



THE BENEFITS OF ALLOWING BUSINESS BACK INTO CANADIAN HEALTH CARE



BRETT J. SKINNER

AIMS Health Care Reform
Background Paper #11

December 2002

Atlantic Institute for Market Studies

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EXECUTIVE SUMMARY

Canadians want a health care system that provides high-quality medical services and is financially sustainable at an acceptable economic price, without excluding less affluent people from access to medically necessary services. In their typically pragmatic way, Canadians are not worried about whether it is the private sector or the public sector that achieves this goal; they just want results. But when Canadians do express a preference for either private or public approaches to health reform, the majority is willing to fund many of their future medical needs themselves rather than pay higher taxes to expand the public model of health care.

A review of the direction of health policy reforms in the rest of the world indicates that Canadians are not alone in preferring such pragmatic approaches to health policy reform. There is an emerging set of values influencing international approaches to health care that is producing a growing similarity between national health systems. The consensus that is emerging is primarily concerned with the following: ensuring universal access to a defined package of medically necessary services; maximizing consumer choice; controlling cost pressures on public budgets; and satisfying consumer demands for timely access to high-quality health care services.

There is a wide scope for competition and private sector involvement in the arrangement and provision of health care under this emerging set of public values. Health policy research identifies a number of benefits that would result from private, for-profit provision of medically necessary services and health insurance. These advantages include reduced waiting times and queuing for services, increased consumer choice, rationalized demand for medical services, reduced cost pressures on government budgets, better overall quality of medical care, and the elimination of the conflict of interest which occurs when governments regulate the services they provide.

There are also criticisms of an expanded role for the private sector in health care. Yet, for every criticism there is an answer somewhere between a pure free market in health care and the government monopoly health system we now have under medicare. Specifically, a well-regulated private competitive market in health insurance and medical services could ensure that everyone has access to medically necessary services while still allowing Canadians the advantages of consumer empowerment and competition among health care insurers and providers.

SECTION 1

INTRODUCTION

Between the years 2000 and 2002, Canadians saw the publication of no fewer than five major government reports on health care. Known by the name of their respective chairpersons, Quebec's Commission d'étude sur les services de santé et les services sociaux (Clair 2000), Saskatchewan's Commission on Medicare (Fyke 2001), Alberta's Premier's Advisory Council on Health (Mazankowski 2001), the Standing Senate Committee on Social Affairs, Science and Technology (Kirby 2001) and the federally sponsored Commission on the Future of Health Care in Canada chaired by former Saskatchewan premier Roy Romanow, have all done extensive research on the current and future states of health care in Canada. As of the writing of this paper, the Romanow commission has yet to release a final report, but has released an interim report (Romanow 2002) that signals its probable conclusions.

Each report recognizes that medicare is not working, but the authors' conclusions and recommendations differ. According to the Clair, Fyke, Mazankowski and Kirby reports, the medicare model is not financially sustainable over the long-term.¹ For Romanow, the medicare model is still a viable policy approach, but the policy is seen to be politically non-sustainable without major new public commitments to counter the financial and other challenges facing Canadian health care.

This paper is part of the research for the Atlantic Institute for Market Studies' (AIMS) own health policy study (Crowley et al. 2002), which similarly concludes that medicare is not financially sustainable under its current structure.

While a consensus has apparently developed among researchers and decision makers that health policy in Canada must undergo serious reforms in order to provide Canadians with a workable solution to the problems faced under medicare, questions remain regarding implementation.

¹ In spite of this observation, Kirby is still recommending a policy of expanding the scope of medicare coverage to include pharmaceuticals and long-term care and proposing income-adjusted premiums to cover the future costs of this larger version of medicare.



SECTION 2

WHAT TYPES OF REFORM DO CANADIANS WANT?

According to a recent poll entitled *The National Pulse on Health Strategy*, 80 per cent of Canadians want major reforms to the health care system. Additionally, “two-thirds of Canadians (66 per cent) tend to be supportive, more or less, of a host of new models of financing in order to reduce stress on the system – for example, where everyone (except those with low incomes) pays a small amount for health care services out of their own pocket. Just under half (45 per cent) tend to be supportive of market-oriented reforms – greater efficiency, accountability and customer service, including private sector companies delivering health care services” (Environics 2002). The *National Post* reported that the same poll found that fewer than half of respondents would support increasing taxes to pay for health reforms (Arnold 2002). However, only 10 per cent of Canadians would accept a health care system that excludes those who cannot afford to pay for services (Environics 2002).

These results need not be seen as a contradiction. As Jane Armstrong, senior vice president of Envionics Research Group says, “Canadians, ever-constant champions of fair play and equity, are devoted to maintaining a system that ensures access to quality health care for all... They’re willing to make changes, even if this includes new and varied ways of financing the system as well as a greater dependence on market forces such as private companies delivering certain health services” (Envionics 2002).

Even more recently, a Decima Research poll found that more than half (55 per cent) of Canadians were opposed to paying higher personal income taxes even if these funds were designated to pay for health care. An even larger majority of respondents (67 per cent) also believed that they would have to rely on their own personal savings to pay to use health services in the future (Lawlor 2002).

A POLLARA poll taken between March and April of 2002 (POLLARA 2002) found that 58 per cent of the public agrees with the statement that their confidence in the health care system is falling while only four per cent say it is rising. The percentages of doctors and nurses surveyed who said that their confidence in medicare was falling were 65 per cent and 68 per cent respectively.

The same poll found that 66 per cent of the public, 74 per cent of doctors and 73 per cent of nurses believe the health system needs “a complete rebuilding” or “major repairs.” Only 43 per cent of respondents were either “very” or “somewhat” satisfied with the timeliness of access to health care services.

Importantly, 76 per cent of respondents believed that any solution to fix health care sustainability would require more money either through taxes or out-of-pocket payments by consumers; 56 per cent were willing to pay more to maintain the current level of health care; and 69 per cent were willing to pay more to increase the range of services or improve the timeliness of care. But when asked specifically about how they would prefer to pay for future health care costs, 70 per cent of respondents were opposed to using taxes to cover future expenses: 37 per cent favoured out-of-pocket payments or private insurance while 33 per cent favoured budget reallocations from existing tax revenues.

What these public opinion polls indicate is that Canadians want a system of health care that provides high quality medical services and is financially sustainable over the long-term at an acceptable economic price, without excluding poorer people from a core package of medically necessary services. And in a typically pragmatic way, Canadians are not worried whether it is the private sector or the public sector that achieves this goal; they just want results. In fact, when Canadians do express a preference for either private or public approaches to health reform, the majority of them are willing to fund their future medical needs themselves rather than pay higher taxes to expand the medicare model of health care.



SECTION 3

BEYOND IDEOLOGY: TOWARD A SUSTAINABLE HEALTH CARE SYSTEM

Comparative analyses of public policy changes among the health care systems of advanced industrial democratic societies indicate that Canadians do not have a monopoly on pragmatic approaches to health policy reform. A new paradigm or way of thinking characterizes public opinion across many countries, one that transcends old ideological labels and divisions. The old paradigm classified health care systems across a spectrum that ranged from “private” or “market” approaches to “public” or “welfare-state” models. The American health care system was normally associated with the market model and the UK’s National Health System (NHS) was seen as an example of the welfare-state model. Yet this distinction is ideological and is not supported by empirical observation of the realities in either health system. No pure system of either the market or welfare-state models has ever existed anywhere among modern industrialized democracies (Chernichovsky 1995).

In the US, for instance, public funds account for around 44 per cent of all health care spending, according to the Centre for International Statistics (1998). The American health sector is characterized by a mix of Canadian-style health insurance systems targeted at the old (Medicare), the poor (Medicaid) and war veterans (public veterans’ hospitals) as well as a heavily regulated private health insurance market that is seriously distorted by perverse incentives built into the US tax code (Henderson 2002). Similarly, the UK system allows a parallel private, for-profit system of health provision and health insurance to operate alongside the NHS (Ramsay 2001). So, while both systems have clear orientations toward one model or the other, both, in reality, have mixed models that attempt to address the multitude of values that each society has regarding health care.

Chernichovsky (1995) identifies an emerging set of values that is influencing international approaches to health policy reform. The result is a convergence among health system designs. The public and policy makers in Western societies are becoming dissatisfied with both market-oriented and welfare state models. Most importantly, this dissatisfaction is not directed at the philosophical ideals of the systems themselves, but at particular aspects or practical outcomes that are undesirable. The consensus that is emerging is concerned with ensuring universal access to a core package of medically necessary services while maximizing consumer choice; controlling cost pressures on public budgets; and satisfying consumer demands for timely access to high quality health care services.

There is a wide scope for consumer empowerment, competition and private sector involvement in the arrangement and provision of health care under this new paradigm. The state ultimately has the responsibility for orderly provision of care and secures an environment that safeguards the viability of institutions and providers from market imperfections while also promoting systemic efficiency, assuring quality and protecting minimum universal access. More specifically, the state remains responsible for:

- Setting health policy;
- Instituting and regulating standards;
- Collecting and disseminating information;
- Promoting competition and consumer choice by regulating monopolies and monopsonies;
- Regulating contracts, fees and reimbursement schedules;
- Supporting research and training for health professionals;
- Funding society-wide measures to deal with epidemics and disasters; and
- Regulating universal access to a defined package of health care.

Essentially, a functioning market in health care, regulated by the state to achieve certain minimum societal goals, increasingly characterizes the direction of health policy in advanced industrial democratic societies. This trend is confirmed throughout the literature on comparative studies of health systems (Eriksson et al. 2002; Musgrove 1996). If these trends are correct, people appear to be more concerned with maximizing personal benefits for everyone in a cooperative way rather than zealously and coercively pursuing some utopian ideological goal to everyone's net detriment.² The public seems to believe that there are aspects of both welfare-state models and market-oriented models that are beneficial.

However, it is important to note that some of the beneficial aspects of welfare-state approaches, like the pooling of health insurance risk across the entire population and providing affordability for the poor, can just as easily be accomplished in a regulated market as they can be under a medicare-style approach, thus minimizing counter-productive state intervention. But there are two motivations that drive resistance to these common sense approaches to health policy: an insistence on egalitarian outcomes and a moral aversion to profit making in the health care industry. Both of these dogmas rule out any role for the private sector in health insurance or in health services. Yet opinion polls in Canada and the international literature on health reform indicate that these ideological requirements for medicare are increasingly out of step with public attitudes.

Furthermore, if these idealistic prerequisites are not applied to other areas of government activity, why should they be applied to health care? As some researchers have observed, "if we choose to accept that inequalities in the quality of housing, diet, or education available are appropriate (i.e. that social justice requires provision of a 'minimal' standard, but allows 'Cadillacs and steaks' for the more affluent), how can the case for a universal one-tier medical care system be maintained...?" (Mhatre and Deber 1998: 466).

² Incidentally this may approximate what economists refer to as a Pareto ethical ideal.



It is also apparent that the social egalitarian goals of medicare are impossibly utopian anyway. In a presentation before the Romanow commission in 2002, former health minister for the government of Quebec, Claude Forget, stated that governments cannot cope with their current responsibilities, let alone new programs. Forget explained that when basic principles are contradicted by day-to-day realities, the public's confidence in the system wanes. He argued that our current definition of comprehensiveness emerged for historical reasons that are no longer relevant today, and that it is irresponsible to make comprehensiveness an objective for the future. The Canadian system, Forget stressed, is not and never was comprehensive; thus maintaining that it is simply sows the seeds of confusion. Forget suggested that we do three things: 1) face the reality that we cannot embrace comprehensiveness any better tomorrow than we can today and renounce the principle; 2) accept that transparency is essential and revenue must determine expenditure, not vice versa; and 3) cover only needed services (Romanow 2002; Forget 2002).

In an interview, Forget later added that, "regular doctor visits and everyday primary hospital care can be handled more efficiently through affordable private insurance programs" (Sokoloff 2002).

Furthermore, it is clear that medicare was never intended to operate according to egalitarian goals. Quebec's Clair Commission report has noted that:

"The notion underlying our health and social services system is that there should be public insurance to protect against the serious risks related to illness, that is, mainly "curing" and "caring." When the system was first established, the aim was to provide every person with access to hospital services, and later to medical services, regardless of ability to pay. This is why the two primary pillars of the current system were called "hospital insurance" and "health insurance."

In Québec as elsewhere, needs have gradually evolved and a wide range of other health and social services are now paid for by the state. Some are governed by specific laws, for example the services provided for under the *Youth Protection Act*, and others are complementary programs administered by the RAMQ. Still others are covered, in principle, by the general budgets of institutions pursuant to the *Act respecting health services and social services*, but they are not precisely defined.

Over the years, the concept of "public insurance" has gradually been supplanted by the idea of "individual right to service," and with it the idea of a well-defined basket of "insured" services has also disappeared. It is not surprising that in Québec, as elsewhere in Canada, there is no longer anyone who can say for sure, without consulting a lawyer, exactly what services are really insured, within what time period, by whom and in what circumstances they must be produced. Nor can anyone say, without consulting an accountant, how much the various categories or units of services cost or what criteria are used to decide which services are insured and which are not, let alone where the money

comes from and where it goes. The *Canada Health Act*, which was passed in 1984, enshrined the five principles of universality, accessibility, comprehensiveness, portability and public administration, principles that no one seriously challenges. These principles are still socially legitimate, though they now need to be modernized. Interpreting these principles according to the prevailing reality of yesteryear only creates inconsistencies, making it difficult to see the logic of the system” (Clair 2000: 128).

Therefore, it seems that if policy makers become willing to abandon the ideological requirement for egalitarian outcomes in health care and an aversion to earning profits for the provision of medical care, then many practical policy solutions become available for consideration that combine the best elements of the market and the social ideals of welfare-state models. This would not mean that everyone would necessarily benefit equally from reforms, but it does mean that there could be absolute gains for everyone.



SECTION 4

OTHER COUNTRIES' PRIVATE, FOR-PROFIT MEDICAL SERVICES AND HEALTH INSURANCE

Allowing business back into Canadian health care is not actually a very radical idea. Canada is almost alone among advanced industrial democratic states in its attempt to limit or prohibit private for-profit health insurance and medical services. The literature on health policy contains many references to the health systems of other countries that demonstrate the degree to which market approaches to health care are accepted outside Canada. Market approaches are increasingly popular even in countries that medicare's proponents point to as models for the Canadian health care system.

For example, Sweden has introduced a number of market-style elements into its national health care system. These include competition between hospitals and the introduction of purchaser-provider splits (Irvine, Hjertqvist and Gratzner 2002); consumer co-payments for physician services and co-insurance for pharmaceuticals and dental care (Robinson 2002); and parallel private for-profit medical services and hospitals (Ovretveit 2001).

In addition to Sweden, other advanced industrial democracies like Australia, Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Israel, Italy, Luxembourg, Netherlands, New Zealand, Portugal, Spain, Switzerland, the UK and the US, all allow parallel private for-profit delivery of health services to operate alongside publicly funded systems; and consumer co-payments through deductibles, user charges and/or co-insurance for publicly funded health insurance (Scott 2001; Robinson 2002; Irvine, Hjertqvist and Gratzner 2002).

In fact, even the states of the former Soviet Union include user charges for access to health services, some dating back to the Soviet period (Robinson 2002). Clearly, many governments around the world acknowledge the beneficial economics of market approaches to health care. Why should Canadians expect less from their governments?

SECTION 5

WHY CANADA SHOULD ALLOW PRIVATE, FOR-PROFIT MEDICAL SERVICES AND HEALTH INSURANCE

Private health care systems comprise two essential elements. The first element is a private competitive market of health insurance to finance health care costs. The second element is a private competitive market for the provision of health services such as hospitals and clinics. Governments have the option to allow neither, both or various degrees of either one.

How could ending the prohibition on private, for-profit comprehensive provision of medically necessary services and health insurance make the health care system sustainable? The literature identifies a number of expected benefits (Maynard and Dixon, 2002; Musgrove 1996; Deber et al. 1998; Chollet and Lewis 1997; Osborne and Gaebler 1993). Depending on the particular design of the health care system and on the degree of privatization allowed, some of the potential benefits include:

- Reducing or eliminating the shortages and rationing that occur in the form of waiting times or queues under publicly financed care;
- Allowing unsatisfied consumer demand for health services to be met;
- Allowing consumer choice of insurer, coverage, and provider;
- Rationalizing and economizing demand for health care by making consumers aware of and responsible for the costs of the health services they use;
- Increased access to the most advanced medical care available through greater capitalization, which produces modernization, improved quality and increased quantity of medical facilities and equipment;
- Controlling the relative growth in costs; increasing the general quality of care; and encouraging innovation through price and quality competition;
- Private sector innovation and efficiency that can have contagious or spill-over effects and catalyze reform in the public sector;
- Reduced burdens on the public treasury, meaning more public funds become available to target assistance for the poor;
- “Trickle down” effects for the needy by having wealthier consumers subsidize capital investments through their demand for the highest-quality care;



- Less strain on or “crowding-out” of other government priorities in public budgets;
- More attractive retention and recruitment incentives for health professionals from improved income opportunities and working conditions;
- Tax savings and;
- General economic growth from lower taxes, a new health care market and an expanding, innovative health care industry.

SECTION 6

EVALUATING THE CRITICISMS OF PRIVATE SECTOR MEDICAL SERVICES AND HEALTH INSURANCE

In spite of the significant potential of the private sector to improve Canadian health care, the health policy literature also identifies a number of arguments against an increased role for private health insurance or delivery of medical services (Maynard and Dixon, 2002; Musgrove 1996; Deber et al. 1998; Evans 2002a, 2002b; Wilson 2000; Boychuk 2002; Guyatt et al. 2002; Deber and Swan 1999). Some of these criticisms have partial foundation in health economics and others are demonstrably false. It is therefore important to acknowledge the limitations of markets while, at the same time, correcting some of the mistaken arguments against them. In the process, policy makers may be able to select those elements of market approaches to health care that complement a new limited set of sustainable social goals for health care.

A Functioning Market and Social Goals

One of the main arguments in favor of the medicare style of government monopoly for health insurance is that private health insurance has a tendency to encourage risk selection or “cream-skimming” by insurance firms. This problem arises because some people may be unattractive or uninsurable risks due to pre-existing, serious or chronic conditions that may make insurance coverage of these people unprofitable. Insurers have a natural financial incentive to avoid insuring risky individuals in order to keep premium levels competitive for the vast majority of the market that is healthy. It can become profitable for insurers to extend coverage to high-risk clients if they are permitted to adjust premium charges to cover this risk; however, doing so inevitably makes insurance coverage unaffordable for those who need it most.

Yet this criticism applies only to a non-regulated private market in health insurance.³ The literature acknowledges that a regulated market for health insurance could theoretically accomplish the same universal coverage as a government monopoly like medicare (Evans 2002a; Maynard and Dixon 2002). In

³It is theoretically possible for a non-regulated market to overcome some of these difficulties. Charitable and *pro bono* care has historically filled the gap where the market finds it unprofitable to extend coverage for health services. However, a regulated market creates a legally enforceable social guarantee of access to health services that would not exist under a non-regulated market.



fact, proper regulation could borrow some of the advantageous aspects of tax-financed health systems in order to overcome problems that occur with health insurance markets, while still capturing the benefits of competition between insurers.

For instance, tax-financed systems like medicare are able to avoid the problems of adverse selection because participation is mandatory (no one can escape taxes) and there is no market segmentation, risk selection or 'cream-skimming' because risk is pooled across the entire population and there is only one insurance option under a monopoly. High risk consumers need not be excluded from the pool for the system to remain financially solvent, because the increased costs from covering their claims for health insurance can be covered by raising taxes without fear that low-risk consumers will leave the pool for less expensive insurers.

But health insurance could just as easily be financed through a system of premiums that would avoid adverse selection, risk selection and market segmentation. One of these is called a community rated premium. This is basically an equal dollar amount charged to everyone in the pool to cover the average costs of claims per person. Alternatively, group rating adjusts the premium to cover the average cost of claims associated with the age-gender category of each applicant, but everyone within the group still pays the same premium. If either of these types of premiums were mandated by regulation for a private health insurance market, then insurers would not be able to exclude segments of the population through price discrimination. Profits could only be earned through competition on administrative cost efficiencies, quality of service or comprehensiveness of coverage. In order to ensure the effectiveness of this policy, governments would have to replace the tax-funded public system of health insurance with a similar premium-financed system in parallel competition with the market. Otherwise, many people would have an incentive to take a free ride on the tax-financed system (Blomqvist 1979).

The law could require insurers to accept every applicant in order to prevent risk selection and cream skimming. In addition, legislators could also make the purchase of health insurance mandatory, thus avoiding the adverse selection that results when consumers wait until they are sick to purchase insurance. If consumers were allowed to wait, they would make it unprofitable for insurers to extend coverage to all applicants. This principle is not dissimilar to mandatory automobile insurance.

As they do in other industries, governments would regulate against monopolies to ensure competition among insurers. Governments could also ensure that low-income people could afford such premiums by subsidizing these individuals. (Musgrove 1996) The net result could be universal coverage, a competitive market, greater consumer choice and reduced government expenditures and taxes.

Efficiency and Quality Concerns

Another argument in favour of medicare is that private health insurance and private delivery of medical services tends to be more costly than public approaches because of the need to generate profits, greater overhead for advertising and marketing, more complicated claims adjusting and record keeping, and less purchasing power, (or the loss of large-scale monopsony buying power). Critics argue that these costs are lower under tax-financed public systems of health insurance and medical care. Attached to this argument is the idea that medicare is better able to control costs than market competition.

But the literature confirms that private hospitals are more efficient than public hospitals. Ferguson (2002a) cites a number of sources to show that, while on the whole, the literature shows no differences in efficiencies between for-profit and not-for-profit hospitals, it is clear that private hospitals (either for-profit or not-for-profit) are more efficient than public hospitals. And even though the literature is evenly divided over the efficiencies of for-profit and not-for-profit private hospitals, there are still many important studies that show private for-profit hospitals to be more efficient than either public or private not-for-profits. And when regulated private competitive markets for health insurance are compared to state monopoly health insurance systems like medicare, the conclusion is that the regulated market model generates similar – in some cases lower – rates of growth in health spending (Thorpe 1993).

Moreover, government health care monopolies have their own unique costs. For instance, some studies show that non-health related workers at public hospitals are paid about four per cent more on average than those at private hospitals (Gratzer 1999). The available research seems to indicate that incentives for efficiency gained from a competitive market more than compensate for any unique extra costs in private health care.

In addition, the criticisms of private competitive markets for health insurance and medical services exclude consideration of equally important non-monetary costs associated with medicare such as reduced access because of longer waiting times or the rationing of services, and quality stagnation for facilities, equipment, and medical care (Walker and Esmail 2002a; Walker and Esmail 2002b; Ferguson 2002c). Once these non-monetary costs are included, it is clear that the extra “costs” associated with market systems of health care are actually better understood as higher levels of capital investment and consumer demand for superior quality care.

It is also notable that the international evidence contradicts the idea that allowing a private sector for health care will lead to greater inefficiencies. A prime example is the parallel system of private care and insurance in the UK, which has not made health care in that country more expensive. The UK's health expenditures, as a percentage of gross domestic product (GDP), are significantly lower than Canada's (Evans 2002a: 51). In fact, many of the countries that have parallel private systems mentioned earlier spend less of their GDP on total health care than Canada does and have much broader coverage, including dental care and drugs, than Canada does. They also have older populations, which means that their demands are proportionally higher than Canada's, and they still have less expensive systems overall.



Furthermore, the logic of suggesting that competition is bad for any industry runs counter to both experience and logic. As Bill Watson (2002) argued in an editorial published in the *Financial Post*, “If reducing the wasteful costs of competition is so important, why don’t we do it in all industries?” Common sense and experience dictate that government-enforced monopolies are less efficient than market competition.

And the logic of the critics even confirms their own belief in the superior efficiencies of private health care. For example, opponents of private health care often complain that a parallel private market will lead to a two-tier health care system in which the wealthy are able to purchase higher quality care or faster access to services. Yet, how could this be possible if the private sector is truly less efficient? If a private competitive market for health care really were less efficient, then it would produce the same (or worse) quality of care with the same (or worse) waiting times for services as medicare, but at a higher price. Higher prices may accompany some segments of the market but the extra expense may actually represent higher value for the consumer, not necessarily less efficient care. Clearly any evaluation of efficiency must encompass an appreciation of value for money, since efficiency relates both cost and benefit.⁴

Some opponents of a market for health services have even made the radical argument that a review of the literature shows that private health service facilities have a higher likelihood of producing mortalities among patients than publicly funded hospitals (Devereaux et al. 2002). The study that made this bold argument reached its conclusions through comparisons between US for-profit and not-for-profit hospital facilities.

But the study was based on highly suspect methodology and faulty logic. A closer analysis of the same studies reviewed in that paper reaches the opposite conclusion from that of the authors. To complete the analysis, the study selected only 14 peer-reviewed papers among 805 available studies. Of these 14, seven studies (including the largest study, covering 7.4 million patients) found no statistical differences in mortality rates between private for-profit and private not-for-profit hospitals; and another study (the second largest, covering 5.3 million patients) showed lower mortality rates at the for-profit facilities. Therefore, a majority of the peer-reviewed studies analyzed, including the two largest studies, had findings that contradicted the authors’ conclusions. There were also many problems with comparability in the data between hospitals and with the definition of private for-profit and not-for-profit hospitals. Dr. David Naylor, dean of the University of Toronto’s Faculty of Medicine, confirmed the problems with the methodology for this study (Gratzer and Seeman 2002).

The study also assumed that for-profit hospitals are constrained by the need to make profits (that is, earn returns for investors or shareholders) and have an incentive to cut corners or to rely on less well-trained personnel, leading to higher mortality rates. However, University of Guelph economist Brian

⁴One of the criticisms of the Canadian monopoly health care system is that no effort is made to evaluate efficiency because no one bothers to collect outcome information. See AIMS’ publications *Public Health, State Secret* (2002) and *Operating in the Dark* (1999).

Ferguson has reviewed the empirical evidence and concluded that private for-profits and private not-for-profits have indistinguishable behaviour in terms of “profit-making” and operate under similar incentive structures. So the motivation to profit, instead of to care for people, that the study suggests is the cause of higher mortality rates, is invalid. Both for-profits and not-for-profits share some form of the profit motive and therefore, could be subject to the same criticism (Ferguson 2002a).

Furthermore, a properly designed information collection and reporting system together with increased consumer choice in a private competitive market would crowd out poor performers. It is hard to make the case that people would go to institutions that had unexplained high mortality rates if a) the information were known and b) people had choice. However, Canadians do not have access to much information about such matters and may, in fact, be having poorly performing public hospitals foisted on them under medicare without being aware (Crowley, Zitner and Faraday-Smith 1999).

If governments took on the less intrusive role of setting standards and then holding all providers to those standards, health quality would be better assured than it is now. If the argument of the study is that US hospitals are not held to appropriate standards for health services by government, then they have to explain why that situation is worse than Canada’s. At the moment, Canada has few enforceable government standards and is highly secretive about both the standards that are applied and the performance of health care institutions (Zitner and Crowley 2002).

Labour Market Impacts

Opponents also argue that a parallel private health care system will draw away health personnel from the public sector, exacerbating existing human resource shortages because higher income opportunities and better working conditions in the private sector will inevitably create powerful incentives for doctors to abandon the public sector.

There is no doubt that this is exactly what would occur. In fact, it is already occurring as doctors and nurses leave Canada for the much more attractive compensation and working conditions offered in the American health care system (Skinner 2002a). But human resource shortages could only occur if the supply of physicians allowed to practise in Canada is held constant. If government did not place artificial restrictions on the number of medical graduates being trained in Canadian medical schools, the supply of physicians would rise to meet demand for their services and shortages would disappear (Ferguson 2002d). A new private market would also likely create a powerful incentive for Canadian trained doctors and nurses to return home from the US further adding to the supply of health human resources. Furthermore, a regulated market could require physicians to spend part of their time in public hospitals in exchange for public funding of medical education or as a condition of medical licensing.



Parallel Private-Public Supply

Some research doubts one of the benefits attributed to privatization, namely that a parallel private system will allow additional finances to be made available for public health care. This view argues that a parallel private system of health care will instead lead to a proportional net loss of subsidization for the public system (Tuohy et al. 2002).

The problem with this criticism is that the study that supports it is not designed to answer the questions it poses.⁵ The study purports to show that, in countries where a parallel private system of health care is introduced, the amount of public dollars committed to the public sector decreases. But this finding is what would be expected; the introduction of private health care is designed to reduce public expenditures. These findings simply confirm the policy decisions of governments to rein in public health care costs.

The fact that public sector spending decreases when a private sector is allowed to operate does not indicate that the proportional amount of spending available per user remaining in the system also decreases. The introduction of a parallel private system allows health consumers to be serviced in the private sector and reduces the number of people accessing publicly provided services, meaning fewer dollars are required to fund the public system. The decrease in public sector spending does not indicate that the proportions spent per user in the public system are less than before, or that the amounts spent per person on poor people has decreased.

In fact, spending on disadvantaged people might have increased. For example, if the data had shown that the proportion of public spending per person (among those remaining in the public system) had declined in absolute terms, it could be concluded that a parallel private system draws existing resources from the public system, thereby making some people worse off than they would have been under a strictly public system. Unfortunately, the study did not contain data on proportional changes in public sector per capita health care spending levels and, therefore, is inconclusive.

Sustainability of the Status Quo

Some have also criticized the need for private sector health reforms altogether. They argue that medicare is financially sustainable in its current design if more public money is allocated to maintain it and, on this basis, characterize efforts to introduce the private sector as unnecessary (Boychuk 2002; Guyatt et al. 2002). Some of these arguments also claim that there is little difference between covering escalating health costs through the tax system as opposed to private consumer payments. The consumer pays in both cases, according to this reasoning. Therefore, they argue that separating public costs and private costs is unimportant as only total costs matter (Romanow 2002).

⁵I would like to thank Dr. Brian Ferguson for pointing out the methodological problems with this study.

Yet these arguments stand in contradiction to the research compiled by the Clair, Fyke, Mazankowski and Kirby reports as well as other independent research published in Canada (Robson 2001; Skinner 2002b), which shows that medicare is not financially sustainable. Furthermore, the conclusion that more public funding will make medicare sustainable is based on a political willingness to raise taxes while the public opinion polls cited earlier indicate that Canadians are opposed to tax increases for medicare. Arguments in favor of tax increases also inevitably fail to consider the broader economic impact from such decisions. Increasing the tax burden on consumers or employers to pay for health care would further weaken Canadian economic competitiveness.

These arguments also assume no difference in efficiency between payment mechanisms. But data from the RAND Health Insurance Experiment (HIE) shows that consumers over-utilize health services when care is “free” at the point of service, without any increase in health benefits over those who had to pay out-of-pocket co-payments (Newhouse 1993).⁶

The argument, that there is no economic difference between using taxes to pay for medicare as opposed to private payments, is incorrect. The “vertical” progressiveness⁷ of tax financing is coupled with “horizontal equity” of the distribution of health care resources under medicare. This is not economically equivalent to the vertical progressiveness alone that would exist if a private health care sector were allowed to develop parallel to medicare (Evans 2002b). Under medicare, vertical progressiveness means that the more affluent pay more through progressive income taxes to fund health care, and horizontal equity means that the more affluent receive the same access to health services as those who pay less.

If a parallel private system of health service delivery were allowed to develop, the more affluent would still pay progressively more through income taxes to fund the public system, but would be allowed to purchase extra or faster services in the private sector, either out of pocket or through additional private insurance. The difference in the balance of costs, and value received for consumers under medicare versus a parallel private system, is significant and explains public resistance to increasing taxes to pay for health care reform.

If pent-up demands for health care are paid for through taxes, a larger proportion of resources is redistributed from the wealthy to the less affluent, without the wealthier receiving proportional compensation in terms of better service. Canadians who can afford to pay for their own health services directly (perhaps up to 80 per cent of the public) may be willing to pay more out of pocket to fund their own demands for health services because they will receive benefits proportional to the costs they incur.

Under tax financing, however, these same people will pay more to fund the health demands of others without receiving a proportional return relative to their increased costs. This inequity makes all the difference from the consumer’s point of view. Therefore, it is not accurate to say that only total costs mat-

⁶ Except in specific, limited cases for which targeted subsidies would be much more efficient.

⁷ Referred to as ‘vertical equity’ by Mossialos and Dixon (2002: 273).



ter and that it makes no difference to consumers whether health care is paid for privately or through taxes. Canadians will reject the idea that they should pay more for health care without receiving a proportional return in terms of better quality and access.

Interpreting the Research on Health Policy

Finally, many misconceptions and mischaracterizations plague the debate on expanding the role of the private sector in health care. For instance, the claim that private payment does not selectively discourage demand for unnecessary care but only affects the sick poor (Evans 2002b) or that user charges “primarily deter those with lower incomes” and therefore “improve access for those most able to pay” (Evans 2002a: 41). As the RAND HIE demonstrates, both of these ideas are demonstrably false (Newhouse 1993). The RAND study shows that consumer co-payments reduce demand for everyone, including the poor. In spite of this reduced demand, there are no adverse health effects from consumers sharing in the cost of health care. Those under the medicare-style plans are no healthier than those under the various co-payment plans in the study. The only exceptions are for a few specific conditions, and the study suggests that these conditions could be covered more efficiently through targeted subsidies than through universal tax-financed approaches to health insurance. Therefore, properly designed user fees or deductibles can selectively reduce unnecessary demands for health care.

Furthermore, it is only logical that if some people are deterred from seeking unnecessary care, access is increased for everyone else in the public system. This is a net social gain. In addition to improving waiting times by deterring unnecessary use of health care, a parallel private system, without restrictions on the number of health professionals and facilities, would allow the more affluent segments of society to seek care in the private system, thereby removing themselves from the public system altogether. Their absence would further decrease waits for services in the public system.

Another misconception is that premiums like Alberta’s are equivalent to poll taxes (Evans 2002b). This is false. Alberta’s health insurance premiums, similar in principle to those recommended by the Kirby report (2002), are adjusted to income and, therefore, are equivalent to a second, or parallel, progressive income tax. To be clear: if premiums are a flat percentage of income, they are equivalent to a proportional income tax; if they are applied as an equal total dollar amount based on average health costs (such as community rated premiums), they are equivalent to a poll tax. Making premiums gradually higher for those with lower incomes (an absurd suggestion) is equivalent to a regressive income tax; that is, the opposite of progressively raising tax rates for higher incomes is progressively lowering rates as incomes increase. Finally, if premiums are adjusted to individual or group health risk, they are equivalent to normal insurance premiums.

So what does this review and evaluation of the criticisms of private health care tell us? It demonstrates that there are limitations to what a private competitive market can accomplish in health care. But it also

makes clear that most of the major arguments against implementing such an approach are not based on sound economics, a fair analysis of existing empirical research, or any consideration that a regulated market can overcome limitations in private health care much more efficiently than medicare. If health policy makers were willing to move beyond a strict ideological insistence on egalitarian outcomes for the health care system, then the advantages of a regulated private competitive market for health insurance and medical services could be realized while still achieving basic social goals.



SECTION 6

CONCLUSION

Are there moral arguments in favor of allowing the private, for-profit provision of medically necessary services? There are many reasons why the medicare model of government monopoly in health insurance and medical services leads to moral and ethical failings.

Strict adherence to extreme egalitarianism leads to perverse moral outcomes like denying people access to services even though they have the means to procure these services more quickly or at a higher quality level. How can governments presume to deny people the right to preserve their own health or life if they have the means to provide for their own health needs? This moral view is implied in the Kirby report (2002) which mentions the likelihood that the courts will begin to side with Canadians who sue governments over the prohibition on seeking care privately that is not being provided publicly.

Some argue that these people can obtain these services in the US market. This argument is faulty because it proposes that the government monopoly medicare model is morally superior to the market approach, yet is at the same time reliant on the US market in health care to sustain its moral position. In addition, it proposes that Canadians should be forced to suffer the inconvenience of traveling to another country for these services. Finally, it makes the horrible economic suggestion that Canadians should spend their money in another country, essentially exporting a portion of our national wealth.

Another moral failing of the medicare approach is that the limits on public funding and the lack of support for tax increases among the public lead policy makers to look for cost controls within the system that can lead to adverse outcomes for health professionals. The virtual conscription of doctors recently under Quebec's bill 114 (Benady 2002) and the artificial suppression of the salaries of medical professionals (Skinner 2002a) is an indication of what lies ahead for health professionals working under medicare. The political nature of public health care ensures that continued cost pressures will be borne by those who work within the system. Inevitably, health professionals will be forced to do more with less.

A real obstacle to reform is the Canada Health Act (CHA), which under current interpretations remains a serious impediment to the introduction of a regulated, private, competitive market for health services alongside medicare. However, the language of the CHA might be vague enough to allow for new, more liberal interpretations of its provisions. In 1994, the Canadian Bar Association published its opinion that there are two valid interpretations to the CHA: one that prohibits a private role; and one that holds that the publicly financed health care system is only a means of ensuring a basic level of medically necessary health care services. According to this view, the CHA was not intended to prevent a parallel sys-

tem of privately funded health care as long as this parallel system does not undermine the public system. Private facilities providing insured services would be permissible, as long as there is reasonable access to public facilities (Deber et al. 1998). If this more liberal interpretation of the CHA is widely accepted or the CHA is amended to incorporate this view, policy makers would be able to consider a wider range of options than those currently available within the medicare model for health care.



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