THE FACTS

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Inside the Chaoulli ruling: Assessing the international evidence

What is the international evidence on private health insurance?

Many countries have a mixed public-private health care system, each with complex features and different regulatory frameworks. The majority judgment of the Supreme Court relied on evidence that mistakenly portrays Canada's private health insurance limits as unique among developed countries. The public-private distinction in health systems is commonly blurred, and while few countries explicitly ban private insurance for hospital and physician services, many arrive at the same end by different means.[1] Countries with social justice and equity goals spend considerable energy restricting the private insurance industry because it tends to increase costs and discriminate against already marginalized groups in society.

Private insurance entails "perverse incentives" to increase costs and undermine equality of access. In the UK, Australia and New Zealand, specialists are employed on a salaried basis in the public sector and a fee-for-service basis in the private sector. They have a financial incentive to maintain long waiting lists in their public practice to generate demand for private-pay services.[2]

Private insurance requires extensive regulation to counteract its ill effects. Dutch regulation of its substantial private insurance system is complex and far-reaching. Individuals cannot seek quicker care in the private sector. Providers are paid the same whether they work in the private or public sector. Treatment is provided in exclusively non-profit hospitals. Successive attempts by Dutch coalition governments to modify the tight regulatory framework while maintaining equal access safeguards have proven extremely difficult.[3]

In Australia, legislation prevents private insurers from avoiding risk by refusing to cover patients with pre-existing conditions or complex needs. The UK introduced measures to reserve time from specialists for work in the public sector. Sweden, Luxembourg, Greece and Italy prohibit doctors from practicing in both sectors at once.[4]

Patients recognize private insurance as a rip-off. Private health insurance became so unpopular in Australia that the federal government had to buttress the sector with massive corporate subsidies and penalties for citizens who refused to sign up. The government funds 30 per cent rebates for affluent Australians who purchase private coverage, coupled with a one per cent

penalty tax on medium and high-earners who fail to take out a policy. In 2000, the government upped the ante by allowing a premium surcharge on customers who did not join before a July 1 deadline.[5]

Private insurance restrictions are one of a number of policy options to protect public health care. Federal and provincial regulation in Canada has somewhat contained the growth of the for-profit health care industry, though several provinces are now more vigorously pushing privatization. Rather than prohibit private insurance, some provinces prohibit physicians from working both in the public sector and in the private sector.[6] Without being able to piggyback on the public system, private markets have limited room for expansion.

What is the international evidence on health care privatization?[7]

Private funding and for-profit delivery lengthen waiting lists. Countries with parallel private hospital systems have larger waiting lists and longer waiting times in the public system than countries with a single-payer system.[8] The same holds true when public and private systems co-exist within a country. A 1997 study by researchers from the University of Manitoba found that patients waited almost three times longer for cataract surgery if their doctors worked in both the public and private sectors.[9] Private health care exacerbates waiting list problems because:

- It attracts doctors and other health care providers, already in short supply, away from the public system.
- Doctors practicing in both systems have an incentive to boost their private practice by keeping waits long on the public side.
- Private clinics and hospitals tend to "cherry pick" patients who are healthier and younger. They cater to the "easier" non-emergency cases, leaving the more costly ones to the public system.[10]

For more research on the impact of privatization on waiting lists, see *Inside the Chaoulli ruling: Real solutions for shorter wait lists.*

Administration costs increase with privatization. In Britain, market-style reforms introduced by the Conservative government and continued by New Labour increased managerial and administrative staff levels across the NHS. Between 1997 and 2002, the number of senior managers increased by 59 per cent, compared with a 27 per cent increase in the NHS workforce.[11] Numbers of administrative and clerical staff rose by 18 per cent in the decade to 1991, while admin costs rose from 6 per cent of NHS spending to 11 per cent over the same period.[12]

Administration costs in the United States are over 31 per cent of health care spending compared to 16.7 per cent in Canada. Canada's Medicare program has overhead of 1.3 per cent; the overhead among private insurers is high world-wide: 13.2 per cent in Canada, 15.8 per cent in Australia, 20.4 per cent in Germany, and 11.7 per cent in the U.S. Underwriting and marketing account for two-thirds of the additional overhead costs.[13]

Public funding subsidizes corporate profits and executives' income. Between 1995 and 2003, labour costs dropped from 57 per cent to 46 per cent of NHS spending while the amount spent on goods and services from the private sector increased from 40 per cent to 52 per cent of spending.[14] US Health Maintenance Organizations' profits of $11.4 billion for 2004 were up 11 per cent over the year before. The previous year, HMO profits registered an 86 per cent gain.[15] The top executives running private plans averaged a salary of more than $15 million in 2002, not counting stock options.[16]

Competition brings more transaction costs. Contracting for services requires formulating precise specifications and standards, administering the contract, and monitoring compliance. The more purchasers are fragmented, the weaker is their bargaining power. In the United States, competition means duplicate claims-processing facilities and providers having to deal with multiple insurance products – all with different eligibility rules and approval requirements, billing and co-payment procedures, and referral networks.[17] A meticulous meta-analysis by P.J. Devereaux and colleagues found that payments for care in for-profit hospitals were 19 per cent higher than in not-for-profit hospitals.[18] Fragmentation also precludes global budgets for providers, one of the factors behind Canada's minimal overhead costs.

Private financing of health care infrastructure increases costs and undermines quality. Public-private partnerships in the UK and Australia, as in Canada, are fraught with problems of poor quality, inappropriate design, and dangerously inadequate standards of cleaning and other support services.[19] In the United Kingdom, the high costs of the first wave of Private Finance Initiative hospital schemes resulted in a 30 per cent reduction in beds and a 25 per cent reduction in budgets for clinical staff.[20]

For-profit facilities deliver a lower standard of care. Investor-owned nursing homes are more frequently cited for quality deficiencies and provide less nursing care,[21] and investor-owned hospices provide less care to the dying,[22] than non-profit facilities. For-profit hospitals and dialysis clinics have higher death rates.[23]

For-profit health care entrenches inequalities in health status and access to care. The Australian government's cuts to the public sector and incentives for private health care have led to severe inequalities for rural and Aboriginal citizens.[24] In the United States, where health care is more expensive and more heavily commercial than anywhere else in the world, 14 per cent of the population, 40 million people, have no health insurance.[25] Eighty per cent of the uninsured are workers.[26] The poorest Medicare beneficiaries spend half their income on medical costs, and unpaid medical bills cause 200,000 bankruptcies a year.[27] Visible minority Americans are at least twice as likely to be uninsured as whites.[28]

Recent research on Sweden shows that equity and social solidarity are being eroded by user fees, public sector rationing and other market-driven health care reforms. Following the expansion of

patient fees, people with lower-income, who have higher rates of chronic illness and disability, were found to delay or forego care more often than those who were financially better off. This was especially true for immigrants.[29]

For-profit health care undermines education of health care practitioners. Public hospitals are almost exclusively the training ground for medical, nursing and allied health professional students. By drawing experienced staff from the public system, the private sector is subsidized by the publicly funded education system and exacerbates training and health human resource problems.

Privatization is often imposed against the better judgment of local providers. In the UK, the Department of Health forced the Primary Care Trusts in Oxfordshire to establish a controversial private sector treatment centre for cataract treatment, despite the doctors' concerns that it would undermine the financial viability of Oxford's existing public eye hospital.[30] By the end of 2005, primary care providers will be obliged to offer patients at least one private hospital among referral choices. Irrespective of what doctors recommend or patients choose, ministers want at least 10 per cent of NHS elective operations carried out by the private sector in 2006, rising to 15 per cent by 2008.[31] This policy has been strongly criticized by the British Medical Association. London NHS managers working for Health Secretary John Reid studied the plans and found they are unaffordable and will undermine the viability of public NHS facilities.[32]

One in a series of six fact sheets on the Chaoulli Supreme Court ruling. Other titles in the series are: What the court did (and did not) say, Real solutions for shorter wait lists, Trade dangers of privatization, The role of drugs in rising health costs, and Taking action.

All can be found at cupe.ca.

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(1 July). The surcharge was an extra two per cent on premiums for each year a customer is aged above 30. This could mean a maximum additional cost of up to 70 per cent for someone aged 65 or over.

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