Private Health Care in the OECD: A Canadian Perspective

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Study Background

- My fields are Public Economics and Industrial Organization (including Regulation)
- The study began in 2000.
- Funded by the Donner Foundation and the University of Winnipeg Major Research Grant Program.
- I visited and interviewed health care officials in

  London, Paris, Brussels, Stockholm, Berlin in 2001.
- Marian Shanahan, former Manitoba Centre for Health Policy Evaluation health economist, and former student, wrote the chapter on Australia.

Different types of health care systems

- There are two broad types of public health care systems in existence.
- **I. Social Welfare Based systems** (sometimes called National Insurance systems)
  - Canada, the UK, Australia and Sweden
- **II. Social Insurance Based systems**
  - France, Germany, Belgium

Different types of health care systems

- Social Welfare Systems: Characteristics

1) Financed largely out of general revenues
2) Single monopoly public insurer
3) Historically, care provided in public hospitals
4) Restrictions on the role of the private sector
5) Physicians compensated on a fee for service basis (Canada, Australia) or salary (Sweden, the UK).
6) Salaries of medical personnel and physician fees determined by bargaining.
7) Planning is used to allocate medical resources
8) Waiting lists exist, especially for elective surgery

Different types of health care systems

- Social Insurance Systems: Characteristics

1) Financed largely out of payroll taxes levied on employees and employers, (like Employment Insurance)
2) Multiple insurers, most not for profit, some private
3) Care provided in a mix of public and private hospitals
4) Regulation of Private Hospitals
5) Physicians compensated on a fee for service basis
6) Salaries of medical personnel and physician fees determined by bargaining.
7) Quality of care governed by Medical Control Council
8) Greater use of markets to allocate resources, however, considerable degree of regulation
9) Virtually no waiting lists

Social Welfare System: Australia

- Australia (Social Welfare System)

  Similar to Canadian system, funded out of general taxation, low population density.

  - Private Insurance both for basic and extended coverage
  - Private Hospitals, regulated by state
  - Waiting lists for surgery in public hospitals, no waiting list for private hospitals
  - Public Hospitals provide care for private patients
  - Extra billing is allowed, most physicians fee for service
  - Shortage of specialists and GPs in rural areas
  - State subisidy of private insurance purchase

Social Welfare System: Sweden

- Funded out of general taxation, Administered by County Councils similar to Provinces.
- Most physicians on salary, 7% in private practice.
- Has been suggested that salary results in reduced efforts by physicians
- Shortage of nurses with specialist training and doctors in remote areas
- Primary health care sector plays a gatekeeper role
- Nominal fees are charged to patients for services (with 12 month ceilings)
- Waiting lists, historic problem
- Purchaser/Provider splits (Contracts with non-government providers). Private Hospital trial
- Nurses welcome competition for their services.
- Swedish observers feel recent changes have improved the system

Social Welfare System - UK

- Funded primarily out of general revenues (81.5%) national insurance premiums (12%) and user fees (2.1%).
- Experimented with various “internal markets” in the 80’s and 90’s in order to improve efficiencies.
- Some success though limited.
- Recently, NHS budget increased by 50%.
- Concordat signed with the Independent hospital sector, now provides 20% of all elective surgeries on contract.
- Doctors can work in both the public and private sector, though private hours limited.
- Private Finance Initiative – private construction of hospitals, once amortized revert to NHS ownership.
- Private insurance – fixed payout for elective surgery in private hospitals

Social Insurance Systems: Germany

- Contribution rate for the “sickness fund” (SHI) – the health insurer is determined by representatives of labour and employer groups.
- There are 754 sickness funds (SHI) which are self-governing and self financing
- SHIs don’t own hospitals, have contracts with provider organizations.
- Payroll deduction same for all members, with an upper limit for yearly contributions
- Physicians in hospitals are salaried, otherwise self-employed.
- There are 52 Private Insurers, civil servants must purchase private insurance
- Germans can opt out of the public system
- More hospital privatization expected.

Social Insurance Systems: France

- Patients pay physician directly, are then reimbursed
- The public system through the Securitϑ Sociale finances 74% of the health care expenditures, patients cover 14%.
- Private hospitals provide all types of care
- Medical control service is part ombudsman and part regulator of private hospitals
- Unemployed have access to care
- Patients keep medical records
- Government efforts to increase control over the system, have resulted in strikes and protes

Social Insurance Systems:Belgium

- Similar to French and German systems with third party insurers (called HIAs – Health Insurance Associations)
- Health system organized much like Credit Union system in Canada - origins were in mutual aid societies
- Waiting lists virtually nonexistent
- 60% of hospitals are nonprofit private institutions.
- Physicians paid on a fee for service basis, fees negotiated between representatives of the sickness funds and the medical profession.
- Free choice of doctor, do not need referral to see specialist
- Patients pay a share of the health care bill
- Hospital entry controlled by Ministry of Public Health.

Issues Related to the Expansion of the Private Health Care Sector

- Economic Issues

  How would the market structure be effected by the introduction of private health care firms – ie. a dual system?

- Political Issues

  How would the political “equilibrium” be effected by an increase in private provision and or private financing of health care?

Economic Issues

- 1) Cost Conditions – Economies of Scale versus Economies of Scope
- 2) No coordination of health care services
- 3) Entry of Private Firms - accommodated or blockaded
- 4) Two Tier and Multiple Tier Health Care
- 5) Is Health Care like Education?

1) Cost Conditions

- The efficient market structure of the health care industry depends on two cost concepts.

1) Economies of scale. That is the cost savings, if any, from large scale production. What is the minimum efficient scale for hip replacements?

2) Economies of scope. That is the cost savings, if any, from providing more than one health care service. Is it cheaper to provide two types of surgery in the same clinic or hospital.

- Very little empirical work has been done in this area.

2) No coordination of health care services

- Present system features a number of independent providers of health care.
- Care can be provided by
  - Physicians
  - Nurses
  - Physiotherapists
  - Drug therapy
  - Chiropractors.
- No coordination to achieve least costly and effective form of care.

3) Entry of Private Firms

- The likely success of introducing a larger role for the private sector depends on whether entry is accommodated or blockaded.
- For example, suppose a private clinic (under contract) with the government plans on expanding the number of hip replacements.
- Where will the medical personnel come from?
- Medical school and nursing school enrollments must be increased to accommodate the entry.

4) Two Tier Health Care

- Two Tier Health Care –

  If consumers believe there is a substantial variation in quality among health care providers, and wealthier people are willing to pay more for health care, a two tier (or multiple) system of health care is difficult to avoid.
- Why? Regardless of the how high the quality is in the public sector, there is a still a market for even higher quality health care.

5) Is Health Care like Education?

- Primary and Secondary education features a variety of public schools and private schools
- Differences in Variety (for example, religious based schools), or differences in quality (higher quality instruction).
- The former features a coexistence of public and private schools, the latter, two tier education system.

Conclusion

- If an expanded role for the private sector is to have a chance of succeeding politically – the universality component will have to stay.
- How might the Private Sector role be expanded politically?
- - Either by left of centre governments faced with a budget crunch, or
- - Governments with “federal immunity”, through experimentation and gradual introduction