs are captured in our analysis, the costs we report are smaller than the CIHI figures for at least one reason that we can identify: costs for salaried physicians who work in some hospital units (e.g., some radiology departments, emergency rooms and intensive care units) were not captured. This underreporting is a limitation, but there is no reason to assume that it distorted the results of our analysis. Of the Winnipeg family physician workforce, only 7% are salaried physicians, most of whose activity is reported through evaluation claims; thus, little activity of this key group (family physicians as a whole) is missed in our analysis.

Our hospital costs are smaller than those reported by CIHI for several reasons. Building capital costs are omitted from our calculations, and we do not report costs associated with educational programs offered in hospitals. We do include costs of ordinary overhead (for example housekeeping and meal costs) that can be assigned to patients in particular units.

We agree with Ross McElroy that the analyses suggest that medical savings accounts and user fees do not make sense and inappropriately target the poor and the sick. However, we do not believe that universal medical care is responsible for physicians ordering unnecessary tests or for unnecessary referrals. The United States with its millions of uninsured is an example of a developed country without universal insurance that holds the record for unnecessary medical expenditures in the name of avoiding legal liability.

Chris Delaney and Jacqueline Quail suggest that poor access to medical care may explain the poorer health status of people with lower socioeconomic status. We know that preventive services such as Papanicolaou smears and flu shots are underdelivered to this segment of the population. However, it is not clear if increased investment in health care is the answer. Alter and colleagues[3] recently demonstrated that although higher-income Ontario residents saw more cardiologists, received more cardiac rehabilitation and underwent more coronary angiography after myocardial infarction than did low-income residents, their outcomes at 1 year were no better. Labonte[4] estimated in 1992 that for the $350 million increase that Ontario hospitals received that year, the province could have funded 70 000 more rent-geared-to-income housing units, 450 000 more subsidized daycare spaces, and 12 000 transitional shelter beds. We really don't know which would have been the better investment in improving health for low-income residents.

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References

1. Roos NP, Forget E, Walld R, MacWilliam L. Does universal comprehensive insurance encourage unnecessary use? Evidence from Manitoba says "no." *CMAJ* 2004;170(2):209-14.
2. National health expenditure trends 1975–2003. Ottawa: Canadian Institute for Health Information; 2003. p. 63.
3. Alter DA, Iron K, Austin PC, Naylor CD; SESAMI Study Group. Socioeconomic status, service patterns, and perceptions of care among survivors of acute myocardial infarction in Canada. *JAMA* 2004;291:1100-7.
4. Labonte R. Health care spending as a risk to health. *Can J Public Health* 1992;81:251-2.

DOI:10.1053/cmaj.1040436