FRONTIER CENTRE FOR PUBLIC POLICY
FRONTIER Backgrounder
BRIEF ANALYSIS

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SHOULD WE ALLOW MORE PRIVATE HEALTHCARE IN CANADA?

Other countries find the public sector quite compatible with universal access

Executive Summary

- A new book puts Canada's Medicare system in context by describing the private healthcare sector in other countries with universal access.
- The economic principles that shaped Medicare categorize healthcare as a good significantly different from others that operate successfully in a market.
- Universal access healthcare programs take two forms, one that treats it as social insurance and one that considers it to be social welfare.
- Although Britain's National Health Service is based on the latter, it has veered quite sharply towards the creation of internal markets that mimic a competitive process.
- The insurance-based systems in France, Germany and Belgium have multiple insurers and vibrant private sectors of healthcare providers.
- Sweden and Australia adopted programs funded by general taxation, but neither country requires the strictly public provision of services.
- One can fervently defend Medicare and still see the value of allowing the private sector a significant role in service delivery.

INTRODUCTION

Discussions about the state of Canada's healthcare system are unfortunately polarized. Defenders of Medicare demonize the consideration of reforms that might expand private provision of services as "Americanization," an effective rhetorical stance because of the very real problems that afflict healthcare in the country to our south. That divide makes all the more relevant and timely the information contained in a recent book published by the University of Toronto Press.

Titled *Private Health Care in the OECD: A Canadian Perspective* and written by University of Winnipeg economist Dr. Philippe Cyrenne (with a chapter on Australia by Marian Shanahan)[1], the book describes the extent to which healthcare services are privately offered in six developed countries other than the United States. The authors' descriptions of the respective systems will come as a surprise to those who think that we have only two choices. Although Canada's Medicare system is not discussed in detail, their research clearly demonstrates that the rules which govern our model are much more restrictive than in any other country with our standard of living.

Dr. Cyrenne firmly and publicly supports certain defining features of the Canadian system, including universal access and the redistributive mechanisms it uses to fund Medicare. Yet in his conclusion, which I reprint directly from the book at the end of this article, he points the way to a reconsideration of the usefulness of an expanded private role.

In this backgrounder, I summarize the research of these two scholars with a view to putting their often technical discussions into language accessible to laymen. Although I have been careful in that process not to misrepresent their views, compression itself means taking shortcuts and cutting out a wealth of qualifying detail. Further, I have largely omitted the last half of the book which

[1] Private Healthcare in the OECD: A Canadian Perspective, by Philippe Cyrenne (with Marian Shanahan), University of Toronto Press, 2004, ISBN 0-7727-8615-1

analyzes the research, often in technical terms familiar only to economists. I heartily recommend that readers who wish to go further purchase a copy of this valuable book.

MARKETS FOR HEALTH CARE

Should we allow a larger role for the market in allocating health care resources? A central argument in deciding that revolves around whether it makes sense to consider health care a good or service like any other, amenable to market forces and perhaps improvable by their application. In the construction of the *Canada Health Act*, the answer to that question was, "No." Philippe Cyrenne opens his book with a discussion of that issue.

In markets for most goods and services, the decisions of providers and purchasers interact to create equilibrium between supply and demand, where the price reflects the marginal cost of the service, including profit. For some goods for which there is irregular demand, people instead buy insurance to protect against the risk of unexpected costs. Insurers pool risks in exchange for premiums, and companies in that business usually provide not only coverage but assume the function of adjuster as well, to guard against moral hazard. They generally cap payouts at a preset limit.

Although that logic holds for health care, the "gatekeeper" role – the assessment of the need for repair and the screening of payouts to ensure that they comply with contracted promises – is more complicated. For many, the assumption that consumers have enough information about their illnesses or conditions to make reasonable decisions about consumption is not necessarily valid. Although imperfect information also exists for many other goods and services, the problem for health care is compounded by its different layers of provision – general practitioners, specialists, hospitals, clinics and technicians. Moral hazard can be intensified; consumers may shop too much, and providers may provide excessive layers of service. Equilibrium may be impossible.

Different countries handle this issue in different ways. In Canada, we have tried to solve the problem by vertically integrating most stages of health care delivery. Except for physicians, the vast majority of whom work independently and receive fees for service, most levels have been incorporated under common ownership. But all other developed countries with universal accessibility to health care have employed a wider mix of public and private arrangements, some of them quite successfully.

TYPES OF HEALTHCARE SYSTEMS

Cyrenne divides healthcare systems in the other OECD countries he considers into two broad categories, those based on social insurance principles and those grounded in considerations of social welfare. In the former, in Germany, Belgium and France, health care is financed primarily through deductions at the place of employment. In the latter, which include Canada, the United Kingdom, Australia and Sweden, costs are primarily paid by governments from general tax revenue. Within that basic framework, other variations condition the two approaches.

Either funding system is consistent with user fees, as a form of deductibles for insurance-based systems and an additional form of revenue for welfare-based programs. Even within Medicare, some provinces charge healthcare premiums, which include safety-net provisions for seniors and those with low incomes. In both structures coverage is mandatory and almost always universal, with insurance-based systems extending welfare-style benefits to unemployed citizens who cannot contribute through payroll taxes. Although supplementary coverage is available within Canadian-style programs for complementary services, countries who use the insurance model allow much wider participation from public and private insurers. In terms of administration, the two models differ considerably. In Germany, France and Belgium, insurers often "operate at arm's length from the government," which acts as a regulator, while in the other countries discussed the appropriate government department acts as both insurer and regulator.

A blurring of traditional boundaries between public and private also complicates the mix. In many countries, they are fading away. For-profit providers can be large corporations or small businesses, all private, but not-for-profit providers may originate in either the public or private sectors and may or may not participate in the ownership of standing assets like hospitals and

clinics. Similarly, lower levels of government in many countries, although nominally in the public sector, often control the delivery of services while asset ownership is held by the national government.

THE UNITED KINGDOM

Established in 1948, Britain's National Health Service (NHS) is the mostly highly centralized in the OECD, and provided the model for Canadian Medicare. "Although day-to-day administration was delegated to regional and local bodies, those bodies were appointed by and accountable to the central government." Often criticized for its lack of flexibility, incentives for efficiency, financial information and choice, the NHS has for a generation been attempting to improve its performance with the use of market mechanisms inside its centralized structure, a phenomenon known as "internal markets."

Designed to "guide the NHS in the direction of better quality care and service at reduced cost," a wide range of reforms to address the "perverse incentives" inside the program's structure have been proposed and some have been adopted. An influential 1985 report concluded that "the principle that the government will make comprehensive health services freely available to all does not mean that the governments must produce them itself." Beginning in 1989, the NHS adopted the concept of a purchaser-provider split. District health authorities began to buy contracted services from public or private providers and general practitioners (GPs), alone or in trusts, started to control budgets for elective, non-emergency hospital care. These reforms expanded services and efficiency, but not as much as expected.

In 2000, another report called for further decentralization, and most notably argued that the NHS would benefit from the use of extra capacity and investment from the private sector. National health care budgets have been considerably expanded, with much of the new spending devoted to the purchase of services from facilities run by private companies and charities. The biggest expansion of hospital capacity in the history of the NHS has been accomplished through contracts and lease arrangements with private pools of capital. Although the NHS remains as committed as ever to the principle that health care be provided as a public service, free of charge, the nature of the arrangements to guarantee that principle are becoming more flexible and creative.

These changes are historically appropriate. Although its size and scope have varied, Britain's private health sector has played an important role. GPs and specialists have always augmented their NHS incomes with private activity. More than 10 percent of citizens, mainly the most affluent, purchase private health insurance that expands access to acute care services. Independent hospitals house about 60 percent of the country's beds. A new "concordat" signed in 2000 with the independent sector clarifies the relationship between private providers and the Department of Health and recommends several kinds of co-operative arrangements.

FRANCE

Cyrenne notes that the French healthcare system, perhaps the most pluralistic of all those with universal coverage, has been overlooked in studies of public and private mixes. It seem a logical candidate for inclusion, because it includes elements associated with markets, like "fee-for service reimbursement, total freedom of provider choice, and important for-profit hospital sector, and patient co-payments." Provision for services is unusually generous, with coverage that includes drugs, physiotherapy and even medically prescribed spa treatments. Yet there are no waiting lists, and France's medical providers actively market their availability in other countries.

About a quarter of national spending on hospitals takes place in private facilities, complementary private insurers co-exist with statutory insurance schemes and co-payments are common. The National Health Insurance program (NHI) operates through payroll deductions and is organized across occupational lines, although the unemployed can make independent contributions and since 1988 local governments have been obliged to pay premiums for low-income individuals. Another idiosyncratic feature of French medical services is the fact that patients keep their own medical records.

The role of gatekeeper is played by an agency called the Medical Control Service, composed of medical professionals who choose its members from among their own ranks. The Service decides whether the payment of medical benefits is justified, and from whom, and oversees both patient abuse and the adherence of providers to legislated regulations. Three quarters of the system's funding comes from employers and payroll deductions from employees, with almost 14 percent from co-payments and about 7 percent from private insurance. The employment taxes are quite high, about a fifth of all wages.

About 87 percent of France's population carries supplemental insurance, and both GPs and specialists are allowed to extra-bill above negotiated government rates. More than half of all beds are offered by private hospitals and clinics, which bill the NHI directly, but doctors practicing in them directly charge patients, who are then reimbursed by the NHI. In the 1990s, the national government enacted controversial new taxes and regulations to contain costs, which included bonuses for doctors who stayed within their budgets and sharp reductions in both hospital beds and staff. As of 2000, the reforms had failed to stem steep increases in costs but had provoked massive political demonstrations.

GERMANY

The German healthcare system has evolved from its beginnings in self-help or mutual aid societies into general coverage. Its stated principles are solidarity, which entails a sharing of risk and contributions based on ability to pay, and subsidiarity, which means that "the state should not assume any functions which the individual, the family or private self-organization could solve better or at least equally well . . . ." Cyrenne describes the result as "an example of how a private healthcare system can coexist alongside a public system."

Citizens with ample incomes and the self-employed can opt out entirely and rely on their own devices. All services are privately provided and paid for by sickness funds which negotiate rates, with the process arbitrated by a third organization with a mixed composition of insurers and providers; all of that is regulated in turn by the national government, which outlines the conditions for delivery and availability. Membership in sickness funds or an alternative is compulsory, with the former covering nearly 90 percent of the population. Uniquely, civil servants are excluded, although the government assists them in obtaining private insurance.

Although they own no facilities nor employ any providers, sickness funds pay for ninety percent of healthcare services, usually by contract. A gatekeeper role is played by the Association of Office Physicians, an intermediary which disperses payments and monitors rates. The trilateral relationship between patients and these two entities provides an umbrella under which competition occurs between sickness funds and among private providers. Because membership in some of the funds has lower risk characteristics, the government requires them to compensate higher-risk entities based on the differences between their incomes and expenditures. This pooling mitigates premium competition and assures that all funds remain solvent.

During the 1990s, the system incurred substantial losses, attributed to a combination of increased unemployment, escalating healthcare costs and, most notably, the absorption of the far inferior health infrastructure in East Germany. The government responded with increased co-payments, penalties for hospitals that overran their budgets and the elimination of inefficient facilities. Most of the latter were state-run hospitals, so that over the decade the total number of beds declined by 12 percent, while the number of private beds increased by 59 percent. Cyrenne comments: "Presently private companies, partly sponsored by private health insurance and other investors, are taking over hospitals and introducing modern management and marketing techniques."

BELGIUM

As in France and Germany, Belgium's universal coverage originated in mutual-aid societies connected to employment. Now called Health Insurance Associations (HIAs), Cyrenne likens them to Canada's credit unions. Over time, hundreds of funds consolidated along ideological and regional lines, with 129 insurers now in six groups, all of them operating as non-profits. About 55 percent of health spending is funded by these associations, with the rest coming from general tax revenue. Membership in an HIA is compulsory, but healthcare delivery is private.

The Belgian central government oversees the system through the National Institute for Sickness and Invalidity Insurance (INAMI), although responsibility for costs has increasingly been delegated to regional authorities. As in Germany, membership in one HIA can easily be transferred to another, and risk imbalances are handled by the pooling of HIA surpluses or deficits, and with central government subsidies. INAMI, whose management is a mix of bureaucrats, employer and employee associations and representatives from HIAs, serves as the administrative middleman, determining conditions of access, prices and regulations.

The gatekeeper role is performed in turn by the Medical Control Service, composed of insurers and provider groups. Because more spending means higher payroll taxes which affect employment, both trade unions and employer's organizations have tried to keep it in check. The health needs of the unemployed are covered by Public Municipal Welfare Centres, which pay the cost of treatment directly or pay the premiums for membership in an HIA.

About 60 percent of Belgium's general hospitals are private non-profits, and another 5 percent are owned by HIAs. Public hospitals and a small number of private, for-profit hospitals make up the balance. Most patients are extra-billed by doctors for 25 to 30 percent of the value of the service, although the poor and the elderly are required to pay less. Although private hospital insurance is allowed to cover both hospital costs and co-payments, the nonprofit status of HIAs gives them a significant competitive advantage and few people buy extra coverage.

Credit for the absence of waiting lists is explained by Belgian officials as largely a function of a larger capacity built into the system over time, both in hospital spaces and the number of physicians. It may also have something to do with an increasing reliance on co-payments, which made up 12 percent of the global healthcare budget in 1987, but 17 percent by 1994. That is mitigated in part by a ceiling on co-payments by the disadvantaged.

SWEDEN

Although Sweden's healthcare system has traditionally operated in a monopoly framework, decision-making is highly decentralized, with County Councils (CCs) and one municipality owning, financing and operating their own facilities. As with Canada, the service is considered a social good, an integral part of the welfare state, funded by taxation. But dispersed authority has created a breeding ground for significant experimentation in service delivery.

Different levels of government have also assumed responsibility for certain medical services, with municipalities, for instance, in charge of taxes which pay for the elderly, the disabled and long-term psychiatric care. County councils own and operate most other facilities, with varying rates of taxation. A long struggle with waiting lists and delays in treatment has prompted increased awareness among policymakers of the limitations of the command-and-control model. Under strong pressure to contain public spending, the central government regulates county and municipal spending through the National Board of Health and Welfare.

More than three-quarters of the money that pays for healthcare is raised through the income taxing powers of CCs, with about 10 percent of the rest coming from central government subsidies and only 4 percent from co-payments. No fees are paid by people under 18 years of age or by the chronically ill. The gatekeeper role is primarily played by general practitioners, the majority of whom are salaried.

Privately run facilities, which contract with health authorities for a share of patient load, are common. In the 1990's, parts of the country, especially the capital region, Stockholm, innovated to increase the responsiveness of providers. Reforms included patient guarantees and a split between purchasers and providers. They encouraged competition among private and semi-private providers, transforming hospitals into corporations, with one sold entirely to a for-profit company, and a gradual increase in the number of physicians and nurses working privately on contract.

These reforms appear to have improved "hospital productivity and efficiency with no adverse effect on the quality of overall healthcare." More than 20 percent of hospital beds are now privately financed. Fourteen out of 26 CC's have established separate purchasing organizations, and Stockholm, the location of the most far-reaching experimentation, has especially engaged in

contracting out of whole sectors of healthcare delivery. That included the sale of its largest hospital, St. Göran's, to a transnational company, Capio, which is charging the Stockholm County Council fees between 7 and 12 percent lower than government-owned hospitals.

AUSTRALIA

Changing in stages, Australia's healthcare system gradually moved in the direction of Britain's, with Medicare legislation in 1984 that provided free inpatient and outpatient public hospital care and public funding of most medical fees. Public, tax-supported funds pay for more than two-thirds of the country's health spending, while the non-state sector pays for almost a third. Responsibility for the provision of services is divided between federal and state governments.

The author of the chapter on Australia, Marian Shanahan, characterizes its healthcare system as "well-organized . . . with universal access to needed healthcare irrespective of ability to pay, a strong private healthcare sector and a medical profession that is politically influential." Public funds pay for only 85 percent of services outside hospitals. The difference is referred to as "the gap," which is subject to an indexed maximum and capped to an annual limit for families. Doctors are allowed to charge more, but a majority accepts the 85 reimbursement without extra billing. In hospitals, Medicare pays all the costs for "public patients" and about 75 percent of costs for "private patients," with the rest of the Medical Benefits Schedule borne by private insurance or co-payments only where allowed by contract.

Provision of hospital services can take place in publicly owned facilities or in a network of heavily regulated private hospitals. The latter do not offer emergency services. Drugs are also provided through a complex, bureaucratic process that includes some co-payments. Care for the aged is the responsibility of the federal government, again with co-payments, but Australians carefully wean out those who can be cared for in their homes and offer extensive supports for community-based care at home.

A parallel system of private insurance was not just allowed to remain in place, its fees are subsidized, and it plays a major role. Unlike the private system in the United States, most premiums are paid by individuals, not employers. The types of products offered by private health insurers, their prices and arrangements for risk pooling are all heavily regulated. Steadily increasing premiums made the option less attractive, and the percentage of Australians enrolled dropped from 50 percent in 1984 to 30 percent in 1998.

Of course, that increased the burden on the public Medicare system, so the Australian government took measures to make it more attractive that included rebates and subsidies. To a Canadian accustomed to hearing the dogma that a parallel private system would tend to divert resources from public insurance, those measures seem remarkable. Another indication that private alternatives instead relieve pressure on the public system is that private Australian hospitals have none of the waiting lists common to that country's public hospitals.

ECONOMIC ISSUES

The last three chapters of *Private Health Care in the OECD: A Canadian Perspective* deal with economic questions that arise from the research presented in the first four chapters. The first two are titled, "Issue in the operation and performance of the selected OECD countries," and "Issues in the regulation of a private healthcare sector." For those with at least an elementary knowledge of economics, I especially recommend the last chapter, titled, "Models of parallel public and private healthcare systems." Although the details of their contents are beyond the intent of this summary of the first half of the book, the information in them is valuable and pertinent both for those who want to see more private-sector involvement in healthcare and for those who do not. The balance of this backgrounder is composed of Cyrenne's words, his concluding chapter.

CONCLUSION

"This study has examined the role of the private sector in a number of OECD countries. While all systems share a commitment to universal coverage, there is a remarkable variation in the role assigned to the private sector. The role ranges from private supplementary insurance to private hospitals and clinics providing services to the public sector.

"A common theme is that the role of the private sector is now too important to eliminate, even in the U.K., which has embarked on a massive increase in funding for the private sector. According to the authors of the most recent healthcare plan in Britain, 'ideological boundaries or institutional barriers should not stand in the way of better care for NHS patients. . . . The private and voluntary sectors have a role to play in ensuring that NHS patients get the full benefit from this extra investment. By constructing the right partnerships the NHS can harness the capacity of private and voluntary providers to treat more NHS patients.'

"It seems clear that once a commitment is made to provide healthcare coverage to all citizens, a great variety of private-sector involvement can be integrated into largely publicly-provided healthcare systems. Overall, the Social Insurance-based healthcare systems, like Germany, France and Belgium, have been successful in providing high quality universal service while allowing a significant role for the private sector. These systems, in contrast to the Social Welfare systems of the U.K., Sweden and Australia, also feature an arm's length insurer or insurers who have considerable autonomy from government. It appears that an advantage of Social Insurance-based systems is that every healthcare decision does not become a political issue. The Social Insurance-based systems seem to be able to meet the expectations of their clientele while maintaining a strong commitment to social solidarity. The German system allows higher income individuals to opt out of the public system and yet the public system still provides a high level of service to those who remain.

"Even with the Social Welfare systems there seems to be a consensus developing that the traditional command-and-control system of healthcare provision has its limitations. A recognition that markets and incentives can improve performance within the area of healthcare is developing. From an examination of the U.K, Swedish and Australian systems, it appears that the most promising role for the private sector is to provide a range of elective surgeries based on contracts with the public insurer. Elective surgeries seem to be the area generating the most dissatisfaction within these systems, and this area of the healthcare system seems to offer the potential for efficiency gains through regulation. It also appears that it is quite difficult to replicate the benefits of a competitive healthcare system within a publicly managed and financed healthcare system like the U.K. A major problem plaguing Social Welfare-based systems is that public provision obscures the cost of providing the different types of medical services. Experiments with private-sector provision subject to government regulation may allow more efficient forms of healthcare provision to arise.

"The countries examined here all share a commitment to ensuring adequate healthcare for all their citizens. This commitment has been maintained while still permitting a range of consumer choice and private-sector involvement. It is hoped that the issues raised in this study can inform debate in Canada regarding the options and possibilities for revitalizing the nation's healthcare system."

About the Author:

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HEALTH SYSTEM	Australia	Belgium	Canada	France	Germany	Sweden	UK
I. Public Coverage							
A. Basic Services							
— Free			X				
— Co-payment	X	X		X	X	X	X
B. Coverage							
— Voluntary							
— Opting Out					X		
— Compulsory	X	X	X	X	X	X	X
C. Extended Coverage							
— Public Premium		X			X		
— Private Premium	X	X	X	X	X	X	X
D. Physician Access							
— Free Choice	X[7]	X	X	X	X	X	X[5]
— Limited	X[7]						
E. Specialist Access							
— Direct (Non-emergency)		X		X[1]	X		
— Referral (Non-emergency)	X		X			X	X
II. Compensation							
A. Physician Services							
— Fee for Service (predominantly)		X	X	X	X		
— Salary (predominantly)						X	X
— Combination (includes capitation)	X						
B. Fee Determination							
— Negotiated (government)	X		X			X	X
— Negotiated (insurer)		X		X	X		
— Market determined (extra billing)	X						
C. Hospital Services							
— Free	X		X				
— Co-Payment		X		X	X	X	X
III. Financing							
— General Taxation	X		X			X	X
— Joint Premiums Employee/Employer)		X		X	X		
IV. Administration							
— Local							
— Regional	X[3]	X[4]	X	X	X	X	
— National	X[3]	X[4]					X
V. Private Health Services							
A. Private Insurance							
— Basic Services (some groups)	X				X		X
— Extended Coverage	X	X	X	X	X	X	X
B. Private Hospitals							
(1) Entry conditions							
— Entry Prohibited			X			X[2]	
— Restricted Entry	X	X		X	X		X
(2) Revenue Sources							
— Public system contracts				X		X[2]	X
— Private Insurance	X			X	X		X
C. Hospital Charges							
— Negotiated or Regulated	X	X[6]		X	X	X[2]	X
— Non-regulated							

Notes:

1. Group 2 coverage allows free choice of doctor and direct access to specialist care (nominal fee).
2. Hospital trial
3. Shared responsibility
4. Increasingly delegated to the regional level
5. Restricted within a geographic area
6. Does not include "amenity services" not covered by Social Security
7. Participants in public hospitals have limited choice of physician, otherwise free choice of physician.

