

AGENCY ISSUES AND THE PRODUCTION OF MERIT GOODS

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“... like a pig to the trough.” Hemingway, *The Old Man and the Sea* (1952)

In any society, the political feasibility of transforming a private good into a public merit good financed with tax dollars will depend on the skewness of the income distribution in that society. In Canada, the income distribution is positively skewed and various merit good programs have been introduced. The transformation of health care into a merit good has created a number of new stakeholders each with legitimate claims on the resources of the health care system. The delivery of quality health care to the sick, in a timely fashion, is no longer the primary objective of the health care system. It is only one objective among many. For the families of the 2000 victims who died as a result of the C. difficile epidemic in Montreal it might appear that the government did not fulfill its responsibilities to society and perhaps individual caregivers were negligent in their duties. However, it should be noted that, given the systematic causation and the system of incentives that is a central component of a merit good system, each member of the health care delivery system acted rationally. No one did anything wrong.

1. Introduction

Economists have long recognized the problem of agency in the private sector wherein the interests of owners and managers do not necessarily coincide. Much of the longstanding discussion in the literature is concerned with the agency of managers with respect to publically held corporations, (Alchian and Allan 1964), (Jensen and Meckling 1976), (Becker 1997), (Barzel 1997), (Ang et al 2000), (Farrell 2001), (Farrell 2003), the analysis of contractual relationships (Menard 2000), and the incorporation of cultural values into the governance system of the firm (Ruys et al 2000).

Some economists and political theorists have noted that problems of agency may also occur in the public sector and argue that incentives are more important than objectives or good intentions in structuring successful public policies (Chubb and Moe 1990), (Migue 1999), (Kelly-Gagnon 2000), (Sowell 2003). The interest of the state in

promoting social measures has led to the creation of government agencies, (Braen 2003) which are often promoted as collective moral enterprises, nominally based on a set of core social values, or operating principles; such as equity, fairness, and solidarity. Such agencies fall within the scope of social policy; they are not business ventures and are financed by the taxpayer (Romanow 2002), (Courchene 2003).

A single-payer health care system may be more operationally efficient than any multipayer arrangement in reducing administrative costs, and it may ensure that no one, who does not die while waiting, will be denied care due to an inability to pay. However, since it is based on a vague concept of collective morality, it is susceptible to co-option by special interest groups who advance their own agenda, using taxpayer dollars, to the detriment of the common good. Collective morality may degenerate into moral relativism whereby the power and resources of the state are used to advance special interests.

Public health care was first established in Canada in the Province of Saskatchewan by Tommy Douglas, and extended by the federal government to the entire country in the 1960s. Douglas, now known as the father of the Canadian health care system, and Canada's foremost defender of socialism, (MacLaren 1990), was premier of Saskatchewan between 1941 and 1968, and first leader of the federal New Democratic Party of Canada.

In the decades prior to World War Two, the general public in Canada was unaware that the scientific respectability of eugenics, had declined in the scientific community, during the First World War, due to an increase in the understanding of complexities of heredity (McLaren 1990). Canadians were not immune to the simplistic eugenic notions of race betterment that swept central Europe in the 1920s and 1930s (McLaren 1990). Doctors, psychiatrists, geneticists, social workers, and mental hygienists accepted the Darwinian claim that mental and moral traits were heritable and that poverty, crime, prostitution, and mental retardation were primarily the products of defective genes (McLaren 1990), (Weikart 2004).

The fear by Protestants in English Canada of the breeding powers of the French Canadians in Quebec was generalized to an overall fear of the breeding power of the feeble-minded (McLaren 1990). Many English speaking Canadians believed that radical measures were justified to protect the community from the degenerate. Special interest groups, such as the Eugenics Society of Canada and Toronto League for Race Betterment, were formed to promote eugenic theories of racial purification (McLaren 1990).

In his early years, Tommy Douglas, the future father of Canadian health care, saw eugenics and Christianity as complementing one another (McLaren 1990). He believed that, in order to protect itself, society had to recognize that mental and physical misfits warranted no better treatment than that once reserved for lepers and criminals (McLaren 1990). Nor does he appear concerned that the projected victims of his policies would be affronted but believes instead that they would actually be appreciative and thankful (McLaren 1990). “When education and legislation have failed there is still One who can take the broken earthenware from life’s garbage heaps and make them vessels of honor in His temple of love” (Douglas 1933).

The eugenic crusade in Canada of the 1930s was never a unified movement (McLaren 1990). It lacked the resources and power to control the social services necessary to re-engineer society according to eugenic principles, and eliminate members of society judged to be undeserving of life. Concomitant with the introduction of socialized medicine in Canada, many of the issues, such as: birth control, abortion, sex education, social welfare and immigration, which preoccupied the eugenics movement during the first half of the twentieth century, have been incorporated into the social envelope of the state. The principles of social engineering have been extended to other public sectors of society, including the judicial system (Eskridge 2001). The fertility rate of French Canadian families, previously a source of great fear among English Canadians (McLaren 1990), as well as the influence of the Catholic Church in Quebec, began to decline with the rise of moral relativism and the socialist state. Over the time period from 1759 to 1959, the French speaking population of Quebec increased from 70,000 to 5,600,000, a compound rate 2.2 per cent per year. The reproduction current rate is approximately 1.3 per couple.

This article adds empirical support to claims that agency problems exist in the public sector. Examination of the Montreal C. difficile illustrates the defects, inherent in a system of government-provided health care, which arise due to the problem of agency. Analysis of the actions of government officials charged with enacting public policy suggests that, in the public as well as the private sector, agent incentives override policy objectives. The article ends with a discussion of the Montreal C difficile case as an example or case study of the public sector agency problem.

2. Public Agency, Systematic and Intentional Causation

The debate between socialists and conservatives about the appropriate role of the state as the agent of society, is not one of opinion but about the economic mechanisms used to allocate scarce resources among competing alternative uses. The political feasibility of competing, economic mechanisms will, in turn, be determined by the social consensus concerning the relationship between cause and effect. Two types of causation, systematic causation and intentional causation, have been identified in the literature (Morse 2005).

In a framework of systematic causation, it is assumed that agents, and others, respond to incentives, rather than objectives. It involves a series of complex, non-linear, multidimensional interactions in which outcomes are not predetermined a priori but develop “in process,” according to incentives and their consequences. Systematic causation is incentive driven. Agency issues can be analysed in terms of cause and effect, by examining the logic of the incentives that are created, rather than just the goals being sought (Sowell 2003). The agency function of government is indirect and consists of the provision of public services, such as national defence and public order, the protection and maintenance of a reliable judicial framework, the definition and protection of a system of private property rights, etc., within which incentives can be defined and the effects of these incentives can be analysed.

Intentional causation is linear and goal oriented. It tends to explain systematic events in the economy as intentional, as being driven by the goals of individuals, as an act of their will. Government, as agent, must intervene directly to correct economic outcomes deemed to be undesirable to certain special interest groups.

3. Public Goods, Private Goods, and Merit Goods

In practice, government exercises two contradictory functions; a protective function, and a re-distributive function. The protective function is a positive sum game, which is concerned with the production of public goods and services, such as: national defence, public order and the protection and maintenance of a reliable judicial framework, the definition and protection of a system of private property rights, etc, which can not be supplied by the private sector. Tax legislation creates a formal contract, which reallocates property rights from private individuals to the public sector. The re-distributive function, may be a negative sum game, when it re-allocates property rights from private individuals to the public sector which are not used efficiently, to promote economic growth.

Exchange in the marketplace cannot occur without: i) a state sponsored system of property rights, and ii) exclusion, which is an intrinsic characteristic of the individual good. Property rights can be defined as the right of individuals to use their goods and services, including labour and time, as they see fit, subject to the constraint that the property rights of others are not violated (Alchian and Allen 1964). Private goods produce a flow of property rights to benefits which, by the nature of their production and consumption, can be internalized by the particular consumer who pays for them while other consumers, who do not pay, are excluded. Benefits are internalized and consumption is said to be rival (Musgrave and Musgrave 1976). Private goods and services can be rejected. Provision through the market is a feasible and efficient allocation of resources that will occur when price is equal to the marginal cost, which is positive (Figure 1, Case 1) (Alchian and Allen 1964).

The existence of “external effects” may reduce market efficiency. Externalities are situations in which: i) due to non-excludability and non-rival consumption, property rights to benefits cannot be limited and charged to a particular consumer, or where, ii) economic activity results in social costs which are not paid by the producers or consumers who benefit from them. The market can respond only to the effective demand of consumers as determined by the prevailing state of the distribution of income and leaves the question of the social desirability of the existing income distribution to public sector decision makers.

Non-excludability and non-rival consumption cause market failure because exclusion is not feasible and consumption is not contingent on paying. Consumption is non-rival because consumption by one person does not reduce availability to others. The term “social good” or “public good” is used to describe all cases of market failure (Figure 1, Cases 2, 3, and 4), (Alchian and Allen 1964) for which a budgetary, non-market public sector process is deemed necessary to provide the good or service.

In some markets, non-excludability and non-rival consumption may be a temporary phenomenon; high rates of technological innovation and change may modify either the production or consumption characteristics, or both, of various goods and services.

The production of public or social goods, such as: national defence, municipal infrastructure, the maintenance of a system of private property rights, etc., is an example of the need for public sector intervention to correct market failure. The characteristics of pure public goods are the opposite of private goods (ERF 2004).

There is no private market for public goods and services because the benefits are: (i) non-excludable because non-payer, “free-

riders,” can enjoy them for no financial cost, and (ii) non-rival in consumption because consumption by one person does not affect the consumption of benefits derived by all others in the community (Figure 1, Case 4) (Alchian and Allen 1964). Each member of society consumes the same amount of public goods and services even though individual tastes and preferences—and thus the individual value of benefits received—may differ (ERF 2004). Since it would be inefficient to attempt to apply exclusion, even if operationally feasible, the marginal cost is zero. Free riders could enjoy the same benefits as paying consumers, and thus no one would be willing to pay for the good, there is no effective demand for the good and the market would break down and a non-market method is needed to provide the good.

A quasi-public good, or near public good, has many, but not all, of the characteristics of a public good (ERF 2004) Quasi-public goods may be; i) semi-non-rival because additional consumers do not initially reduce the benefit to others and /or ii) semi-non-excludable in cases where it is difficult or expensive to exclude non-paying consumers. There are cases in which exclusion can be applied, but because consumption is non-rival, should not be applied (Figure 1, Case 3) (Alchian and Allen 1964). For example, in the case of radio, cable television, or satellite telecommunication broadcasts, the marginal cost is zero because reception of a telecommunications signal is not affected by the addition of another consumer. The use of jamming devices to limit availability to those who rent clearing devices would be inefficient because X's reception does not interfere with Y's.

Market failure may arise where consumption is rival but exclusion is not feasible for technical reasons (Figure 1, Case 2) (Alchian and Allen 1964). For example, the use of the available road space in traffic-congested streets during rush hours is rival. Exclusion in the form of auctioning off or sale of the available space would be efficient and could be applied. The use of crowded road space would be allocated to those who value it the most and offer the highest price. The development of electronic devices to record vehicle use of urban infrastructure adjusted for peak or off-hour use, may permit the imposition and computerized billing of user charges in the future.

Non-rival and non-excludability in consumption (Figure 1, Case 4) (Alchian and Allen 1964) do not necessarily occur simultaneously, although in many cases they do. Of the two, the non-rival aspect of consumption is often more significant because it renders exclusion inefficient and thus undesirable even if technically feasible. In the case of national defence, streetlights, etc. exclusion cannot and should not be applied, because both causes of market failure overlap.

Figure 1
**MARKET FAILURE AS DETERMINED BY THE
 CONSUMPTION AND PRODUCTION EXCLUDABILITY
 CHARACTERISTICS OF AN ECONOMIC GOOD**

Production Exclusion Consumption	Feasible	Not Feasible
Rival Divisible Marginal Cost > 0	Private Good Market Efficient (Case 1)	Private Good Market Failure Due to non-Excludability (Case 2)
Non-Rival Indivisible Marginal Cost = 0	Social Good Market Failure Exclusion is inefficient due to zero marginal cost (Case 3)	Social Good Market Failure due to non-Excludability high Excludability costs Exclusion is in efficient due to zero marginal cost (Case 4)

Some private goods and services are reputed to create externalities or social effects which are undervalued due to the failure of the market to recognize their full information value. People who ignore the value of external effects and make their consumption decisions based only on private benefits, may not be acting in their own best interests. It is assumed that only the state has sufficient information to place an accurate value on external effects and should intervene to ensure that consumption decisions reflect full information values. External effects may be positive in the case of merit goods, or negative in the case of demerit or «merit bad» goods.

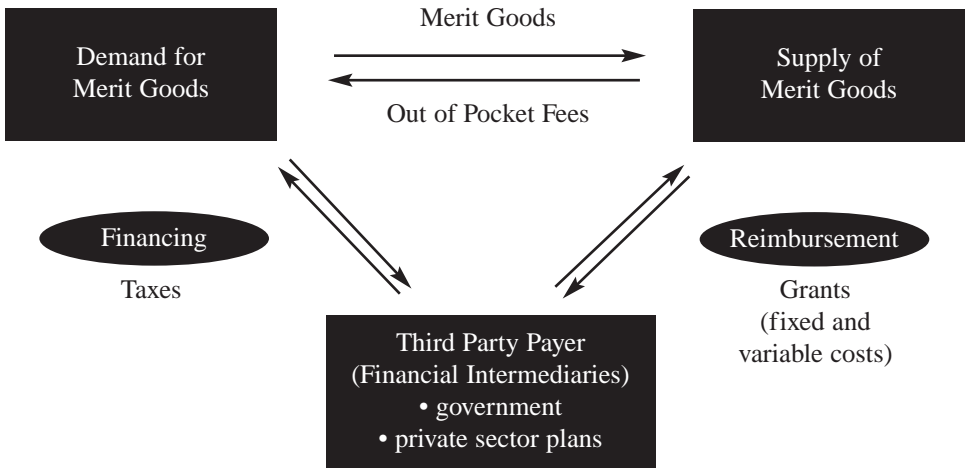
Merit goods are private goods and services, such as; education, health care, housing, pension plans, which are assumed to create positive external social benefits, as well as internalized private benefits. People, who are ignorant of the real value of the positive external social benefits of merit goods, and make their consumption choices based only on internalized private benefits, may not be acting in their own best interest, because they underconsume the merit good. Government must intervene to provide merit goods to everyone, free at point of use and financed through taxation, regardless of whether the individual wants them or not.

Demerit goods or “merit bad” goods are private goods and services, which generate undervalued negative external social effects which are claimed to be intrinsically unhealthy, and degrading to consumers (Johnson 2005). Such demerit goods would include; tobacco, alcohol, psychoactive recreation drugs, culturally taboo food products, gambling devices, sexually explicit art and literature, prostitution services, the provision of disapproved medical services such as birth control counseling or abortion, the teaching of unconventional political, economic, or religious doctrines. Consumers who make their consumption choices based on internalized private costs may not be acting in their own best interest, because the market fails to recognize the full information cost of these external effects. Ignorant of its real cost, they overconsume that demerit good. Thus, it is argued, government should intervene in the marketplace to prohibit the production, sale and consumption of demerit goods.

The market for a merit-public good can be illustrated as in Figure 2. The demand for public services arises from individual members of society, and the supply is provided by specialized service providers. In the case of a private sector merit good transaction, the full transaction price is paid out of pocket as indicated in the top part of Figure 2; it must be sufficient to cover the full service cost and the individual consumer bears the full risk of the transaction.

Figure 2
MODEL OF THE MARKET FOR MERIT GOODS

Production and Delivery of Merit Goods



4. Agency

An agent is one who acts for another in business or politics. Most agents respond to incentives and their consequences much in the same way as other individuals. Agency problems, which arise when agent incentives diverge from those of the client, can best be analysed by examining the logic of the incentives that are created, their causes and effects, rather than examining just the goals being sought.

In a perfect world, the agent would work in solidarity (Rice 2000) with the client, and agency problems would not arise. Agent incentives, as consequences, would not matter because the self-interest of the client would be congruent with the self-interest of the agent. Agents would have the incentive to act unselfishly, as a matter of principle, and place the well-being of the client above his own.

In an imperfect world, when the owner of an economic enterprise is also the manager, the self-interest of the owner and the self-interest of the manager coincide. When owners and managers are different people, agent incentives may diverge from those of the client. An agent, if left unmonitored, may pursue his own personal risk-return preferences to the detriment of the client.

A network of material, moral and coercive incentives, developed according to the principle of subsidiarity, may be used to align the self-interest of the agent with that of the client. In the private sector, decisions concerning the allocation of scarce resources are made, as described by the principle of subsidiarity, through the decentralized market place (Rice 2000). Structures may be designed, in which agent incentives, at the organizational level in most direct contact with the client, are allocated in a decentralized marketplace according to the principle of subsidiarity. Agents are motivated to perform their obligations and fiduciary duties faithfully, due to the formation of expectations that diligent service in the interests of the client will be congruent with his own long-term self-interest. The employees of business firms; directors, managers, and employees, are expected to use their delegated authority to maximize the total financial returns from the firm to the shareholders, who are the owners of the firm (Johnson 2005). Any reductions in benefits to clients, stemming from contracts governing the separation of ownership, financing and control, are known as agency costs.

The purpose of civil society and human law is to promote the common good which is the sum total of social conditions which allow people, either as groups or as individuals, to reach their fulfillment more fully and more easily (Rice 2000). The common good, the social order,

and the development of the social order is always focused on the good of the person and must be subordinate to the order of persons including his economic welfare. The function of social activity is to help individual members of society not absorb them. As summarized by the principle of subsidiarity it is an injustice for the state or its larger and higher level organizations to arrogate to itself those functions which can be performed efficiently by smaller and lower-order bodies.

In societies based on the political/legal principle of popular sovereignty, all legitimate political authority within that society derives ultimately from the will or the generalized consent of the subject population (Johnson 2004). Government officials, judges, and politicians are charged to use the power granted to them to make public-policy decisions, consistent with the principle of subsidiarity, that further the common good of the person including his economic welfare.

The purpose of schools or health care is to supply a flow of services to a target group of recipients. There are two basic groups of stakeholders: i) consumers, and ii) suppliers. Schools exist to provide children with academic training, the essential information about society and the world. The purpose of the health care system is to provide health care to the sick. Physicians, nurses, hospital administrators, teachers, school boards, and other service-oriented professional caregivers are supposed to use their specialized knowledge and skills solely in the best interests of the patients, students, or clients who have placed themselves and their resources in professional hands in exchange for the professionals' promises to act on their behalf (Johnson 2005).

When government intervenes in society to provide merit goods, a network of material, moral, and coercive incentives, inconsistent with the principle of subsidiarity, is created in which government claims total competence. The self-interest of the agent is realigned primarily with the self-interest of the state and only with that of the client when it does not conflict with that of the state.

In the private sector, agency risk may be reduced or eliminated by competition between managers in managerial labor markets (Fama 1980). As the size of the firm increases, the two functions usually attributed to the agent, management and risk bearing, may be treated as naturally separate factors of production within a set of contracts known as "the firm." Although individual stakeholders act from self interest, they realize that their own individual destinies depend, to some extent, on the success of the management team of the firm in competition with the management teams of other firms. As the number of stakeholders increases, potential agency incentive problems, associated with the separation of ownership and control, would tend to be resolved by the

discipline exerted on managers by managerial labor markets both within and outside the firm.

Unlike the private sector, the Canadian single-payer system may increase potential agency problems in the health care sector because it precludes competition among sellers of health care services, suppresses the development of competitive labor markets and reduces the allocational efficiency, found useful in resolving potential agency problems, in the private sector (Fama 1980). In the Canadian system, health care providers—doctors, nurses, etc.—hold monopoly power because they are the sole providers in their respective areas of expertise; hospitals hold monopoly power because they do not compete for patients on the basis of either prices or quality of service (Kirby and Keon 2004). This has created an imbalance of power between governments, as funders, and groups of service providers, which arises due to two factors: (i) health care is an essential service; governments and the public greatly fear strikes in the health-care sector, (ii) unlike other industries, work rules, which describe who does what and under what conditions, are virtually never part of the collective bargaining (Kirby and Keon 2004).

5. The Multi-Dimensional Agency Relationship of Merit Goods

The transformation by government of a private good into a merit good is often accompanied by the creation of a large public bureaucratic infrastructure, inconsistent with the principles of solidarity and subsidiarity, in which the private incentives of public sector agents diverge from those of the client recipient group and override the policy objectives for which the merit good was created (Chubb and Moe, 1990).

For example, when education is designated a merit good, a multitude of additional stakeholder property rights are created, including; teacher unions, school boards, caretakers, caretaker unions, bus drivers, bus driver unions, school principals, the association of school principals, school bus manufacturer, their employees and unions, as well as special interest groups in society at large. All of these special interest groups have legitimate claims, which are of equal importance to the rights of families to receive a certain type and quality of education for their children. Quality education is no longer the primary objective of the “merit good” type of education. It is only one objective among many. When additional funds are not allocated to compensate the additional stakeholders, fewer resources are spent in the classroom.

The public bureaucracies established to manage the school system, the health care system, etc, are similar to other public social

institutions. Unlike the private sector, where the organizational structure is controlled indirectly by government through the creation of property rights, and agent client incentives are more clearly defined, the proper constituency of any public social institution is huge and heterogeneous. Its interests are represented by politicians, administrators, and various special interest groups at all levels of government. There is little or no significant variation in organizational structure from one social institution to the other, and agent client relationships are less rigorous because they are shaped directly in response to non market, political factors. Public social institutions have no immutable or transcendent purpose, except to do what the public authority of the day wants them to do (Chubb and Moe, 1990). Decisions concerning merit goods are not made with regard to an immutable or transcendent purpose, such as the education of children or caring for the sick, but directly through the political process and are manipulated for political gain by the public authority (Chubb and Moe, 1990).

Many public policy initiatives, which call for direct state intervention to create new merit goods, are, in reality, income redistribution programs which depend, not on the moral values of the society, but the skewness of the Pareto distribution of income in that society (Farrell 2003a) (Mandelbrot 2004). The tax system is a negative sum game, which divides society, according to the distribution of income, into winners and losers, where winners compensate losers. The political feasibility of using the tax system to impose a government monopoly to supply a given merit good will depend on the skewness of the income distribution, which will determine the number of winners, and the size of their winnings (Appendix 1) (Farrell 2003a).

In many cases government programs, which are intrinsically incapable of achieving the goals for which they were nominally imposed, do serve to re-distribute income to the wealthier members of society, often exacerbating the social ills they were supposed to eliminate. A study of social welfare spending in Canada indicates that of \$227 billion spent on income redistribution in 1997, only \$87 billion was actually devoted to the poor (Kelly-Gagnon, 2000).

6. The C. Difficile Epidemic in Montreal

Montreal has long been a centre for education and research. Even after the election of various nationalist provincial governments which transformed the city from an English-speaking national city, the economic capital of Canada in 1979, to a French-speaking regional city, similar in economic influence to Milwaukee in 1999 (Martin, 1998),

Montreal has maintained an international reputation as a bi-polar centre of medical research composed of the English speaking McGill University Hospital Centre (MUHC), and Le Centre Hospitalier de l'Université de Montreal (CHUM).

In the early 1990's, in an attempt to maintain and strengthen its position as a major international research centre, the English speaking MUHC proposed that the government of Quebec invest approximately \$4 billion in a new super hospital, and pay for it by closing a number of hospital beds in older, general purpose hospitals and consolidating all health care services in the super hospital. Simultaneously, the French speaking CHUM developed their own mega hospital project and demanded an additional \$4 billion in government financing.

Much of the MUHC and the CHUM medical communities lined up behind their respective new projects even though some had serious misgivings. For example, hospitals are ideal breeding grounds for all kinds of bacteria. Some medical caregivers were concerned that the reduction in the number of beds and the concentration of services in the same physical location, could lead to an increase in nosocomial, hospital acquired illness, whereby patients who are treated for one ailment may become infected by harmful agents such as: *C. difficile*, enterococcus, or staph aureus. In the absence of a professional feasibility study, some citizens were concerned about the diversion of taxpayer funds from providing health care to financing elaborate research facilities of uncertain value to the general public. In addition, still others were concerned about the ability of the Government of Quebec to control costs. The Olympic Stadium fiasco of 1976, initially budgeted at \$153 million, which ballooned to over \$1.6 billion, and which still carries an outstanding debt of \$300 million, serves as a reminder to many taxpayers of the power of special interest groups to exploit public projects for their own ends.

6.1. Clostridium Difficile

Clostridium difficile (*C. difficile*), is a hardy, spore forming bacterium that can survive for weeks on almost any surface and can be spread from hand to hand via the feces. While it doesn't pose a health threat to healthy people, it can flourish in the intestines and colon of patients with weakened immune systems and releases a toxin that can be fatal. Patients who receive antibiotics for illnesses, such as pneumonia, are at risk because other, harmless, intestinal bacteria are also killed off as a side effect, which may result in an overgrowth of *C. difficile*. Cases of *C. difficile* are not unusual. In the United States, the ratio of infections is three to five per thousand. However, in Quebec the

probability of dying from hospital acquired illness is much higher. Over the time period from April 1, 2003 to March 31, 2004, there were more than 7,000 cases of *C. difficile* in Quebec. A prospective case-control study of 12 hospitals in Quebec over a 5.5. month period in early 2004, found that the infection rate was 22.5 cases per 1,000 admissions and the 30-day attributable mortality rate was 6.9 per cent (Loo 2005). In 2003-2004, as many as 2, 000 people may have died in Quebec because of *C. difficile* infections. Earlier estimates had pegged the number of deaths at 1,200 (Pepin 2005).

The ongoing *C. difficile* epidemic in Montreal, can be used to illustrate some of the agency issues, Figure 3, associated with the production of merit goods.

6.2. Technical Factors

A. Product Characteristics

1. Excludability. Health care services are, for the most part, excludable on both the consumption and production side.
2. Rival consumption. The consumption of health care services is rival.
3. Some types of public health services are thought to have external effects and are treated as merit goods.

B. The Production of Public Goods

1. System of Property Rights. While a system of constitutionally defined individual property rights is not included in the Canadian constitution of 1982, de facto property rights are generally respected on an ad hoc basis.

C. Transaction costs are positive.

D. The income distribution in Quebec and Canada is positively skewed.

6.3. Political Factors

A. Merit Good. In Canada health care is considered to be a merit good to which everyone has a right.

B. In Canada health care is a government monopoly. After health care was nationalized in Canada, during the 1960's, a government monopoly of health care was imposed, and all non-government sources of supply were eliminated. In Quebec health care is paid from tax revenues. Services are price

controlled and government set, and artificially low prices have created a shortage, as demand exceeds supply at below market prices.

1. Reduction in the supply of health care services. During the mid 1990's, in an attempt to reduce escalating health care costs, the provincial government used its monopoly power to reduce access to health care: the number of hospitals was reduced; doctors, nurses, and other health care workers were bought out with cash payments and grossed up pension plans. This has created an ongoing scarcity of health care workers. Older taxpayers, many with life threatening health conditions, who had prepaid for many years via the income tax system, for future health care benefits, were unable to receive timely treatment. Some died before receiving treatment. Unlike a shortage of health care services, where services cannot be acquired at the going price, a scarcity of services means that the services do not exist, at any price.

2. Asymmetric information. Users of the health care system do not have access to the same quality of information as the government provider. Possibly in an attempt to save money, the first response of the Quebec government to the C. lethal difficile epidemic was to cover it up, deny there was a problem, and do nothing.

The second response was to announce a study of the problem. The Health Minister, Philippe Couillard, a medical doctor, acknowledged that, although the government became aware of the deadly outbreak in April of 2004, a surveillance program, which will not produce results until April 2005, was not announced until August 2004. The Federal Health Minister has initiated a national study, at 25 teaching hospitals across the country, which will run from November 1 to March 31, 2005 and will determine whether new strains of C. difficile are causing more severe reactions to the infection, and, if so, where the new strains occur. The study will be conducted by the newly established Canadian Public Health Agency, which is located in Winnipeg. Chief medical officers from across the country will meet in Ottawa with the chief public health officer, and they will discuss the issue. The national microbiology laboratory is assisting in the testing. In Saskatchewan a new stadium-size microscope in the \$173.5 million national synchrotron facility will provide high powered light to study the three- dimensional

protein structure of *C. difficile* which may, in 15 years, produce a drug treatment. The net effect of announcing a study of the problem is to postpone and possibly avoid government expenditures.

Errors Of Omission

In addition to a series of policies designed to shift the cost of managing the *C. difficile* epidemic from the state to the private individual, there were a number of low-tech procedures which could have been instituted to protect the common good.

The first step in dealing with the *C. difficile* outbreak would have been to have the government of Quebec admit that there is an outbreak.

A second step would be to ensure that doctors and nurses use the low-tech, low-cost, methods to prevent infection, pioneered in 1840 by Louis Pasteur in Paris. Having health care workers wash their hands between patients could prove more effective in saving patient lives though less career enhancing.

According to an expert in infectious diseases at the MUHC this is extremely difficult to enforce because hospitals in Montreal are not equipped with enough hallway sinks for doctors and nurses to wash their hands between visits (Derfel, 2004).

A third step would be to ensure proper hygienic cleaning in Quebec hospitals. In the mid-1990's hospital budgets were cut by the government. As a result, hospitals in Quebec are filthy; patient rooms are much more infested with bacteria than in the past. Patient toilets and sinks are not properly cleaned and disinfected. Due to cutbacks in the number of workers, housekeeping staff, in some hospitals, have been ordered to spend only 36 seconds cleaning each toilet per patient room. To compensate for the lack of time, the staff will properly clean only one out of every two toilets, leaving the toilet that is less dirty and spending 72 seconds cleaning the dirtier toilet. The next day the other toilet is cleaned (Derfel 2004).

A fourth step would require that hospitals to stop putting patients with *C. difficile* into hospital rooms with uninfected patients. In some hospitals in Montreal, infected and uninfected patients are routinely mixed together in rooms with as many as four occupied beds. An official with the MUHC, while conceding that this practice is far from ideal, said that the hospitals have no other choice because of a shortage of single rooms (Derfel 2004).

What this means is that, at the price the government health care monopoly is willing to pay for hospital rooms, the number of rooms

demand exceeds the number that the hospital is willing to operate. Due to government underfunding, many hospitals have shut down entire floors to save staff and operating costs; there is a large number of hospital rooms in the system that are unused.

Unlike fee for service patients who, as a source of new cash flow, are assets to the medical care system, patients who have pre-paid their health care through years of heavy income tax payments, are a liability to the government-funded health care system. In an attempt to save money, the underfunded government health care system will cut corners. In the case of *C. difficile*, instead of re-activating the unused facilities, patients infected with contagious illnesses are mixed into the general patient population.

In some cases, if in a room with two beds, one patient is infected and the other is not, a pseudo-isolation procedure is followed; a curtain is drawn around the bed of the infected patient; the patient is given a portable commode and told not to use the washroom, and a marker is put up on the curtain informing the staff of the *C. difficile* status of the patient. Uninfected patients are not always informed that they are sharing a room with a person with *C. difficile*.

7. Conclusion

Before the establishment of income tax systems based on the legislated reallocation of property rights from private citizens to the government, liberal democracy was based on the principle that government could do nothing unless specifically authorized by law; that citizens could do whatever they wanted unless prohibited by law. During the twentieth century in many western societies, the rules were inverted and a fundamental conflict of interest was incorporated into the social structure. Now, government can do anything it wants, unless prohibited by law. (Migué, 1999). Since government establishes and enforces the law, it can often ignore the principles of solidarity and subsidiarity, and legislate to legalize its own actions. The traditional concept of agent responsibility is inverted, often to the detriment of the private citizen.

Private sector agency theory is based on the assumption that agents respond to incentives much in the same way as other individuals and if left unmonitored will pursue their own personal self-interest to the detriment of their clients. In societies in which the distribution of income is negatively skewed or normally, in which government finds no political benefit in merit goods and income redistribution, agency problems which involve the production of public goods may be expected to be similar in nature to private sector agency production problems.

When the income distribution is positively skewed, government may find that the institution of merit goods, with a right to access by all, politically advantageous. Most merit good programs are goal rather than incentive oriented, which obscures the agency dimensions of the undertaking.

For the families of the 2,000 victims who died as a result of the C. difficile epidemic in Montreal, it might appear that the public agent did not fulfill its responsibilities to society and perhaps individual caregivers were negligent in their duties. However, it should be noted that, given the systematic causation and the system of incentives that has been put in place, each member of the health care delivery system acted rationally.

Health care bureaucrats make their choices from the alternatives, which are actually available to them based on the incentives, created by government funding and the constraints on available knowledge. Given the economic-political system, which currently exists in Quebec and Canada, many of the factors which contributed to the C. difficile epidemic in Montreal, are the result of a set of perfectly rational actions by caregivers.

Where a policy or institution has been established by top political leaders, such as the Minister of Health, bureaucrats subject to their authority may hesitate to contradict their beliefs or the counterproductive and negative consequences that later follow from these policies and institutions. Messengers who bear bad news may risk their careers or—in some countries—their lives. Montreal hospital officials who cut costs by reducing housecleaning staff, fail to install sinks so that doctors and nurses can wash their hands between patients, mix infected and uninfected patients together may be quite rational, however negative the effect on the patients who become infected. Needless to say, the politicians are not about to admit that it is their intervention in the health care market which is responsible for the chaos in the social structure of Quebecois society, of which C difficile is only one symptom.

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Figure 3
**AGENCY ISSUES AND THE PRODUCTION
OF MERIT GOODS**
The C. Difficile Epidemic in Montreal

Technical Factors

Product a) excludability of consumption and production
 b) rival consumption
 c) market failure – external effects

Public goods a) system of property rights

Transactions costs are positive

The income distribution is a positively skewed Pareto distribution

Political Factors

Merit good

Government (supply side) monopoly

a) reduction of the supply of hospital beds,
doctors, nurses, support staff

b) asymmetric information

Agency Problems

Preference for research over health care – new super hospitals

Personal job security

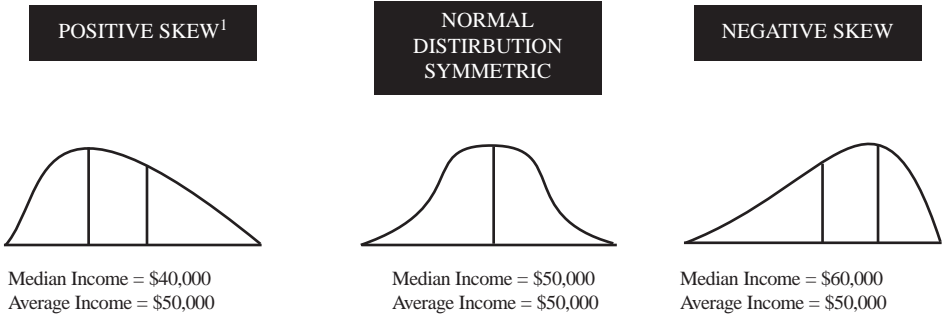
Appendix 1 The Effect of Income Skewness on the Demand for Merit Goods

For example, if the annual cost to provide a merit good; educate a child for a year, provide health care for a year, etc, in a bottom-up free market system is \$6,000, and there are n families in the society, and each family consumes one unit of the merit good per year, the total cost to society is $\$6,000 * n$. If the average annual family income is \$50,000, total annual income of society is $\$50,000 * n$, society will spend 12 per cent of its annual income on that merit good, $\$6,000 * n / \$50,000 * n$, each family receives \$6,000 in benefits. If a top-down income tax is used, the rate will be 12 per cent.

If the median family income is \$40,000, Figure A1, and some families have high incomes, which increase mean family income to \$50,000, the distribution of family income will be positively or right skewed. When the median annual income is \$40,000, 50 per cent of the population will pay $\$40,000 * (.12)$ or \$4,800, for one unit of the merit good, worth \$6,000, before quality decline adjustment. A majority of families will vote for tax-supported public provision of the merit good, because of the perceived wealth transfer of \$1,200. The marginal tax rate (MTR) of a majority of taxpayers is less than the average tax rate (ATR), $MTR < ATR$. When the income distribution is symmetric, Figure A1, average income will equal median income and the wealth transfer will be \$0.

When the income distribution is negatively skewed, Figure A1, median average income will exceed average income and the perceived wealth transfer will be -\$1,200. The marginal tax rate (MTR) of a majority of taxpayers will exceed the average tax rate (ATR). In the case of a normally distributed income, $MTR = ATR$, and negatively distributed income distributions, $MTR > ATR$, government will not support the creation of merit goods and will not create agency problems in the management of merit goods because such a redistribution program will not attract voters.

Figure A.1
**THE EFFECT OF INCOME SKEWNESS ON
 THE DEMAND FOR MERIT GOODS**



1. Median Income	\$40,000	\$50,000	\$60,000
2. Average Income	\$50,000	\$50,000	\$50,000
3. Average Income – Median Income	\$10,000	0	-\$10,000
4. Public Good Value	\$6,000	\$6,000	\$6,000
5. Median Public Good Cost (Median Income) X (T = 12%)	\$4,800 \$1200	\$6,000	\$7,200
6. = (4) – (5) Nominal Wealth Transfer	\$1200	0	-\$1,200
7. Relationship Between Marginal Tax Rate, MTR, and Average Tax Rate, ATR	MTR < ATR	MTR = ATR	MTR > ATR

The Pareto income curve is positively skewed and was thought to show how income was distributed in most societies. Mandelbrot and Hudson (2004).